before said, to accomplish the same thing in another patient, failed, but from what cause further observation must determine. Was the success in the one case a mere accident? Was the rapid healing due to anything specific in the fluid used, or to mere covering up from the air? The latter does not appear probable, as other agents which could only act by excluding the air when applied in the same way directly to the surface of a granulating sore have usually augmented the suppuration, and injured the sore. This, and other collateral points, will demand further attention.

In conclusion, it may be observed, that the practice of grafting will always afford an hospital surgeon much subject for interesting study and thought, and cannot fail to suggest many useful practical hints of wide use in his profession.

NOTES ON CONSUMPTION.

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II.—VARIETIES OF CONSUMPTION.

ANOTHER form of phthisis, for which has been claimed a special classification, is that described by Dr. Andrew Clark (*Transactions of Clinical Society*, vol. i, p. 174) under the name of "Fibroid Phthisis". I must confess, however, that, notwithstanding its introduction by so well known and accurate an observer, I have as yet failed to recognise it as a distinct form of the disease. It may turn out, perhaps, that I differ from my friend Dr. Andrew Clark more verbally than essentially, as I quite admit the existence of such cases as he has described. I consider them, however, as differing in nothing from the more ordinary forms of phthisis, except in the presence of an unusual amount of fibrous development.

Few cases of consumption go through their several stages without the deposition of more or less of the fibroid element within and around the pulmonary tissues. Without such deposition, indeed, phthisis would run, much oftener than it does, a rapidly fatal and acute course. Fibrous material often serves both to bind down the lung to the thoracic walls and to strengthen the pulmonary tissue, thus preventing a rupture of the lung and consequent pneumo-thorax. It also serves to contract the diseased lung; and, by forming bands running into the pulmonary substance, contracts, and sometimes even obliterates, tubercular cavities. Such conditions, indeed, must be sufficiently familiar to all practical pathologists. Cases, however, now and then occur, in which this fibrous development is most unusually apparent. I have seen lungs thus contracted to less than a third of their normal volume, and causing such displacement of the heart and other organs as to lead to some difficulty in the diagnosis between phthisis and chronic pleurisy. In one case of this kind which I saw some years back with Dr. Walshe, the pleura was thickened to the extent of more than half an inch, the fibrous material having in some places undergone cancerous degeneration, apparently of a secondary character. Many cases, which have been described and figured as instances of healed-up vomicae, are, I believe, nothing more than examples of dense fibrous matter having been deposited upon and within the lung-substance, in order to contract its volume and strengthen its tissue. I agree, therefore, with Dr. Andrew Clark as to the existence of certain cases of phthisis accompanied with great fibrous development. I am at issue with his views only so far as he considers such cases as peculiar forms of phthisis, and as presenting a claim for special classification.

Phthisis is, in my opinion, one of the diseases of organic degeneration, consisting essentially in the development or deposition of a certain lowly organised and variously constituted material, which we call tubercle. In the great majority of consumptive cases, I believe that such deposition is not due to inflammatory action; any inflammation, whether pulmonary, bronchial, or pleuritic, which may accompany it, being of a secondary kind. In not a few cases, however, consumption has a completely different mode of origin. It may arise either from simple idiopathic pneumonia, or from that form of lung-inflammation which, either from its original association with a tubercular diathesis or from its tendency to develop it, has been termed phthisical, or caseous, or tubercular pneumonia. It may arise, too, although it does so much less frequently, from that form of low and congestive capillary bronchitis which so often simulates real pneumonia. In such inflammatory and congestive conditions, indeed, many of the most acute and intractable cases of consumption have their origin. It needs only that a simple and ordinary pneumonia, or an attack of congestive capillary bronchitis, should be imperfectly recovered from, and that the patient should then degenerate in health, or that one of these diseases should

originate in a person already what is commonly called "below par", or otherwise predisposed to tuberculous affections, in order that the resulting lung consolidation or congestion may sooner or later become the seat of tubercular decay. In such instances, the material deposited in the lung, which under more ordinary and healthy circumstances would undergo absorption, either is from the first of a lowly organised or possibly even of a tubercular type, or it sooner or later becomes so, and gradually undergoes the same changes and gives rise to the same symptoms as a tubercular deposit which has been formed by the more gradual and uninfammatory process spoken of previously.

I have long been of opinion that true pulmonary consumption always arises in one of the ways above described: the chronic cases more generally from the slow and uninfammatory process of tubercular deposition; the more acute cases rather from tubercular changes consequent to pneumonia or bronchial congestion. I believe, however, that the greater number of cases combine during their career both of these pathological conditions, undergoing, in their progress, certain modifications depending upon the existence of either the one or the other. Many cases, for example, may commence in the slow and gradual deposition of tubercle of varying degrees of vitality, and may then be hurried onwards by a secondary pneumonia or bronchitis which gives rise to further tubercular degeneration. Other cases may begin in a degenerated pneumonia or bronchitis, which, becoming more or less quiescent, may be succeeded by the slower and more ordinary process of tubercular deposition. Every possible intermixture and alternation, indeed, of such conditions, must necessarily occur, affording another and a very simple explanation of the almost endless differences met with both in the symptoms and progress of consumption.

The practical bearing of this simple view of phthisis is sufficiently evident. If, in very many cases, we are afforded, by the slow formation of the tuberculous deposit, a fair chance of arresting the disease by the alteration of circumstances likely to favour such deposition, how important must be the recognition and the treatment, in all such cases, of any secondary congestive or inflammatory attack. And, again, if pneumonia and certain low and congestive forms of bronchitis be not only very possible, but also very frequent, causes of phthisis, how important must be the treatment of every stage of such diseases, and how essential the consideration that their danger does not pass off with their acute symptoms, but that in the consolidations and structural changes which these so often entail, and which are so apt to be either overlooked or disregarded, consists perhaps the greatest danger of our patients.

[To be continued.]

CLINICAL MEMORANDA.

REMARKABLE CASES OF REVACCINATION.

THE following cases of successful revaccination of persons who might have been supposed to be protected will be found interesting.

CASE I.—W. B., aged 40, Scripture reader, had been inoculated as an infant, vaccinated at 10 or 11 years of age, revaccinated at 18 on joining the Royal Marines, and had five good cicatrices. As he had to visit in a neighbourhood where small-pox was rife, I advised that he should be revaccinated, and was rather surprised as well as pleased to find that two out of three places took, and presented on the eighth day lymph-vesicles, surrounded by a red areola.

CASE II.—Mrs. B., aged 38, wife of the above, was never vaccinated, but had small-pox when eighteen months old, and is deeply marked. She was vaccinated in three places, all of which took, and resulted in lymph-vesicles, each forming on the eighth day a true "pearl on the rose".

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Fitzroy Square, W., March 1871.

TRACHEOTOMY IN YOUNG CHILDREN.

I WOULD supplement the case given by Mr. Cooper Forster by those noted by Meigs and Pepper in their work on the *Diseases of Children*. I myself have operated on a child under two years of age, but only to add to the "euthanasia" (all idea of averting the tendency to death being abandoned before I was asked to operate by the gentleman in attendance); and with such intent, I presume, Mr. Vincent Jackson would waive his objection to the operation even in very young children. To those who may not be acquainted with the work from which I quote, I would recommend it as an exhaustive treatise on the subject of which it treats, and I consider it a most valuable addition to the literature of