relieved, he was induced to accept my offer to make him an in-patient in King's College Hospital; and, on December 10th, he was admitted into that institution under my care. On his admission, and as long as he was in the hospital, the physical signs were, and remained, precisely as I have given them above.

After a few days' rest in bed, his symptoms were greatly relieved. His dyspnoea was scarcely observable; his appetite was good; he slept well, and was cheerful, and, save when occasional slight attacks of cough and expectoration brought on an access of dyspnoea, he presented few subjective symptoms of any distinct import.

After, however, he had been in the hospital about ten days, the cold weather, which had been for a long time severe, became intense; this seemed to depress him physically; he became somewhat confused and incoherent in his manner, and, on the 23rd, somewhat unexpectedly, he died from exhaustion, after only thirteen days in hospital. There was no aggravation whatever of the chest-symptoms; but he had not vital energy enough to resist the continued depressing influences of protracted cold. A case of thoracic aneurism in the very next bed to this patient died a few days afterwards in precisely the same manner, not directly from the effects of the aneurism, but from exhaustion induced, to a great extent, by the depressing influence of cold.

We did not feel quite sure what we should find on *post mortem* examination. In its general aspect, the case resembled one of malignant tumour within the thorax; but, save the dyspnoea, there were none of those pressure-signs which generally accompany such disease; and, with rest in bed, the dyspnoea disappeared. He had no pain, no orthopnoea, no anxiety. He ate and drank and slept well. There was very little cough; indeed, there was an almost entire absence of subjective symptoms. We had a history of a previous attack or attacks of pleurisy, and we were assured that there had been an effusion into the right pleura, and subsequent absorption of the fluid. There was clearly considerable contraction of the right lung, sufficient to cause the heart to be displaced from the left to the right side of the chest; there was also considerable compensatory expansion of the left lung. But there was no noticeable retraction of the left side. I have seen the heart displaced in this way, drawn over to the right side, from the contraction of a large cavity in the upper part of the right lung; but, in such a case, there is also usually very marked flattening or depression of the chest-wall opposite the seat of the cavity; or the heart may be pushed over to the right by a large effusion of fluid into the left pleura, and may contract adhesions to the right chest-wall, and so be permanently fixed there. But this was certainly not the case in the instance before us; for the left side was clearly occupied by a greatly distended and very emphysematous lung.

In the next place, the question arose, Could the symptoms and physical signs observed in this case be satisfactorily accounted for by supposing that there had been an effusion of fluid into the right pleural cavity; that this had been slowly absorbed; and that the lung, having been prevented from expanding by bands of lymph, and the chest-walls prevented by rigidity from retracting, the left lung had slowly dilated, and pushed the heart over to the right side? The dyspnoea on exertion, which was the chief subjective symptom, would thus be accounted for by the contraction and compression of the right lung, the highly emphysematous distension of the left lung, and the cardiac displacement. The absence of all pain and tenderness, of all pressure-signs, such as dilated veins, stridor, dysphagia, aphonia, etc., and the disappearance of the dyspnoea with rest in bed—all these circumstances, together with the stationary condition of the physical signs, tended to obscure the nature of the case, although they in no way diminished its clinical interest. On the other hand, the evident cachexia, the emaciation, the peculiar dingy pallor of the countenance, pointed to the probable existence of malignant disease within the chest.

Post mortem examination revealed the existence of a tumour about the size of a large orange, situated in the posterior and middle mediastinum, pushing down the base of the heart. It was of a whitish colour, and cut with a moderately firm section. It enclosed in its substance many black bronchial glands. A small process of this tumour had grown into the right bronchus, so as to almost completely occlude it. In the apex of the right lung, there were three or four rounded masses, the largest of the size of a filbert, moderately firm, and whitish in colour, and resembling in appearance the larger tumour. The right lung was firmly adherent to the chest-wall throughout, and the pleuritic adhesions were so strong, that the lung could only be removed by lacerating its substance. The lung-substance was crepitant at the apex, but the middle and lower lobes were firm and indurated from complete collapse. The left lung was markedly emphysematous. The heart was found to lie horizontally, the base turned quite to the right side, and on a level with the apex.

On microscopical examination, the tumour presented the characters

of medullary cancer; the fibrous tissue was more abundant than usual, but the cells were well marked, and contained, for the most part, several large nuclei and sometimes nucleoli.

NASOPHARYNGEAL POLYPUS: HYPERTROPHY OF THE MUCOUS MEMBRANE: TRACHEOTOMY: REMOVAL OF SUPERIOR MAXILLARY BONE: DEATH.

By ARTHUR S. UNDERHILL, M.B.

A BOY, aged 14, was brought to my surgery in the early part of last month, suffering from difficulty of swallowing and great difficulty of breathing, particularly when in the recumbent position. He had had occasional attacks of hæmorrhage from the nose. The disease commenced eight months ago with an inability to blow down the right nostril. He had gradually grown thinner; the hæmorrhage, which was sometimes very considerable, had greatly debilitated him; in fact, so weak was he that he was unable to walk any distance, or even to stand for any length of time. On examination, the soft palate on the right side was seen to be bulging considerably forwards and downwards, so as entirely to preclude the view of the pharynx; the bulging was tense, with no fluctuation. On attempting to pass the finger down the pharynx and to hook it over the soft palate, a number of small oyster-like bodies were felt entirely occluding the posterior nares and much contracting the cavity of the pharynx; they seemed to be sessile and closely packed together; no pain was felt after the manipulation, but there was very considerable hæmorrhage. In consultation with my father, I decided to perform tracheotomy as a first step, as the patient's condition was not such as to warrant a very severe operation, and it was imperative that his breathing should be relieved. The night before the operation, so great was the dyspnoea that his attendants had to constantly change his position and shake him, as they were afraid that his breathing would entirely cease.

After tracheotomy, the relief was immense. He slept well, and became very lively; but the polypi increased rapidly in size, so much so, that it became a matter of difficulty to swallow even liquids. I accordingly, as a *dernier ressort*, excised the right superior maxillary bone fifteen days after the first operation. This I accomplished with less hæmorrhage than I anticipated. The bones, being young and soft, separated readily, thus enabling the operation to be rapidly performed. We found the mucous membrane to be everywhere very considerably thickened, and a number of small polypi varying in size from a pea to a moderately sized oyster studding everywhere the mucous membrane as far down as the finger could reach. Some of these were torn away with the finger-nail; and others lower down were removed with the *écraseur*. The operation was necessarily a bloody one, and the actual cautery was necessary. The boy temporarily rallied, but gradually sank seven hours after the operation.

I wish to suggest that, in future major operations about the mouth and air-passages, tracheotomy should be performed as a first step. In this case, I was compelled to do it. Tracheotomy (at all events, before adolescence) is an easy and comparatively safe operation; and chloroform can so safely and so effectually be administered through the trachea-tube without hampering the operator or his assistants, and the patient has a free opening to breathe through, not being choked, as they usually are, by the blood which necessarily trickles down the air-passages, and when coughed up sputters over the operator. Having a tube in the trachea also allows a sponge to be placed at the back of the pharynx, and so prevents any blood from entering the œsophagus or trachea. I should recommend that a tube be used without a fenestrum, so that, if it fit the trachea well, no blood can possibly enter the trachea through it.

MATERNAL IMPRESSIONS.—A *propos* of recent papers in the JOURNAL on the subject of maternal impressions, the following may be interesting. In a *Discourse delivered at Montpellier*, and published in London in the year 1698, Sir Kenelm Digby refers to the dread of a drawn sword which was manifested by James the First, and attributes it to the fright received by Mary in consequence of the murder of Rizzio in her presence when she was pregnant. Sir Kenelm was knighted by James; on that occasion, he says, the King could not look upon his sword, and adds, "he had almost thrust the point into my eye had not the Duke of Buckingham guided his hand aright".

GEORGE F. ELLIOTT, M.D.