then the indications are in favour of a long pedicle and the absence of pelvic complications. If, on the other hand, the uterus be drawn up out of reach, or is fixed and can be moved only with the tumour, more especially if it be tilted to one side, then the pedicle will probably be short. Some minor cysts may be felt at the roof of the pelvis, and, if there be much fluid outside the tumour, the recto-vaginal *cul-de-sac* may be felt distended. I have not yet, however, met with this sign of ascites; not even in the exceptional case I have referred to did it help me.

Auscultation of ovarian tumours gives chiefly negative signs, but these are often of value, as in the case of perfect absence of intestinal gurgling over the tumour. A loud friction-sound is often heard, but this is only an indication of a dryness of the peritoneal surfaces where it is heard, and there is sure to be an absence of adhesions at the spot. The hydatid fremitus, so well described by Mr. Wells, I have not been fortunate enough ever to meet with.

Tapping, either for the removal of ascitic fluid or the contents of a cyst, is often a great help towards an accurate diagnosis. By the removal of peritoneal dropsy, we may discover the actual relations of an ovarian tumour, or we may even find that the supposed tumour has no existence. By the removal of the contents of a large unilocular tumour, or of the contents of one or more of the major cysts of a multilocular growth, we may determine the existence of pelvic adhesions, the existence of pregnancy, or of some other condition that may alter in great measure our views as to treatment. I am strongly of opinion that preliminary tapping in doubtful cases is not resorted to with sufficient frequency; for Mr. Spencer Wells has certainly disabused us of the idea that it is such a very formidable proceeding as was once taught and believed, and he has shown that it is very efficacious in gaining time and in clearing up difficulties. The chemical and microscopic examination of fluid withdrawn by tapping has not as yet yielded any greater certainty than any of the other signs I have previously referred to. No one can speak more authoritatively than Mr. Wells on any subject connected with ovarian disease, and he has written on this point as follows. "While it is certain, therefore, that, in cases of doubtful diagnosis, complete reliance cannot be placed on the chemical characters of fluid removed from the abdomen, and that the rule of paralbumen being the characteristic of ovarian fluids, and fibrin of serous fluid, and the conjoint presence of paralbumen and fibrin pointing to a mixture of the two fluids, is open to many exceptions, it is still true that the rule is sufficiently often correct to become an aid of some value in arriving at a diagnosis, and to encourage us to attain more accurate knowledge by more extensive observation and more complete research."

Great stress used to be laid in former times on the diagnosis of adhesions; but, with greater experience of the disease, we are now led to disregard almost wholly any adhesions that are not visceral or pelvic. Parietal adhesions seem to be of very little consequence; and, if of any great extent, they may be diagnosed, provided the tumour be not of extreme size, by carefully watching the movements of the tumour during respiration. If it be free in front, its upper margin may be seen gliding under the abdominal wall synchronously with the play of the diaphragm. Mr. Wells states he has seen the umbilicus move with an adherent tumour during respiration. Perhaps, the most trustworthy point in the diagnosis of adhesions is a careful inquiry into the patient's history, for the occurrence of febrile attacks accompanied by localised abdominal or pelvic pain.

The diagnosis of the variety of tumour in each case is of importance in guiding us to its treatment; therefore, it is not for the mere exercise of ingenuity that I recommend every practitioner dealing with a case of ovarian tumour to exhaust every point on which I have dwelt, together with many others to which I have not alluded, but which the individual peculiarities of his case and his personal shrewdness may suggest. Above all, let me urge the necessity of reasoning by exclusion, and of making repeated examinations at intervals before any certainty of diagnosis is felt. Three times it has occurred to me to remove ovarian tumours which had hastily been set down at an early period of their history as floating kidneys, that diagnosis being made in all three cases because the wish was father to the thought, and because the practitioners who made it had not learned the value of patience. It is this want of patience that is to blame for those melancholy instances of blunders, altogether unpardonable, where the abdomen has been opened in cases of normal pregnancy mistaken for ovarian tumours.

A final means to be employed in the diagnosis of ovarian tumours, a *dernier ressort* in cases of doubt, is the exploratory incision. Such a proceeding is quite justifiable in any case of abdominal tumour which has been watched for some time, and where none of the ordinary indications suffice to make its nature certain. It is also to be recommended as a preliminary to the surgical treatment of some tumours, either

uterine or ovarian, when the possibility of removal is doubtful, and the relations of the tumour can be ascertained only by exploration. The mortality of exploratory incisions has, in Mr. Wells's practice, seemed to have been small enough to support this opinion, and out of five I have not lost one.

[To be continued.]

ON MODIFIED SYPHILIS.

By J. MORGAN, F.R.C.S.I.,

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THE remarks of Surgeon-Major Oliver in the number of the JOURNAL for May 9th, 1874, lead me to hope that this subject, which I ventilated at the meeting of the Medical Society of London on February 9th, has attracted attention, and will lead practical observers like Mr. Oliver to throw aside the bondage of preconceived opinion, and will disturb the blind faith which is accorded to the dicta of observers on the Continent more especially. Why, in these countries, where, from density of population and disregard of compulsory legislation, the venereal disease in all its forms is particularly rampant, we should be less capable of forming accurate deductions, I cannot understand; yet we find men with vast fields of information and observation in their own immediate sphere prefer to follow, and even strain to accept, the dogmas of foreign syphilographers. We all admit that climate, habits of life, legislative interference, diathesis, etc., have wonderfully modifying influences in other diseases; still it is constantly endeavoured to mould our deductions so as to suit the views that have been dogmatised and sanctioned elsewhere as to this affection. The maxim *nullius in verba magistri* should be specially applied in investigating the phenomena of this disease, and all deductions should be tested by the common sense of applied facts and observations. The dualists have issued the dogma of the existence of an infecting and a non-infecting sore, but, to avoid the difficulties which will constantly present themselves, have invented the mixed chancre or sore—a source which introduces the local effects of the non-infecting with the constitutional results of the infecting ulcer, or a sore presenting a convenient amount of duplicity of character to explain any break in the chain of proof as to the duality of the venereal sore. Others, again, will lay all the errors of diagnosis to the want of discerning power in the surgeon, who, they hint, cannot distinguish induration or appreciate the mild degree of induration termed "parchment", from the dense and cartilaginous feel of a cartilaginous induration. Others, again, and, indeed, as Mr. Oliver remarks, it is a not unfrequent suggestion, say, when instances are brought forward totally subversive of the dual theory, that the surgeon did not see or discover the real infecting sore—a speedy and easy way, and an extensively applicable one, no doubt, of overcoming the difficulty. While, as my own observation shows me, strict duality cannot for a moment be admitted, yet the rule holds good that, from the true indurated chancre, constitutional symptoms are apparently invariable, yet, from the non-indurated sore, constitutional signs of a modified and usually milder nature are not infrequent. In hospital practice, I see constantly soft patchy sores in the male followed by constitutional signs. Mr. Oliver, a staff-surgeon, gives his experience for sixteen years amongst the military; he says the modified form of syphilis, or descent modified syphilis, is in 70 per cent. of "the primary syphilis" patients, the form met with; and that "not more than 30 per cent. of these can be considered as true syphilitic chancre, but merely the local evidence of the transmission of secondary syphilis"; and he remarks, in confirmation of the modification by descent of syphilis, that, while constitutional evidences will follow both the indurated and non-indurated sore, yet that the cachexia (which renders syphilis so formidable) is absent, or reduced to a minimum, in those instances where secondaries follow the non-indurated sore; this evidence, coming from a practical source, and based on statistical observation, is very remarkable. Surely, if they followed from a true indurated sore which was not found out, the symptoms should be formidable, whereas they were found to follow the type of "absence of cachexia" and of evidences "easily dispelled"; in fact, modified syphilis required but modified treatment. It is satisfactory to find thus an approximation at least to the solution of the difficulty, in reconciling the various treatments recommended by army surgeons more especially; and this explains, in a great measure, why it is that, in military practice, syphilitic evidences usually are docile to treatment of a comparatively simple nature, while in private practice, where the disease is more usually obtained from the better class of female communicators, the true virus is received.

At the meeting of the Medical Society of London, I showed, from the experience of the Lock Hospital in Dublin, where a vast number of

patients came under my own observation, that the occurrence of the indurated sore in the female was rare indeed, while constitutional consequences were constant. This observation was confirmed by testings made, and statistics taken, where soft sores capable of inoculation, and often accompanied by buboes, were nevertheless followed by constitutional signs. The records of the various Lock Hospitals in this country prove this also.

"Any and every form of sore, whether with or without induration, may, in the female, be followed by constitutional signs." So says the surgeon to the Curragh Lock Hospital, and it is idle to suppose that he is incapable of forming a judgment. The surgeon to the Cork Lock Hospital, also of great experience, says: "Practically, I know no symptom which will enable me positively to pronounce on the contagiousness of a given sore in the female."

I am sufficiently patriotic to suppose that these surgeons, and many others at home, are as competent to observe, and are as truthful in their records, as those on the Continent; and, when I find these results corresponding with what I see every day both in male and female patients, there is no alternative left but to believe that what is seen abroad does not concern the same stamp of the disease as here; some modifying influence must exist. I believe it to be the fact that syphilis is capable of modification by descent, and that the vast majority of primary sores are not derived from sores, but from the inoculated discharges of constitutionally infected women. As Mr. Oliver remarks, "soldiers' women" have usually fallen to the lowest order, and have been saturated with the syphilitic taint, the local evidences of which have long disappeared; they are, nevertheless, capable of giving a sore or sores which have by no means the aspect of the typical chancre; I have over and over again tested this property of inoculability, and produced a sore on the patient's self, or on others also syphilitic, which, though typifying the chancreoid or soft sore aspect and conduct, must have carried with it the virus of its parent. As these inoculated sores produced the same results as inoculations from the recognised soft sore, we may fairly assume the exciting cause was the same. All agree that the soft sore is inoculable on syphilitic patients, and pursues a certain course; but, by direct testing, I have shown that, though no sore exists, the discharge of a syphilitic female produces on syphilitics the sore identical with that produced from the soft sore or chancreoid; hence we have indicated the source, and a very abundant one, of the infection of soldiers alluded to, under the aspect of the soft sore or chancreoid, followed by constitutional signs usually of a milder type, fortunately, and without constitutional cachexia.

Some of the testings I have made are very remarkable, and point to this source of contamination with much certainty. The following is a good illustration, as proof of the inoculative power of the discharge of constitutionally infected women, such as are admitted constantly to the wards of the hospital.

A very fine ruddy complexioned girl, aged 20, had been some months previously under treatment for intense syphilis, with ulcers of a rupious character. On admission (July 6th), she was suffering from a reopening of an extensive ulceration of the nates, and from severe syphilitic pains. She also had an abundant vaginal discharge. No primary sore of any kind was to be discovered.

From a single drop of the discharge, the following inoculations were made, each with fresh and never previously used pins' points.

July 7th. On herself; produced an intense sore, which lasted for several weeks.—On Carr, on whom inoculation from a simple discharge of a non-syphilitic woman had already failed; produced a sore which lasted several weeks.—On A. Kavanagh; produced a smart sore.—On J. Byrne; produced a regular chancreoid sore.—On Julia Carroll; produced a regular chancreoid sore.—On H. Conroy; produced a regular chancreoid sore.

Nothing much more active as a virus could be desired, yet the patient had no primary sore whatever; and the manner in which the inoculations were performed, and then covered with watch-glasses, rendered any extra virus incapable of being admitted. In this instance, it might be said that the patient carried into hospital the virus which was capable of producing these inoculations. Such a possibility as this I, however, disposed of by another observation, which I made thus, as proof of the inoculative power of the vaginal discharge, and of its giving origin to a pustular sore, capable of reproduction in its kind.

M. White, aged 20, with tumid labium, patches, vaginal discharge, no sore to be seen, indurated inguinal glands, alopecia, pains, and cachexia—admitted June 1st. The following inoculations were performed:

June 22nd. With M. Burke's discharge; failed.

June 23rd. With Conroy's discharge; failed.

June 25th. With Eustace's discharge; failed.

June 27th. With her own discharge; succeeded.—From her discharge

on M. Lewis; succeeded.—From her discharge on A. Healy; succeeded.—From her discharge on M. Carthy; succeeded.—From her discharge on M. Burke; succeeded.—From her discharge on C. O'Donohoe; failed.

June 29th. From her discharge on A. Healy; succeeded.—From the auto-inoculation from her own vaginal discharge of the 27th on M. A. Carroll; succeeded, and produced a smart sore.—From her discharge on J. Warren; succeeded.—From her discharge on J. Byrne; succeeded.

June 30th. From her discharge on Bayley; succeeded, and produced a sore lasting for several weeks.—From her discharge on M. Eustace in two places; succeeded.

July 2nd. From Lewis's pustular sore (produced by the inoculation of vaginal discharge of June 27th) on Leonard; succeeded.

[To be continued.]

THE PATHOLOGY AND TREATMENT OF SPASMODIC ASTHMA.*

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SPASMODIC asthma, in its various degrees and complications, comes across the path of all of us; and, although it is happily not a fatal disease, yet it is one which gives rise to a large amount of suffering, and tends to cripple many active-minded and otherwise healthy people. It is a complaint, too, which has not received as careful a study at the hands of medical men as it deserves; and it must be confessed that it happens not rarely that the patient knows about as much concerning the way of treating his complaint as the practitioner who is attending him. It is difficult to avoid this, where idiosyncrasy and multiple causation exercise so large an influence; but it nevertheless behoves us to study with unswerving perseverance the leading features of every case, and to aim at arriving at a classification which may in future prove a satisfactory basis for successful treatment. Now, in order to get a just idea of the pathology of spasmodic asthma, we should contemplate it in its purest form, unalloyed by bronchitis, its occasional accompaniment, uncomplicated by emphysema, its frequent result. Such an example presents itself in cases arising from inhalation of dust or certain strong-smelling particles, such as ipecacuanha, where the attack passes off on removal from the exciting cause. A person with healthy lungs, and free from any suspicion of cough or short breath, inhales the dust of a threshing-floor, experiences a sense of oppression in his chest, and finds it difficult—aye, almost impossible—to draw a deep breath; he is aware of a whistling sound accompanying each act of respiration, and speedily attempts to withdraw from the exciting cause. If he do so, his breathing will soon become easy, and the spasm will leave no after-result on his lungs. If we could examine his chest during the dyspnoea, we should find the following physical signs: sibilant and sonorous inspiration at the root of the lungs, and almost entire absence of respiration in the lower portions. There might possibly be slightly increased resonance of the chest; but, after the attack, none of these signs will be present, and the respiration-sounds will be perfectly normal. This is the purest and perhaps the slightest form of asthmatic dyspnoea. If the individual, however, remain longer exposed to the irritant atmosphere, his breathing will become more and more difficult, and his efforts to introduce air into his chest in proportion greater. By holding on to some convenient object, he will endeavour to fix his shoulders as high as possible, so as to bring all the muscles of respiration, both ordinary and extraordinary, to his aid; and yet with little relief, for his respiration only becomes prolonged and more difficult; an inharmonious concert swells within him; his thorax becomes more dilated with air, which each inspiration adds to, and imperfect expiration hardly diminishes; the diaphragm is pushed down; and thus the heart, liver, and spleen become for the time displaced, while his dusky and livid countenance shows how much the circulation is obstructed. If we now examine his chest, we find it hyper-resonant even in the cardiac and hepatic regions; sibilant and sonorous rhonchi coming and going in all directions, the expiration loudly prolonged and wheezy, and the respiration altogether more marked where the bronchi lie than where there is only vesicular tissue. I would draw your attention especially to the transitory character of the physical signs, as being

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