thought, her lungs, because of her increasing cough and because she had a certain amount of physical signs.

And now I will read you an account of the *post mortem* examination thirty hours after death. The diaphragm was greatly arched; the spleen more under the chest-walls than it was felt to be during life; the lower end covered by the transverse arch of the colon, which is distended with flatus; the costo-colic ligament was very broad. The liver lay very obliquely, so that the left lobe extended very little beyond the middle line; the body felt in the right lumbar region was part of the right lobe of the liver itself, lying vertically, and extending much below and in front of the kidney, so that it would not have been possible to feel the latter; the intestines and peritoneum were redder than natural. Both lungs were studied throughout with grey granulations; there were evidences of recent pneumonia, and much muco-purulent matter in the bronchial tubes. The kidneys were healthy. The spleen weighed 17 ozs.; it was 8½ ins. in length, and 4½ ins. in breadth; the trabeculae were more visible than they should be; the Malpighian bodies less so; the tissue generally was much firmer and tougher than natural. The liver was not enlarged, but its cut surface was granular, the margin of the granules being very vascular, the granules pale and soft. The spleen lay high under the ribs, for the diaphragm was greatly arched after death, because the patient died at the termination of an expiration. This is a point not always sufficiently thought of in considering the *post mortem* position of organs. The patient dies at the termination of the deepest expiration he ever made in his life, and the diaphragm is greatly arched in consequence, and the organs lie higher up under the ribs than they were felt to do during life. There was scarcely any fluid in the abdominal cavity. I mentioned to you the possibility of a certain amount of fluctuation being caused by a distended colon containing fluid. The condition of her lungs was sufficient to enable us to say what was the cause of death. The spleen presented the characters that we commonly find in those which have been the subject of chronic congestion and of the changes consequent on congestion. It is possible, very possible, that her living in the neighbourhood of a marsh may have had something to do with the spleen disease. The white patch on the anterior margin of the spleen was at the spot where it had rubbed up and down during respiration. We felt it to do so, and as it pressed against the chest it led to thickening of the capsule. The microscopic characters were just those of a spleen that had been long congested, containing a large number of fibro-plastic corpuscles in the process of development into tissue. It was as if the cellular tissue of the organ were becoming much increased in quantity.

Those are the principal points in connection with this case. I should mention to you the case of the boy who was lately in the hospital, and who died of pericarditis. We found that his spleen contained a considerable excess of blood. It was much enlarged, but never descended below the margin of the thorax. But, in addition to the congestion, which was probably due to the state of her heart, we found two spots on the spleen, of which I should like to read you an account.

"There were two crimson spots at the surface of the spleen. One was about an eighth of an inch in breadth, and a quarter of an inch in depth, extending into the substance of the spleen, the broadest part being at the surface. The other was somewhat larger, somewhat paler; and the tissue around was very dark. They were both wedge-shaped, both almost structureless and granular. The one looked like a recent clot of blood of that peculiar form; and the other was a little puckered at the surface, and the tissue around rather congested."

Now, these spots were the result of the circulation in the blood of minute particles of fibrine; in fact, they were due to embolism, and to coagulation of blood around the particle of fibrine, which was exceedingly small; and, being arrested here, blood accumulated in the vessels around, and was extravasated. These spots are not uncommon in the disease from which this boy suffered—acute rheumatism, with endocarditis; and in these plates you will see representations of the same thing in the kidney. Particles of fibrine are carried from the valves of the heart, are arrested in the capillary circulation of the liver or kidney, and so give rise to these wedge-shaped fibrinous-looking masses. Rayer termed the condition "rheumatic nephritis". We might just as well term the condition in the spleen "rheumatic splenitis". Rokitsky has termed it "capillary phlebitis"; but now there is no question that these wedged-shaped masses are due to embolism.

I should have mentioned to you that, in cases of acute tuberculosis, the spleen is enlarged; and in children it is often at the same time the seat of a deposit of tubercle, but in the adult it is the exception to find tubercle in the spleen. You know that the organs are most prone to deposit of tubercle which are in a state of active work; and you know in what an active condition in the child are the spleen, lymphatic glands, and Peyer's patches, all of which are then especially liable to deposit of tubercle in early life.

Cancer of the spleen is exceedingly rare; you would think first of

everything else. But it is the seat, now and then, of a deposit of cancer, which assumes usually the nodular form; but it is very rare, and I have never seen it, except in conjunction with deposits in other organs. There was a woman in the hospital lately whom I suppose to have cancer of the spleen. You all saw her. She lay in my female ward; her name was Beaumont, her age 49. She had scirrhus cancer of the right breast, and a cancerous mass in the anterior wall of her rectum. Her liver was rather large and hard, perhaps infiltrated with cancer. She was sallow, and offered a good specimen of the appearance of the subjects of cancerous cachexia. In this woman, a large tumour occupied the left hypochondrium, and passed up under the ribs. It was hard, with a sharp edge, which met the margin of the thorax at a right angle. It was plainly the spleen. Its dulness extended up to the level of the nipple, and the lower edge was on a level with the umbilicus. It was situated just beneath the parietes, moved up and down with the movements of respiration, and could be pushed a little from side to side by the hands behind and in front of it. Its surface was irregular, and, in the anterior border, several distinct nodules could be felt. It was not tender. The woman left the hospital, and, after a few weeks, died in the country.

ON THE REMOVAL OF HÆMORRHOIDS BY PAINLESS OPERATIONS.*

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THE division of hæmorrhoids or piles into "external" and "internal" is arbitrary, though useful for purposes of description. It must not be supposed that there is any marked line of demarcation between the two, or any peculiarity of structure, except that, in the former, a part of the swelling is covered by the external integument—a structure that is highly sensitive.

The removal of hæmorrhoidal swellings, whether by the ligature or the knife, has till lately been always attended by severe pain; while, contrary to the opinion once entertained by the profession, serious after-consequences occasionally ensue. Cases of phlebitis—of deep-seated pelvic suppurations—have occurred in my own practice, and, although rare and manageable, have always been the cause of anxiety. The immediate danger, against which surgeons endeavour to guard at the time of operation, is hæmorrhage. Now, in dealing with a strictly external pile, the removal may be at once effected painlessly and safely by first freezing the part with ether-spray, and next by cutting it away with the scissors. Should there ensue any hæmorrhage, the open end of the vessel can be readily secured either by a needle or by a ligature.

Piles which are strictly internal, and offer no narrow basis or peduncle, may be safely treated by strong nitric acid. The patient, being on his hands and knees, strains so as to cause a protrusion of the affected part. The enlarged veins are next touched carefully with nitric acid, and the part is returned; an opiate suppository being finally introduced. By such means, the whole mass is often destroyed after one operation, and the patient experiences no further trouble, the vessels becoming consolidated.

The more important question is, How are we to deal with those hæmorrhoidal swellings, partly internal, and partly external, which consist of large venous trunks, which it would be dangerous to divide without precautions, and which could not be well removed by acid or by cautery? The clamp and hot iron of Mr. Henry Smith effect the removal of these swellings on very safe and easy terms. The operation is too well known to need notice from me here, beyond that of approval. I perform the following operation in some cases. The hæmorrhoidal mass having been protruded beyond the sphincter ani, I seize it with a pair of double hooked forceps, and freeze it with ether-spray. Next, I pass a long pin through its base, and apply ligature-silk in a figure of eight, so as to press the veins enough to arrest hæmorrhage, but not to cause strangulation (the latter being always the most painful part of the process). The frozen veins are then sliced off near to the line where the needle is inserted. The patient is scarcely conscious of any surgical operation, if these steps are performed well and quickly. In the course of a few hours, all fear of hæmorrhage has passed away, when the needle can be withdrawn, and the silk taken off.

Should it be necessary, the base or pedicle of the swelling may be charred with the gas-cautery. It will be remembered, that the crystals of ether are inflammable; and the surgeon must be prepared for such an emergency as that of igniting them, should the gas-cautery be used.

* Abstract of a Clinical Lecture delivered at St. Bartholomew's Hospital.