capillaries, acting as a stimulus to the normal nutritive function of the skin.

If we move a step further, and visit, so to speak, the more highly organised tissues of the skin, we shall meet not very rarely with an eczematous congestion of that organ which results in hypertrophy of the vascular portion of the derma, and particularly its papillæ cutis. And these cases of increase of growth of the epithelium on the one hand, and of the vascular tissues of the skin on the other, lead us onward to larger and more massive forms of hypertrophy—forms which are already foreshadowed by the cedematous hypertrophy of a large portion of a limb, and sometimes of the entire limb; a state to which I have ventured to assign the distinctive appellation of "spargosiforme;" and cases which in all but their mode of origin may be fairly compared to the Arabian elephantiasis.

We must now retreat a step to take into consideration a form of hypertrophy resulting from eczema which affects a special portion of the epithelium, namely, the nails; and the morbid appearances which are presented in this case are analogous to those massive hypertrophies of the epidermis which we have already contemplated in preparations 42 to 45. From attacking the walls and matrix of the nails and manifesting its pathological metamorphosis in the horny matter of the nails, I have termed this affection *eczema onychicum*.

This is not the only example by many of the intervention of pathology for the illustration of normal structure; and pathology in this instance may be said to have contrived a rude model by which to distinguish that portion of the nail which is the product of the matrix from that which is produced on the surface of the latter by the vallicula unguis; it is the former of these which has undergone the morbid change, while the latter remains comparatively unaffected.

Just as eczema onychicum carries us back to hypertrophy of the epidermis in conjunction with eczema, another preparation, which is numbered 513, recalls us to the ichorous and the purulent exudations which we have already had occasion to submit to inquiry in connection with moist eczema. The pus-globules in the purulent secretions of eczema are generally derived from the epidermic cells; and in some instances we meet with an illustration of a portion of skin converted into a secreting surface without any abrasion of the epidermis. Such a state of the skin finds its nearest parallel in the mucous membrane; and we might by a figure of speech make the statement that the skin was converted into mucous membrane. Even the secretion bears a close similitude with the secretion of an inflamed mucous membrane; and the form of affection may very aptly be denominated *eczema mucosum*; and the same name may be applied to any part of the mucous membrane which is exposed to the air, and manifests a similar morbid process.

The disease is a peculiar one. The exposed part of the mucous membrane of the lips becomes inflamed; it pours out a muco-purulent secretion; the secretion dries and hardens; and in a short time one or both the lips may be enclosed in a sheath of dark brown or black colour and possessing the density of horn. I have usually met with this affection in young women, and occasionally in young men, one of the examples of the latter class being a young gentleman who was engaged to be married in a few months. In his case, it occurred to me that the too free use of the lips might have been the exciting cause of the disorder, and with his existing prospects the disease threatened to become chronic.

In reviewing the illustrations of eczema up to this point, we find that their number is fifty-three, and these fifty-three preparations supply us with a fair history of the various manifestations of the disease. It is to be hoped that time will add to their number, and that every year our stores may become richer and richer still.

THE LEVÉE.—At the Levée held on Saturday last, by his Royal Highness the Prince of Wales, on behalf of the Queen, the following members of the medical profession were presented:—Surgeons F. B. Baker and W. R. Lane, Grenadier Guards, by the Field-Marshal Commanding-in-Chief; Dr. Burrows, on appointment as Physician Extraordinary to the Queen, by Sir Henry Holland, Bart.; Dr. E. S. Cleveland, Surgeon, Madras Army, by the Secretary for India; Assistant-Surgeon C. Gray, Rifle Brigade, by Colonel Lord A. Russell; Dr. Robert H. More, R.N., Assistant-Surgeon H. F. Nathan, R.N., and Inspector-General Salmon, M.D., R.N. (on being appointed Honorary Physician to Her Majesty), by the Director-General of the Medical Department of the Navy; Assistant-Surgeon J. H. Connel Whipple, M.D., Coldstream Guards, by his Serene Highness Prince Edward of Saxe Weimer. The levée was also attended by Sir Henry Holland, Dr. Arthur Farre, Dr. F. Farre, Dr. C. D. Phillips, Dr. H. Cooper Rose, Dr. Sall, Dr. Sieveking, the Director-General of the Medical Department of the Navy, and Mr. Erasmus Wilson.

CLINICAL LECTURES ON SOME SURGICAL CASES.

DELIVERED AT

The Medical School of the Middlesex Hospital.

By CAMPBELL DE MORGAN, F.R.S.,
Senior Surgeon to the Hospital.

LECTURE II.

GENTLEMEN,—In the practice of your profession, mistakes are of as much importance as successes; and, if we profit by them as we ought, much more is to be learnt, and learnt, too, more impressively from them. The first case to which I shall draw your attention to-day is one which affords a practical illustration of my remark.

Some time ago, Dr. Goodfellow asked me to see a patient with him, who, he thought, was the subject of nasal polypus. She had considerable firm elastic swelling, with duskiness of the face, on the left cheek and side of the nose, with protrusion and eversion of the left eyeball. She could scarcely breathe through the left nostril; and the palate on that side was somewhat swollen and vascular. She was cachectic-looking, and had emaciated rapidly. She was, too, suffering from discharges and occasional hæmorrhages *per vaginam*, which digital examination proved to be due to incipient cancer of the uterus. Her only other symptoms were frequent sickness and a general torpid condition. She suffered very little pain in the face or head, and her chief complaint was of weakness and exhaustion. Now, although it is unusual, in my experience, to find cancer of the uterus complicated with cancer elsewhere—excepting, of course, as extensions from the neighbouring pelvic organs and glands, or parts in direct relation with them—I did, nevertheless, regard this woman as the victim of cancerous disease advancing rapidly towards the eye and brain through the bones of the orbit and skull. She was in consequence transferred to the cancer-ward, under my charge. She remained, however, but a comparatively short time; for her symptoms were soon aggravated. The sickness remained; she became more drowsy, and ultimately comatose; and in this state she died. I confess that so strongly was I convinced that this patient was affected with some deep growth involving the posterior regions of the face, and going on to invasion of the cranial cavity, that I did not look so closely to the case as I should otherwise have done. The symptoms correspond with those occurring in cases where cancer makes its way through the skull to the brain. You get a progressively drowsy or comatose condition, but without any active brain-disturbance. I have seen cases where, though the patients have retained consciousness, and indeed taken an interest in what was going on about them, to within a few days of death, the one hemisphere of the brain has been almost destroyed by malignant disease. But what did the *post mortem* examination reveal in this case? I am bound to say, gentlemen, my diagnosis was by it completely falsified. There were necrosis of the left nasal bone, and an enlarged and hardened, but not ulcerated, os and cervix uteri; but no cancer in the neighbourhood of the skull, orbit, or nostril. In fact, all the organs and parts of the body, excepting those mentioned, were in a fairly healthy state; and all swelling of the face had disappeared. That mere necrosis of the nasal bone should produce such grave symptoms, ultimately ending in complete stupor and death, without disease of the organs of organic life, is hardly conceivable. Those of you who saw this case will for ever bear in mind the experience which it affords and the lesson which it teaches.

Let us now turn to another case lying in Pepys Ward. A man was admitted ten days ago with considerable swelling of the right leg, which, he said, was of only one week's duration. He is twenty-two years of age, and of a pale pasty appearance. He says he has not lost flesh; but his pulse is uniformly quick. His right thigh measures three inches at the centre more than the left, and the skin is of brawny firmness. The swelling in the leg is also considerable; but the skin gives a different impression to the touch; there is only simple cedema. Before the swelling began, he suffered considerable pain down the thigh, but now is quite free from all uneasiness. His general condition is fairly good. At first, one was at a loss to explain this condition, as no hardness or tumour could be felt in the pelvis or abdomen, and no cause existed which would account for phlebitis or plugging of the femoral or iliac vein. It occurred to me that he might have deep-seated inflammation, periosteal or other; but the local and general symptoms did not correspond with such a notion. It was observed, on

further examination, that he had but one testicle; and, on inquiry, the patient said that in January 1869 he had had his right testis removed by Mr. Hulke for disease. The account afforded of him at that time by Mr. Hulke is this: that in December 1868 he was admitted for slight gonorrhoea, and acute orchitis of three days' duration, for which he was treated in the ordinary way; and the intensity of the symptoms soon subsided, and assumed characters which led Mr. Hulke to believe that it was not mere chronic induration after orchitis. The swelling, however, remained. On January 29th, 1869, an incision through the scrotum and tunica albuginea showed the structure of the testis to be abnormal; and it was in consequence removed. Only a small portion at the front and upper part was found to be healthy in structure; and the rest, both to the naked eye and microscopically, gave all the characters of medullary cancer. Here, then, we have a key to the swelling as it now exists in the thigh; and now, after two years' immunity, this patient is, I have no doubt, suffering from secondary cancerous deposit in the glands of the pelvis. It is rare for medullary cancer of the testis to leave the system so long free from secondary disease, though you may find the records of survival after from four to ten years from the time of operation. These, unhappily, are exceptional cases. The majority of patients die within from twelve to eighteen months of the appearance of the disease, whether operated on or not. In this case, the interval is probably to be explained by the very early removal of the organ after the first appearance of its morbid condition. For it is pretty clear that the testis was not the seat of cancer previously to the orchitis; because, setting aside the fact that, had it been so, the inflammatory action would more likely have seized upon the left testis than the right, the patient is quite sure that no alteration in size had taken place in it before the date mentioned—three days before his admission. We must bear in mind that soft cancer of the testicle is one of the most rapid malignant growths with which we are acquainted. Although the patient has been apparently well for so long a time, the germs of the disease must have been present in a quiescent state, and now at length are developing in the neighbouring glands. Since his admission, not only has the right leg increased, but the left also has become larger; and therefore, although the first return was in the glands of the same side as the diseased testis, we see that the disease is rapidly advancing, and has now invaded those of the left; yet no tumour can be felt externally. To-day, I find the skin softer and less brawny to the touch; and this possibly might lead you, as it does the patient, to think that the cause of the condition is disappearing. Not so, however; for this change is not at all incompatible with the presence of cancer; for, in the later stage, the veins either accommodate themselves to the surrounding deposit, or the collateral venous circulation is increased, so that entire subsidence of the oedema may ensue. Though the condition of the lower limbs has improved, you see that the patient is losing flesh and strength, and that the pulse is becoming progressively quicker; and these are often the only indications of rapidly advancing internal cancer. Bear in mind this; and also the fact that the elements of cancer may exist a long while without showing themselves as an actual disease in any of the organs or tissues of the body.

I will now draw your attention to a remarkable case which you saw a fortnight ago upon the operating-table. A man forty-five years of age, in good general health, and who had been a temperate and regular liver, was admitted into Forbes Ward in January, with a large tumour growing from the left pectoral region. Three or four years ago, he says, his trunk and extremities to the wrists and ankles were anasarctous and tense, but the left side more so than the right. For this, he was treated with iodide of potassium and hot baths, and the oedema disappeared; but, twelve months ago, he noticed a lump of the size of a small apple at the outer and upper end of the left breast; this grew rapidly, until, on admission, it measured in its longest vertical circumference $8\frac{1}{2}$ inches, and transversely $11\frac{1}{4}$ inches. It was soft in one spot to the outer side, where it felt elastic and almost fluctuating. It was apparently movable upon the chest-wall, though evidently stretching the pectoral muscle over it. The skin was not adherent, save at the point where it was soft and fluctuating; and there was no oedema of the arm. Springing from behind the left clavicle was a hard immovable tumour, that extended some distance up the side of the neck. This I regarded as probably of the same nature as the large tumour, but in a state of degeneration; for the evidence was conclusive that it had at one time been considerably larger than at present. Two questions suggested themselves on his admission. First, what was the nature of the disease? and, secondly, what was to be done? It was, in appearance and in rapidity of increase, like encephaloid, which may too, unlike scirrhus, be painless in its growth. But the absence of any sign of failing health, of implication of the skin, and of enlarged veins upon the surface, led me to think that it was not encephaloid, but either a sarcomatous or a fibro-cystic tumour. Happily, examination after removal confirmed the negative part of this diagnosis; and the microscope has revealed the nature of the growth to be similar in structure to lymphatic gland-tissue; it was, in fact, a lymphoma. Now, as to what was to be done. Supposing the worst, and that the tumour was of a cancerous nature, it was advancing so rapidly that in a short time it would clearly be fatal. His general health appeared good; and the tumour was, if not freely movable, yet not fixed at its base. In the hope, then, that it might not be encephaloid, I determined to remove it. Even had it proved cancerous, the operation would have given some comfort at least. You saw the difficulties of the operation—the close proximity of the tumour to the axillary vessels, and the large arterial and venous trunks which ran into it. The man has not had a single bad symptom, and is now up. Favourably as all has gone on, we must not lose sight of the fact that there is a strong tendency to secondary deposits in lymphoma, as there is in many non-cancerous morbid growths; and, as in the previous case, we may find by-and-by evidences of recurrence in loss of flesh and progressive weakness.

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ABSTRACT OF A LECTURE

ON THE OPERATION OF TRACHEOTOMY: WITH CASES.

By GEORGE BUCHANAN, A.M., M.D.,

Surgeon and Lecturer on Clinical Surgery, Glasgow Royal Infirmary; Professor of Anatomy in Anderson's University; etc.

GENTLEMEN,—I propose to call your attention to-day to the operation of tracheotomy, with special reference to its performance with the view of saving life in the later stages of croup and diphtheria. These two diseases are characterised by the effusion of a false membrane on the mucous surface of the air-passages; in croup, the lymph being deposited first in the trachea, with a tendency to spread down into the bronchi, sometimes up into the lower orifice of the larynx; in diphtheria, the deposit being seen first on the fauces, tonsils, and pharynx, with a tendency to spread down through the upper opening of the larynx into the trachea, and even into the bronchi. When in either disease the effusion of lymph is excessive, the respiration is impeded to such a degree that the patient dies of suffocation.

I shall not take up your time with any general remarks on the nature, causes, and symptoms of these affections, nor give you any indications for their treatment in the earlier stages; for, though I have very well defined ideas on these subjects, most of you are aware that both in teaching and practice I confine myself exclusively to surgical cases. In consequence, I have no opportunity of observing the effects of remedies, except such as are afforded by the reports of those medical men who request my assistance in the more advanced stage. But there is one point to which I beg most earnestly to call your attention—it is that, in both of these diseases, but more especially in diphtheria, and more manifestly when they occur as epidemics, they may exist in one of two types, the sthenic or asthenic. In the asthenic, the tendency is to cause death by exhaustion—failure of the vital powers; in the sthenic, by suffocation. You will hear it sometimes stated that, because diphtheria is a general disease—somewhat like scarlet fever—and the lymph effusion but the local manifestation of it, therefore it is unphilosophical to propose tracheotomy in such a case; but you will remember that this operation has never been suggested with any intention of cutting short the disease, nor ought it to be performed when there is great prostration. It is in the sthenic form alone that it is admissible. And what I would urge on you is this, when you find that your patient, whatever be the original disease—croup or diphtheria—is not improving by the treatment you have been adopting; when you find that the effusion is going on to produce suffocation; when the tendency is to death by apnoea more than by exhaustion, then you ought to step in and perform tracheotomy for the purpose of preventing immediate death, and so give longer time for the patient to live through the disease and ultimately throw it off. Nay, you will find, after a comparatively limited experience, that you will be able to recognise early in the progress of a case whether the tendency is to apnoea or exhaustion; and I would be inclined to urge my own experience as a reason for performing tracheotomy in the class of cases in which it will inevitably be required, before