of Sebastopol; nothing be left behind to recall a strife best forgotten; and the ashes of the warrior dead could even be brought home to lie in the fatherland.

I have come to the conclusion that cremation is a desirable thing; and when I bring to remembrance the revolting sights I witnessed when a boy in some Lancashire churchyards, and compare them with the quiet necropolis at old Dardanus, or the urn-burial sites on the plains of Troy, in both of which I have repeatedly dug for days with an increasing pleasure, I find myself wondering how it has come to pass that we practise burial with its many faults, and do not burn our dead. I feel myself almost beginning to be thankful that the dead are beginning to "rule our spirits from their urns" in a realistic, and not in a poetical sense. There is something majestic and even pleasurable in the idea that it will soon be possible, in all civilised shores, to leave our mother Earth, not with a partial, but with a fully consummated sacrifice upon her altar, bidding her adieu none the worse, but rather the better, for our sojourn with her. In my capacity as Secretary to the Cremation Society, founded by some of our most thoughtful men, and which, I trust, will form the parent society of many hundreds of others, I have the privilege of knowing how very many groan and labour under the burden of enforced burial, and how many now "hail with satisfaction and joy the prospect that a chariot of fire may receive them, instead of the cold and darksome grave".

ABSTRACT OF LECTURES ON THE SURGICAL TREATMENT OF ANEURISM.

Delivered at the Royal College of Surgeons of England.

By T. HOLMES, F.R.C.S., Professor of Pathology and Surgery.

LECTURE V.—*Popliteal Aneurism (continued).*

THE first topic treated of in this lecture was the effect which the previous use of compression has on the success of the ligature, should this operation afterwards become necessary. It is generally taught that this effect is favourable; that doctrine resting mainly, if not entirely, on the statistics published by Mr. J. Hutchinson in the *Medical Gazette* for November 29th, 1856. But those statistics are too meagre to be the basis of any certain conclusion; and, although it is true that the previous use of compression may cause the enlargement of the collateral vessels, and so diminish the risk of gangrene; yet prolonged compression, by the suffering and confinement which it involves, must probably affect the result of the case unfavourably. Certain it is that, in the hospital table before referred to, the numbers (which are much larger than Mr. Hutchinson's) show a greater proportion of failure in the cases treated by ligature after compression, than in those treated at once by ligature. This is attributable, probably, in part to the fact that compression succeeds in the best cases and fails in the worst, as much as to any effect of the compression itself. The total result of the cases of popliteal aneurism in which the compression-treatment was adopted (including those in which it failed, as well as those in which it succeeded) was almost identical, both in the proportion of deaths and of failures, with those treated on Hunter's method, by the ligature used at once. This fact seemed to the lecturer to argue greatly in favour of the compression-treatment; since, by means of it, a large proportion (amounting to about a quarter) of the whole number of cases of popliteal aneurism were cured without any danger to life whatever, and in many cases with little or no suffering; and, in those who recovered, the limb was stronger and better nourished, in consequence of the less obstruction of the main vessels. At the same time, there is every reason to believe that the proportion of cures can be very greatly increased by better methods of pressure and more care in applying them. The total result of the table is most gratifying, as proving how large a proportion of cases of popliteal aneurism are cured, in one way or other, in our hospitals. The whole number of cases of popliteal aneurism in the table was 212; the total number of deaths only 30—*i.e.*, 14.1 per cent.—many of them due to other diseases; and in only 4 cases was the treatment left incomplete; 12 recovered after amputation. All the rest (166) were cured with preservation of the limb.

Still, though the success is great, it cannot be denied that further improvement is possible and desirable; and this will probably be obtained by the further development and the more careful performance of compression.

The history of the compression-treatment was briefly sketched; and reference was made to the great percentage of cures which followed the Dublin method of partial and interrupted pressure, in which the circulation was never entirely commanded, and the pressure was altogether

relaxed at intervals. These details are taken from Mr. Joliffe Tufnell's book published in 1851. Reference was made also to the results (as far as they could be ascertained) which have been since obtained in Dublin, which still appear to show a very much greater proportion of cures than has been reached elsewhere, though the method of partial interrupted pressure has now been in great part abandoned for the total interruption of pulsation in the sac, either permanently or temporarily. These data, however, have not as yet been completed; and perhaps it may be impossible to collect all the cases which have occurred since Mr. Joliffe Tufnell's book was published; but, as far as they go, they appear to show that in Dublin only about a quarter of the cases resist compression, and that of these the very great majority are cured either by ligature or amputation; death being quite exceptional, and caused in many cases by visceral disease. If this is so, it is a plain proof that the large proportion of failures of compression in London and elsewhere depends on some imperfection, or probably on want of care, in carrying out the details of the method.

The lecturer then spoke about the methods of compression, avowing his disbelief in Broca's theory of active and passive clots; since the constant success of digital pressure sufficiently proves that the passive and complete coagulation of the blood very commonly leads to definite cure; and that, when it does not do so, the clots exercise no irritating influence on the sac, but merely melt away again, and the aneurism returns to its former condition. The method of digital pressure was shown to be superior to any instrumental method, on account of its comparative freedom from pain, and the possibility of avoiding simultaneous pressure on the vein. Its drawbacks—*viz.*, the labour and the number of assistants required—have not usually been found very serious even in private practice; and it can be carried out, if the assistants are well trained, with an amount of accuracy which is seldom attainable either with the weight or any form of instrument. But minute care should be given to see that no pulsation ever passes through the sac; and it is well not to begin till the circulation has been somewhat reduced by rest and light diet. Numerous instances were produced of the rapidity of cure in favourable cases, and of the ease with which the patient can in such cases undertake his own treatment. When there is any reason to apprehend disease of the femoral artery itself, it is especially desirable to make the pressure with the finger, rather than with an instrument. The assistance of a weight laid on the finger of the compressor spares his muscles, and enables one person to carry on the compression for a much longer period.

There are cases, however, in which the pressure of a weight or of some form of tourniquet succeeds better. Of all forms of instrument, that invented by Dr. Carte seems the best.

The subject of popliteal aneurism was reserved for completion in the next lecture.

THE DIAGNOSTIC VALUE OF INCONTROLLABLE VOMITING IN CERTAIN FORMS OF HEPATIC ABSCESS.

By W. C. MACLEAN, M.D., C.B., Surgeon-General;
Professor of Military Medicine in the Army Medical School, Netley.

CAPTAIN N. R., an officer of the Indian Army, arrived at Madras about the end of April with a history of hepatitis. This officer's regiment formed part of the force assembled for exercise at Bungaloe in the early spring of this year. On the termination of the manoeuvres, Captain R. rejoined his family at the hill-station of Kamun-Duroy, near Ballary. The journey from the heated plain to the hill-summit was made on foot, at the cost of some fatigue. The sudden change of temperature, after being overheated, was followed by a chill. Hepatic symptoms supervened. As soon as he could be moved, he was sent to Madras, where he came under the care of Dr. Andrews, Dr. Liston Paul seeing the case in consultation. To the above gentlemen I am indebted for the following particulars. Dr. Paul wrote to me as follows.

"Returning with Dr. Andrews from successfully evacuating a liver-abscess in the case of another officer, I was asked by Dr. Andrews to see Captain R. I found him in good spirits, declaring himself to be much better, and able to drive out daily. I examined him carefully. The liver was not enlarged in any direction, and the only tender spot was over the region of the gall-bladder. His pulse was not high, and he was free from fever; but he had lost flesh considerably, and he complained of vomiting 'greenish-looking matter' at least once a day, generally after food. I did not," adds Dr. Paul, "think there was any evidence of an abscess in his liver, and diagnosed the case as one of chronic hepatitis with involvement of the gall-bladder."

Captain R.'s wish was to go to the Neilgherry Hills. From this

Dr. Paul dissuaded him, and advised him to take a sea-voyage. Dr. Paul did not see the patient again for a week, when he found him quite collapsed and rapidly sinking. For three days, Captain R. had been vomiting the same green-coloured bilious matter, almost without ceasing. This symptom resisted the most careful treatment, directed by Dr. Andrews. Neither food nor medicine was retained for an instant, until a few hours before death, when the vomiting ceased, more, as it appeared to his attendants, from exhaustion than from the remedies used.

I am indebted to Dr. Andrews for the following account of the *post mortem* appearances.

The body was emaciated. Rigor mortis was normal. The lungs were healthy. *Heart.* The muscular substance was undergoing fatty degeneration. There was a fibrinous clot in the right ventricle. The *Liver* was large, softened, and congested. The stomach was tied and cut off just above the cardiac orifice, and was carefully removed; but, when the duodenum was reached, it broke down under the pressure of the fingers, and the contents, a black fluid, escaped into the cavity of the abdomen. The oblique portion of the duodenum was of a deep chocolate colour, softened, thickened, and ulcerated. Upon examining its internal surface, pus was observed to ooze from a minute aperture on the right side. Tracing this with a probe, it was found to lead into an abscess about the size of a cricket-ball in the lobulus quadratus of the liver, full of laudable pus. The liver, gall-bladder, pancreas, stomach, and duodenum, formed one adherent mass, united by the inflamed lesser omentum. The great omentum was inflamed in patches. The serous covering of the transverse colon was ash-coloured, softened, and adherent to the liver; the mesocolon was inflamed and thickened. The gall-bladder was distended with thick tarry-looking bile. The ductus communis was apparently impervious. The stomach and bowels were full of a dark fluid, and the mucous membrane was congested throughout. The *Kidneys* were both congested; the left was enlarged, with commencing fatty degeneration.

Dr. Andrews adds: "The immediate cause of death was, I consider, exhaustion, from inability to retain food in the stomach. The above described condition is more than sufficient to explain why this was so. Had the patient lived a few hours longer, the issue might have been different, as the abscess was on the point of discharging itself into the duodenum, thus relieving stomach and duodenum from pressure, and making nutrition possible."

I have published this case because I think it of interest and importance from a diagnostic point of view. The real significance of persistent vomiting following on hepatic symptoms, however slight, did not escape the observation of Morehead, who, writing on the diagnostic value of the symptoms of hepatitis, thus expresses himself: "Nor may we overlook the relations of the concave surface of the liver to the stomach, and the explanation which this affords of the occasional occurrence of vomiting." And he adds: "But this symptom is more frequently observed in the advanced than in the early stages of hepatitis;" that is, as in the case before us, when suppuration has occurred, and the abscess presses on the stomach and duodenum. I can call to mind several cases very closely resembling that of Captain R., one with a more fortunate issue. A lady, after a chill, had slight hepatic symptoms, so slight as to cause little alarm. The liver was but little enlarged; there was hardly any pain, not much fever (it was before the days of the clinical thermometer, which in hepatitis is invaluable). From an early date, the stomach was irritable. At last, after a marked rigor, vomiting became almost incessant, the exhaustion of the patient became extreme, and her death was hourly looked for. Suddenly, nearly a pint of pus was vomited; the irritable condition of the stomach subsided; nutrition became possible; and this lady returned from the very gates of death to good health.

If fresh evidence were required as to the untrustworthiness of the absence of pain as a sign of hepatic abscess, the case of Captain R. furnishes it. It can never be sufficiently kept in mind that, unless the capsule of the gland partakes of the inflammatory action, a large abscess may exist without pain being complained of. We have now at Netley an officer who served on the expedition to the Gold Coast. He was brought to Netley raising daily, through the right lung, ten or twelve ounces of purulent matter from a liver-abscess on the convex aspect of the right lobe. In this case, the liver was much enlarged; but the utmost freedom of percussion and palpation was allowed without eliciting a complaint even of tenderness. Nevertheless, I was soon led to the opinion that there was another abscess deep in the substance of the gland, for the following reasons: 1. The enlargement of the liver; 2. The case had a dysenteric history, multiple abscesses when hepatic mischief supervenes being the rule in such cases; 3. Persisting high temperature, the thermometer ranging from 101 to 104 deg. Fahr., notwithstanding the free discharge of pus; 4. Progressive emaciation,

Acting on this evidence, I passed the longest needle of Dieulafoy's aspirator between the eighth and ninth ribs in the axillary line, four inches deep into the substance of the gland, reaching an abscess, and evacuating twenty-four ounces of pus by means of the aspirator. It was found impossible in this case to retain a drainage-tube in the cavity of the abscess, as it always will be when it is situated so far from the surface, more particularly when, as in the case of this officer, the liver is adherent to the diaphragm, and made to partake freely in the movements of this muscle.

THE GAINS DERIVED FROM THE USE OF THE LARYNGOSCOPE.

By GEORGE JOHNSON, M.D., F.R.S.,

Professor of Medicine in King's College; Physician to King's College Hospital.

ONCE more, in reply to Mr. Thornton: I am aware that the muscles of the larynx may be affected by extension of disease from the mucous membrane. I have seen such cases often; but I do not consider this an "idiopathic disease" of the muscles. Moreover, in the case which forms the subject of this discussion, there was no history of any affection of the mucous membrane, which, during life and after death, appeared perfectly healthy. The crico-arytenoid articulation was opened after death; and in the specimen, which is preserved, it may be seen to be quite normal. The muscles were not examined microscopically.

Early in the ensuing session, I purpose to make a communication to the Royal Medical and Chirurgical Society, in which I hope to be able to give a satisfactory physiological explanation of bilateral spasm and bilateral palsy of the laryngeal muscles resulting from pressure on the trunk of one pneumogastric nerve.

CLINICAL MEMORANDA.

MAMMARY ABSCESS IN AN INFANT.

DR. STEPHEN's report in the JOURNAL of July 25th of a case of mammary abscess in an infant three weeks old recalls to my mind a similar case that I saw last year. On referring to my register of obstetric cases, I see that I attended Mrs. D., a primipara, aged 40, on July 25th, 1873. She was safely delivered of a male infant. On August 9th, I was called in to see the infant, and found him suffering from two mammary abscesses, which I opened, and from which escaped a considerable quantity of greenish pus. The infant recovered, and I heard no more of the case. I had not seen the infant for some days previously to August 9th, so cannot, of course, say whether, as in Dr. Stephen's case, the abscesses originated in the retention of milky secretion. But I think there is sufficient similarity in my case to make it worth recording, especially as it is the first case of the kind I have seen, and the one reported in the JOURNAL appears to be unique in the experience of Dr. Stephen and his medical friends.

A. PLATT WILKS, M.B. Cantab., Ryde.

CASE OF HYDATID OF THE BRAIN: EPILEPTIC CONVULSION: DEATH.

The following case is, I think, interesting from its rarity, and also from the *post mortem* examination explaining certain peculiar symptoms which existed during life, and likewise the sudden epileptic seizure and death.

A. G., aged 17, an inmate of a reformatory for the last two years and a half, consulted me in June last for a slight ulcer of the leg, which quickly healed; but my attention was directed to her general health and her strange conduct. She would steal things, and secrete them under her bed, without any object. She refused her food, or crumbled it up and hid it in her pockets. She would lie on the floor and sleep in the daytime, but at night was restless and noisy, disturbing the other inmates of the room. She placed books and other articles under her pillow, which, she said, was to make her head ache. She told her companions that she was shamming, that she might be sent to a hospital. On one occasion she attempted to strangle herself with a piece of ribbon tied tightly round the neck.

As I could discover no actual disease to account for this strange erratic conduct, I attributed it to hysteria, the result of amenorrhoea, she having menstruated but once. The matron informs me that, until the last few months, she was one of the best behaved and intelligent girls in the institution; and that, even so late as two days before her