alone, the especial instruments of the surgeon's art, guided by an intelligent brain, are our only requisite aids to skilful research. Neither are we, as in the rest of the frame, much the gainers by necroscopical exploration. Indeed, it would seem that the skin, being at all times under our visual observation, and always within our reach, is especially adapted to supply a field whereon the pathological phenomena of internal and concealed organs may be studied, and perhaps better understood than in the organs themselves. In the instance of inflammation, these remarks require little or no corroboration; but it is also my belief that considerable light may be thrown on other and more obscure pathological processes by the observation of similar phenomena taking place in the skin.

A survey of the pathological processes affecting the integument tends to show that the state of inflammation of the skin which is denominated eczema may present itself to our observation in a dry as well as in a moist form; in the dry form being represented by simple hyperæmia and exfoliation or desquamation; and in the moist form, by hyperæmia, vesiculation, exudation, and incrustation. While not unfrequently the eruption presents the double form, in general it may be dry, but, after rubbing or scratching, will burst forth into a state of moisture; and it is one of the pathognomonic characters of eczema of every kind, to be liable, in the presence of any aggravating cause, to pour out a more or less abundant exudation.

CLINICAL LECTURE ON THE SCROFULOUS DISEASES OF CHILDREN.

BY EDWARD CLAPTON, M.D., F.R.C.P.,
Physician to St. Thomas's Hospital.

GENTLEMEN,—I purpose to-day giving you a rapid sketch of the principal scrofulous diseases which affect children. Strictly speaking, this can hardly be termed a clinical lecture, inasmuch as I have no patients in the wards at the present time suffering from any of these affections; but it is intended as a sequel to my last lectures on Phthisis and the Scrofulous Diseases of Adults. My present remarks are based almost entirely on cases which occurred amongst the medical out-patients whom I have only recently relinquished. Let me take this opportunity of urging upon you the importance of devoting as much of your time, valuable as it is, as you can spare to attending the out-patient practice of the hospital. It is true, this practice is very unsatisfactory in many respects—more so, perhaps, to the physicians and surgeons than to the students; but you will find many diseases which you will never have a chance of observing in the wards, and opportunities will be afforded you of obtaining facilities to clinical study, which can hardly be obtained elsewhere. Even the great run of common and uninteresting complaints are not without their value, as it is of such that the majority of your cases will consist when in practice.

Amongst the poor of London, scrofula in one form or other is fearfully common. A very large proportion of the children who attend as out-patients suffer from it.

There may not be any marked manifestations, but that condition which may be termed scrofulous debility is perhaps the most common of all. The characteristic symptoms are well known:—a delicate appearance generally; loss of flesh; muscular fatigue after very slight exertion; a rapid irritable pulse; cheeks pale, though flushed by the slightest excitement; large pupils; tongue coated and studded with prominent papillæ; offensive breath; capricious appetite; and, in the majority of instances, mental precocity. This constitutional state is due, as a rule, to hereditary causes; but it is obviously aggravated, and may even be engendered, by bad air, bad food, and bad clothing.

Several instances have fallen under my notice of what may be termed scrofulous fever, the symptoms being not unlike those of acute tuberculosis, only that death occurred before there were any actual tubercular deposits.

The following recent case is a good example. C. M., a girl, aged ten years and a half, residing at Camberwell, had always been considered very healthy until three weeks previous to her death. Four or five brothers and sisters had died of rapid phthisis, inherited, probably, from their mother, who belonged to a very consumptive family, but was still living. The young patient suffered from an intensely feverish condition, without any of the characteristics of the ordinary forms of fever; a very frequent pulse; skin hot, but perspiring; rapid emaciation; senses acute; white coated tongue; no pain, diarrhoea, or delirium; no physical signs of disease in the chest. She was conscious and

sensible to the last. On a *post mortem* examination, there were found no tubercular deposits in any part, and, indeed, no evidences of local disease. Had the patient lived a short time longer, there would doubtless have been considerable tubercular disease of various organs.

Amongst children, scrofula generally exhibits itself in one or other of the following forms:—glandular disease; tubercular peritonitis; tabes mesenterica; tubercular meningitis; and cerebral tubercle. Other conditions, as scrofulous ophthalmia, scrofulous disease of joints, etc., fall under the surgeon's care.

Scrofulous Disease of Glands.—This is found chiefly in the neck, sometimes in the axilla or groin. It is always associated with some of those general symptoms already mentioned; indeed, there is very little difficulty as to diagnosis. Of course the glands may become enlarged from other causes, as injuries, inflammations, skin-diseases, etc., in their neighbourhood, but these are easily detected; and in such cases the glandular swellings are smaller, more even, and more sharply defined in outline. Suppuration does not occur in the majority of cases of scrofulous glands, as far as I have seen; and when it does, it is very slow and sluggish, the skin first becoming purplish-red and adherent. I do not think it a good plan to make an incision until it becomes evident that by further delay an ulcerous opening must speedily form, in which case considerable and permanent disfigurement will ensue by reason of a large, irregular, ugly cicatrix. I believe the best local treatment to be a linseed meal or bread poultice applied every night, with a little iodine ointment spread on that part covering the enlarged glands. As to internal treatment, iodide of iron with cod-liver oil is chiefly relied on, though in the majority of cases this should be preceded by a purgative dose of grey powder and rhubarb, and a mixture containing chlorate of potash and bark. I have always found chlorate of potash peculiarly suitable for scrofulous children whenever there is a febrile condition or gastric disturbance. Steel wine with infusion of quassia, and an occasional dose of scammony and calomel, are generally ordered when the patient is troubled with ascarides—a very frequent accompaniment of the scrofulous condition. Sometimes, instead of ascarides, a gelatinous-looking mass is passed after this purgative dose, and subsequently the young patients greatly improve in health. In such cases the mucous membrane of the intestines is lined, as it were, with a varnish of tough unhealthy mucus, which prevents the proper absorption and assimilation of food, and beneath which ascarides are readily developed. In cases of increasing emaciation, when the cod-liver oil cannot be taken or retained, one or two teaspoonfuls of glycerine in milk form an excellent substitute, and under its use these thin delicate children certainly seem to acquire fat and strength. Open-air exercise should always be enjoined, as also warm clothing, and wholesome, generous, unstimulating diet; but it seems a mockery to enter into the subject of diet with respect to the great majority of poor children who are brought as out-patients to hospitals.

Strumous Ascites is the result of chronic tubercular peritonitis. This kind of inflammation almost always runs on slowly and insidiously to the effusion of serum. No great amount of pain attends it, such as is found in other forms of peritonitis—sometimes only aching or a sense of uneasiness arising from distention. It is produced by tubercular deposits in the peritoneum, or rather in the subperitoneal tissue. A very slight deposit may be sufficient to cause extensive ascites. Sometimes, however, countless numbers of miliary tubercles have been found after death lying within the folds of the omentum. I have often been surprised at the recoveries which take place from this form of ascites, even when no diuretics or eliminatives of any kind have been given. Although the strumous diathesis may have been well marked, yet the recoveries seem to be complete as far as they go. I remember one case in particular, that of a lad of 14, on whom I wished at one time to have the operation of paracentesis performed, so extreme was the swelling, but it entirely subsided under the use of mercurial alteratives, quinine and iron, and cod-liver oil. This plan of treatment answers much better in such cases than acting powerfully upon the various secretions. In a few rare instances, ascites has arisen from enlarged scrofulous glands pressing on the vena portæ.

Tabes Mesenterica.—I do not think that this disease is so common as is generally considered. Thin scrofulous-looking children with large abdomens are doubtless met with very frequently, and they might hastily be recorded as cases of tabes mesenterica; but, if we account accurately for all such affections as chronic tubercular peritonitis, atonic dyspepsia, portal congestion with distended intestines or fecal accumulation, and that kind of chronic tympanitis which accompanies worms in weakly children with depraved appetites, those remaining as true tabes mesenterica will be found to be comparatively few. This, perhaps, may account for the numerous so-called cures of this disease, which in itself is really as fatal as phthisis pulmonalis. Little can be done for these patients beyond attending to their general health, and relieving urgent

symptoms as they arise, such as pain, irritation of the bowels, diarrhoea, etc. For the latter a mixture containing rhatany, paregoric, and glycerine seems to answer best. Such patients are immensely benefited for a time by being sent, when possible, to some eligible sea-side place, as Margate.

Acute Strumous Hydrocephalus, the result of tubercular meningitis, is not often seen in London hospitals, although tubercle of the brain is very common, at least amongst the out-patients. How many children we find labouring under the following symptoms: a pale, delicate appearance; dilated pupils, perhaps strabismus; frequent headache or heaviness of head; occasional vomiting coming on suddenly, preceded by vertigo and not necessarily occurring after food; a slow and perhaps irregular pulse; capricious appetite; starting or shrieking, or grating the teeth at night, and sometimes epileptic seizures. In the majority of instances there are evidences of scrofulous disease in the chest or abdomen, or in the glands of the neck. Some of these symptoms may be slight, or even wanting, but the indications as to the true nature of the case are generally sufficiently evident. The great fear is lest the attacks of vomiting should be mistaken for simple biliousness, or gastric disturbance of a dyspeptic nature, and treated accordingly. Such an error of diagnosis, and consequent prognosis, would be likely to prove very damaging to your reputation in practice, though hardly so detrimental to the young patients as might be supposed. They are generally greatly relieved for a time by cholagogues, aperients, and even mercurials, followed by stomachic tonics; but the distressing symptoms recur again and again, and before long, more decided cerebral symptoms indicate the true nature of the disease. Sooner or later a fatal termination ensues, whatever treatment may be adopted. These young out-patients mostly attend with great regularity for a considerable time without any marked change, and then we miss them all at once. They have been seized with either convulsions, or coma, or acute hydrocephalus, and are quickly carried off. When the disease has come to this pass, indeed, recovery is worse than death; for they are sure to be afflicted with incurable paralysis (if the central part of the brain have been affected), or epileptic convulsions (if the surface), or the mental faculties will be hopelessly impaired. Other distressing conditions will exist in addition, according as particular nerves are implicated—amaurosis, if the second nerve be affected; ptosis, if the third; double vision and strabismus, if the sixth. As to the treatment of cerebral tubercle whilst still in an early and quiescent state, and unattended by of the graver symptoms, I have always found more benefit from hypophosphites and cod-liver oil, with an occasional dose of calomel and rhubarb, than from any other medicines.

The following case is a fair example. J. B., aged 8, came under my care in January last (1870) as an out-patient. He had always been a delicate and somewhat rickety child, and had suffered severely from the usual diseases of infancy and childhood. His mother attributed his present illness to exposure to the sun the previous autumn. The symptoms were frequent frontal headache; occasional slight convulsive fits affecting the left side; shrieking in his sleep; fretfulness and general excitability; slight otorrhoea; occasional vomiting; and torpid bowels. He was treated at first by mild aperients and stomachics; subsequently by quinate of lime, under which his general health improved for a short time; then by iodide of iron, which seemed to cause more intense headache and general feverishness; and lastly by hypophosphite of soda and cod-liver oil, which he continued a long time with marked, though gradual, improvement in every respect. In June he died almost suddenly. He had fallen down and struck his head against a door. This was quickly followed by complete stupor, with paralysis of the left side, and death two days after. In another recent case of a similar character, a boy's death was attributed to a "smart tap" on the side of the head by a schoolmaster. I need hardly say that this is a culpable way of inflicting punishment on a child under any circumstances; but, in the case of delicate children with latent cerebral disease, it must always be attended with considerable danger.

With respect to the general statistics of deaths from tubercular diseases, I find in the last published annual report of the Registrar-General, that, out of the 480,000 deaths (in round numbers) in England and Wales from all causes, no fewer than 68,300, or about 1 in 7, were from the various forms of tubercular disease. Of these, 16,000 were under five years of age: 51,400 were from phthisis; 7,200 from tubercular hydrocephalus; 6,900 from *tabes mesenterica* (including tubercular peritonitis); and 2,800 from other scrofulous diseases. Of those who died of hydrocephalus, nearly two-thirds were under two years of age; and of those who died of *tabes mesenterica*, nearly one-half were under one year, and almost all under six. Altogether, this is a frightful score; but it is some satisfaction to know that the deaths from tubercular diseases, including consumption, have been, on an average of years, steadily decreasing.

CLINICAL LECTURE

ON

ACUTE SYNOVITIS AND TRAUMATIC ANEURISM.

Delivered at the Leeds School of Medicine.

By T. R. JESSOP, F.R.C.S.,

Surgeon to the Leeds General Infirmary, etc.

GENTLEMEN,—During the two months which have elapsed since I last addressed you in this place, several cases of surpassing interest have been admitted into my wards in the Hospital. From these I have selected two, which seem to me to present special points of importance for comment. The first is a case of acute synovitis of the knee-joint resulting from injury, for the relief of which I adopted a new mode of treatment. Here are extracts from the notes as furnished to me by my dresser, Mr. Heald.

John Handly, a collier, aged 20, was admitted into No. 4 Ward on the 22nd of last November. He stated that three weeks previously, when at work in the pit, he was accidentally knocked down, that he fell with his right knee wedged in between two corves, and that he lay in this position for a very considerable time before he could be extricated. On being placed upon his feet, he was able to walk home, assisted by two of his mates. On the following morning, as the joint was much swollen and very painful, his friends applied for and obtained the help of the dispensary surgeons, under whose care he remained until his admission into the Infirmary. When first seen at the Infirmary, the joint was tense with fluid, appeared twice as large as the left knee, and was hot, shining, very painful, and exquisitely tender. There was a general febrile condition—hot skin, dry tongue, thirst, and rapid pulse. He was ordered to have the limb placed in an extended position, upon a McIntyre's splint; to have eight leeches applied to the joint, and these to be followed by an evaporating lotion. Milk-diet, an aperient, a saline mixture, and a chloral draught at night, were prescribed. On the 30th November an ice-bag was substituted for the lotion. This, I need hardly tell you, is the usual treatment of acute synovitis, and in the majority of such cases will succeed in effecting a cure. In this instance, however, it did not suffice; for, from the time of his admission (the 22nd November) up to the 4th December his condition gradually grew worse; the joint became more tense; the pain did not abate; the febrile condition increased; all the active symptoms remained; and the temperature of his body had reached 102, never having been below 100. Under these circumstances, I determined to adopt a plan of treatment with which I had previously succeeded in an exactly similar case; viz., to open the joint under the protection of carbolic acid.

Your books will teach you that a joint should only be opened when the acute inflammation has run on to suppuration. So long as there is a hope that the inflammation may be subdued, so long are you to withhold your knife; but the moment the inflammation has gone on to the suppurative stage, then the joint is to be opened. That, as a general rule, is good teaching; latterly, however, some surgeons have become dissatisfied with the "usual" mode of treating these cases—finding, no doubt, that in a not inconsiderable number of instances destruction of the joint has been the result—and have ventured to do that which, I imagine, every surgeon of much experience has over and over again longed to do; viz., to give exit to the fluid, whose presence in the joint, by keeping the synovial membrane in a continued state of tension, becomes not unfrequently the cause of destruction. The plan which they have adopted is to tap the joint with a trocar, hoping thereby to avoid the introduction of something which—I will not use the word "germs," for although, as you well know, I am a firm believer in the antiseptic treatment, I am not quite prepared to accept Professor Lister's assertion, that a full belief in the germ-theory of putrefaction is absolutely essential to success in its application to surgery—I prefer to call septic material, the entrance of which would almost inevitably lead to putrefaction and consequent intense suppuration in the joint.

Some time before I saw any account of the treatment of acute synovitis by tapping, I opened, antiseptically, with a bistoury, the knee-joint of a man (a patient in No. 3 Ward) whom you will remember¹ suffering from the effects of an injury received a short time before his admission. The operation was followed by the best possible result.

In the case which we are considering, on the 4th Dec. I made an opening into the joint, an inch in length, in the axis of the thigh, commenc-

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