Alcoholic cirrhosis is the common "hob-nail," or gin-drinker's liver, generally small, hard, and granular; met with, clinically, very frequently in association with ascites. I think this association is, perhaps, too much insisted upon. Frerichs found ascites absent in one third of his cases. An advanced stage of this disease is quite compatible with apparent health, and the performance of the ordinary duties of life. Some years ago, I examined the body of a foreman engineer at one of our collieries, who had died suddenly of hæmatemesis from this cause. I was told that he had not lost a day's work for two years; and, in spite of being a hard drinker, was a much valued servant and a good workman. An eminent London physician of the last generation died suddenly in the same way at Bath railway station, whither he had gone on professional business.

Ascites is usually held to be simply a dropsical effusion dependent upon obstruction to the portal circulation in the liver. But it is sometimes distinctly associated with inflammatory action, and it is possible that this may play a more important part than is at present admitted. The known good effects of early and repeated tapping in getting rid of this inconvenient effusion are difficult to account for on the purely mechanical theory. On the other hand, this mechanical theory offers a ready explanation of the liability of the non-ascitic cases to die of hæmorrhage, as the main cause of their freedom from ascites is the great development of the collateral venous circulation, and especially the dilatation of the œsophageal veins.

Cardiac or cyanotic cirrhosis is caused by prolonged venous congestion, depending upon cardiac or pulmonary disease. The liver is, at first, enlarged, but may atrophy. It is usually hard, with a thickened capsule, and is of a dark colour. The liver-cells around the radicles of the hepatic vein, in the centres of the lobules, become destroyed, and are partly replaced by fibrous tissue. There is often slight jaundice, the liver is tender, the peritoneum contains fluid, and the nature of the case is explained by the state of the thoracic organs.

Biliary cirrhosis is best seen in cases where there is some permanent or protracted occlusion of the common duct, as by a calculus. A history of early jaundice is always the leading clinical feature. The liver is enlarged, but may undergo atrophy; its surface is smooth, its tissue deeply bile-stained, and traversed by fibrous bands. Charcot believes this form is specially characterised by the appearance, under the microscope, of numerous newly formed biliary canaliculi; but, as you see from the specimens exhibited this morning, this appearance is quite as well seen in the section of tubercular cirrhosis which I shall describe immediately.

Syphilitic Cirrhosis.—Frerichs says that constitutional syphilis may give rise to three forms of liver-disease: interstitial hepatitis, hepatitis gummosa, waxy disease. In the case of J. R., these three were combined. It is difficult to say how much of the interstitial hepatitis was due to alcohol, and how much to syphilis; but syphilitic hepatitis is a diffuse lesion, not growing around the lobules, but invading them. In the sections from the present case, you will observe that there appears to be a combination of these processes, the lobules being surrounded by the growth, but the areas of newly formed tissue are much more extensive than I have ever met with in alcoholic cirrhosis. The deep cicatrices and fissures are the effects of gummata which have healed, leaving these losses of substance. The waxy degeneration is not uniform, but occurs in patches.

Syphilitic hepatitis is most often met with in children, the subjects of congenital syphilis, but visceral syphilis is not common in Birmingham, and we often go a long time without meeting with a specimen on our *post mortem* table. I ought to mention that gummata in the liver, as a rule, give rise to no symptoms, and are therefore not diagnosed during life.

Tubercular cirrhosis occurs in phthisical subjects, without producing any symptoms. The liver is enlarged and smooth, of normal consistence; but, on section, its surface shows a meshwork of fibrous bands, running between the lobules. I described a case in a paper, published in the *Transactions of the Pathological Society* for 1878, and I now show you a section of the liver. I wish particularly to draw your attention to the great development of newly formed biliary canaliculi.

Malarial cirrhosis is the indurated and pigmented liver found in the subjects of chronic malarial poisoning. The organ is usually large and dark, tough on section, and, under the microscope, the new growth is seen in the portal canals, fissures, and spaces of the liver, from whence it penetrates the lobules (Hayem). The connective tissue is loaded with pigment. Jaundice is variably present. The condition is rarely met with in this country.

From time to time, you will have opportunities of seeing examples of most, if not all, of these types of cirrhosis, and of following out their clinical features in greater detail.

ILLUSTRATIONS OF EXCEPTIONAL SYMPTOMS AND EXAMPLES OF RARE FORMS OF DISEASE.

By JONATHAN HUTCHINSON, F.R.S., LL.D.,
Emeritus Professor of Surgery at the London Hospital.

[Continued from Page 1159.]

XII.—CASE OF ASPHYXIA OF EXTREMITIES (RAYNAUD'S DISEASE): PATIENT A HEALTHY YOUNG LADY: SOME FACTS AS TO INHERITANCE.

WITHIN a month of my having seen Miss B., another example of this condition, in almost exactly the same degree of severity, came under my notice, which seemed to discredit some of my conjectures as to possible causation. In this instance, the patient was a young lady (Miss W., aged 21), who had never suffered from any enfeebling illness, and in whom there was no proved inheritance of gout. It was known that her paternal grandfather had been much troubled by dying of his fingers, and that her father was so also, to a slight extent. Her father, who was still living, had a very slow pulse, not more than 40, but he was, otherwise, in good health. The grand-parent referred to had been robust, and had lived to nearly 90, but the condition had clearly been such as to attract attention. Whether the liability to gout was wholly absent, I cannot feel sure. Her mother knew nothing of it, but I had attended a sister of her's, an aunt of the patient, many years ago, for a severe form of acute tuberosum of the nose. This affection is very rare in women, and, probably, never occurs excepting when hereditary. In men, it is often a consequence of free living, in association with gout. I must not, however, lay too much stress on this, since it cannot be held to prove more than that there was, on both sides, a probable inheritance of feeble circulation.

Miss W. was, when I saw her, aged 21, well grown, rather stout, and, excepting that she was too pale, she appeared to be in excellent health. She was a student at Cambridge, and lived, in all respects, like other people. Yet her fingers were habitually as livid as those of a corpse. It was not a cold morning when she called on me, yet her finger-nails were quite blue. Her hands were dusky, the lividity disappearing by degrees, from the fingers upwards, and being replaced by a dull red. On the backs of the hands were many of the ill-defined, dull, crimson blotches, like the spots on plaice. Her fingers and hands generally were a little swollen, and were thus rendered stiff and awkward. Her nails were all slightly rough, and showed conspicuous white spots. On the back of her right hand and wrist were a number of little spots, all about the size of a split pea, which had only appeared during the last fortnight. They were all scaly, and were too uniform for common psoriasis. There were a few like them on the other hand.

It appeared that nothing peculiar had been observed in the state of Miss W.'s hands, until, at the age of fourteen, she went to a boarding-school at York. Here she suffered much from cold, and her hands began to be dusky. Before that, she had suffered much from chilblains, and had noticed that her hands would die if put into cold water. Since they had become livid, she had suffered much, in cold weather, from deep cracks in the fingers, near to the nails. I did not examine Miss W.'s feet, but was told that they were nearly in the same state as the hands, but not so bad.

Miss W. had observed that she was very easily heated by exercise, and readily took cold. Nothing, she said, helped the circulation in her hands so much as walking. It was far better than lawn-tennis, which often, although heating her, made her hands very blue. She was always most comfortable in hot weather, but found heated rooms oppressive. A muff kept her hands much warmer than gloves. Her pulse was soft and feeble, and did not count more than 64. It was more feeble at the right wrist than at the left. There were no signs of heart-disease, but very deliberate action.

Miss W. had several brothers and sisters, who showed no peculiarity of circulation; but it was feared that one sister, much younger, was going to develop a similar condition.

XIII. FEEBLE CIRCULATION AND FLUSHING: INHERITED GOUT AND CHILD-BEARING AS POSSIBLE CAUSES.

An interesting example of enfeebled circulation was offered in the case of Mrs. G., a lady aged 25, who had been married four years, and borne three children. She inherited gout, and also, as she said, feebleness of heart. Her chief reason for consulting me was a painful and very annoying tendency to flush. She was vivacious, and fond of society, and said that she was obliged to abstain from dining out on account of her tendency to flush up crimson on the slightest provocation, or without any cause whatever. She assured me that it occurred to such

an extent that every one noticed it. It was usually excited by some ridiculously inadequate emotion; a question being addressed to her, or the name of a friend being mentioned. With this tendency to flush scarlet over the whole face and ears, was associated extreme coldness of the extremities; her fingers became, as she described it, "like carrots," red and cold. Her feet were always chilly, but not so much so as her hands. I found her pulse very soft and compressible. She had never herself suffered from gout, and had never had chilblains. The symptoms of which she complained had been present, more or less, all her life, but had much increased of late. She loved warm weather, and never found it too hot.

(To be continued.)

A CASE OF EXCISION OF THYROID CYST.

Abstract of paper read before the Medico-Chirurgical Society of Nottingham.

By RUPERT C. CHICKEN, F.R.C.S. Eng., Nottingham.

I FIRST saw the case December 5th, 1884. The patient was a tall anæmic young woman, aged 29. The tumour was central, regular and elastic; the surface was smooth; it was very movable. It disappeared behind the left sterno-mastoid when the patient lay down; it moved with the thyroid cartilage freely on swallowing. On the following grounds, I recommended excision: 1, other methods were inefficient; 2, the growth was increasing; 3, it was an annoyance to the patient. I consider that these reasons are sufficient to justify excision.

The operation was performed on February 3rd, 1885. A central incision was made down to the fascia propria of the tumour; the cutting by knife was now done. A finger was inserted into the wound, and the tumour separated from the surrounding parts; whatever impeded enucleation was tied in two places and divided. The vessels were, in this way, easily recognised and secured. Every band that could not easily be broken was so treated until the tumour was free. The cyst was about the size of a Tangerine orange, and had a broad thick base, as thick as the thumb and forefinger combined. A strong double silk-ligature was passed through the middle of this, and the pedicle tied in two halves. The ends of all ligatures were left long; the wound was closed, and dressed with aseptic sponge. The patient lost perhaps a dessert-spoonful of blood. The smaller ligatures came away in a few days, but the two on the pedicle held firmly for eleven weeks, when chloroform was again given, and they were removed with a fine tenotomy-knife. The wound healed immediately, and has left only a very small scar. Up to the present date, there has been no bad symptom, either of the nervous system or in the wound itself.

REMARKS.—In the simple central hypertrophy of tumours of the thyroid body, excision is the most satisfactory treatment that can be adopted. All methods, no doubt, would bring forward their record of cures, but none are so clean and sure as the knife. Iodine, mercury, conium, setons and tapping are, at the best, tedious, dirty and irksome. The perchloride of iron, too, is especially apt to be followed by unpleasant results. Of electrolysis, I have had no experience in thyroid cases. These are the three objections to excision which we have to overcome.

1. The sentimental and unwarrantable condemnation of the operation by existing authors, mostly copied out of one book into another. They sanction the operation only as a means of snatching the life of a patient from imminent danger; for the relief of deformity—never.

2. The long-after results of the operation, where the gland has been completely removed; myxœdema, idiocy, etc.

3. The real practical anatomical difficulties. These are of two kinds, connected with the parts which must, and the parts which may inadvertently be, divided. I have never seen a case of simple hypertrophy or cystic disease where it would be necessary to remove the whole gland. If only a small bit of healthy gland can be left, there will probably remain as many of those mysterious ductless cysts as will suffice to carry on the occult functions of the organ, and thus prevent the occurrence of the unknown and unexplainable neurotic sequences, which often follow extirpation of the whole body.

The most troublesome tissues which must be divided are the numerous inosculating veins, which arrange themselves into plexuses in the superficial thyroid region; the thyroid arteries and veins; and the little thyroidea ima, sometimes swollen to large proportions.

The enlargement being central and the capsule of fascia being simply stretched and pushed between other organs, enables it to retain its power of mobility. There is no necessity, but danger, in using the

blade of the knife in separating the tumour or gland. The tissue around the thyroid is particularly loose and very easily broken down with the finger. The more mobile the gland is, the better are the prospects of excision. In separating the growth, an artery or vein even is easily recognised by the touch, tied, and divided between the ligatures. If this be properly and firmly done, hæmorrhage is only exceptionally possible. If the knife be not used, nothing can be cut: if the finger or blunt instrument be used with only moderate force, nothing of importance can be torn. But let this emphatically be borne in mind: that, after the first incision, nothing is to be cut until it has been first tied in two places. The pedicle may be ligatured in as many portions as is desirable.

By these means, the special dangers are reduced to a minimum, and there remain only the other things common to all surgical operations. I would draw attention specially to the after-dressing by a large soft sponge, kept thoroughly aseptic.

If the operation can be done—(as it is only too often done)—satisfactorily when the patient has been worn down with hard breathing and anxiety, his spirits depressed with suffering, how much more safely and satisfactorily ought it to be performed when the growth is small, and the patient in comparatively good spirits? The mass to be removed is smaller, the shock is less, the blood-vessels are smaller, and the anatomical relations of the growth are fewer and less important. If the prospects for the patient are better, so, also, is the operation for the surgeon; the connective tissue is softer and more easily broken down, and the small vessels are plainer to the touch than where there has been a long course of counterirritants and absorbents.

If the operation is easy for the surgeon, and of better hope for the patient, so, also, is the treatment more pleasant. What can be more disagreeable than doing a long term of penance with a seton in the neck, varied by occasional constitutional disturbances and constant discharge, or the unsavoury companionship of liniments, plasters, and ointments?

A CASE OF MYXŒDEMA.

By C. E. ABBOTT, M.R.C.S.,

Medical Officer of Health, Brintree Rural District.

Read before the Essex District of the East Anglian Branch.

MRS. C., aged 42, the wife of a working man, consulted me first on August 20th, 1882, for general weakness, numbness, unsteadiness in walking, etc.

Previous History.—Her father was alive, aged 78; her mother died four years ago from fits; she has three brothers and three sisters, all alive and well except one sister, who suffers from "womb affection."

Illnesses.—There are no signs or history of syphilis, or of intemperance. About thirteen years ago she had small-pox, and since then, she states, she has never felt well. She had "fever" when she was 6; this left some disease of the bones of the forearms and hand; cicatrices remain on both forearms and hand. There is no history of any previous mental disturbance. About ten years ago, considerable mental strain was caused by her eldest son, who suffered from chorea, and after this caused much anxiety; and at this time there was other illness in the family. The patient states that this trouble affected her, and she expresses herself as being broken-hearted. Some weight is to be attached to this statement, from the fact that one of the assigned causes of this disease is anxiety and domestic worry (Dr. Ord). The patient went to live at Stratford about nine years ago, but returned to her native place on account of the change not suiting her. She has been engaged in the usual domestic duties since marriage.

The catamenia began at 13, and have since been regular, but somewhat profuse; there has been the usual cessation during pregnancy, and much "loss" after the birth of each child.

She has been married fifteen years, and has had eight children, five boys and three girls, and two miscarriages (first miscarriage after fourth child, and second next pregnancy). Instrumental delivery was required in five labours. The youngest child is seven years old; three children died; the causes of death being convulsions, injury at birth, and teething. The patient has suckled all her children. It would seem that the youngest child was born about the time the present illness began. The patient is not able to state the part of the body in which œdema first occurred.

Her physiognomy is peculiar; the features are expressionless, the lips large and pendulous, and the connective tissue round the eyes is puffy, but does not pit on pressure. The face is pale and "waxy"; on each cheek there is a red blush. The lips are red. The fauces and uvula are translucent from œdema. The tongue is much larger than normal. Speech is characteristic; it is somewhat slower