the posterior chamber just in front of the lens. Soon afterwards the lower part of the cornea was punctured, with the hope that the separated foreign body might be washed out with the evacuating aqueous humour. This actually occurred, and it was then found to be a minute coniferoid-looking growth, bearing series of spores arranged in chaplet-like fashion.*

We will merely mention the fact of the existence in India of a terrible disease, known by the name of 'Madura foot', in which a fungus, closely allied to some *Mucors*, seems to extend outwards from the bones and ligaments, growing destructively through all the tissues of the part. In exhibiting a specimen at a recent meeting of the Pathological Society, Mr. Jabez Hogg also expressed his belief that this fungus takes origin from some altered tissue-elements in the foot itself, rather than from externally derived germs.

The occurrence of such growths within closed cavities not exposed to the incidence of external germs, and their not more frequent presence in the ramified air-chambers of birds (where germs might so well lodge and grow), tells just as much against the supposition of their external derivation, as does the comparatively rare and occasional presence of the growths in these cavities militate against their being developments of some out of the multitudes of minute and invisible germs with which the tissues of higher organisms are believed by a few persons to be permeated. This latter view is only countenanced by the occurrence of facts which are considered by others to be equally capable of receiving a totally different explanation.

Certain insects, moreover, are not unfrequently the seats of remarkable parasitic growths, which, although they may after a time manifest themselves externally, either take origin in, or at all events start in their development from, some internal portion of the body, and are unknown to exist in any other situations. This is the case, for instance, with the strange *Sphærea Robertsii*, which grows from a caterpillar (*Hepialus virescens*) in New Zealand; with *Sphæria entomorphiza*, which appear in pairs from the middle line of the back, at the junction of the thorax and abdomen, in many of the West Indian beetles; and with many other anomalous growths which have from time to time been met with upon members of the insect world.

[To be concluded.]

OSSIFICATION OF THE THYROID CARTILAGE, FOLLOWED BY NECROSIS: TRACHEOTOMY AND DISCHARGE OF BONE.

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PRIVATE J. CURTIS, 31st Regiment, aged 38, was admitted to the Royal Victoria Hospital, Netley, at the 12th December, 1871.

Previous History.—He had been nearly twenty years in the army. He served five years at the Cape of Good Hope in the 73rd Regiment, and three years in India, including active field-operations during the mutiny in 1857-8. Having completed his first term of ten years' service, he claimed his discharge, and shortly afterwards he re-enlisted in the 31st Regiment. While serving in Portsmouth in 1866, he contracted a sore on the penis. The character of this sore is not stated in his official medical documents, and it is therefore impossible to say whether it was a true syphilitic chancre or a soft non-infecting sore. He was treated with iodide of mercury, but not to the extent of salivation; and as none of the constitutional effects of syphilis appeared for a period of four years afterwards, it is difficult to connect the symptoms which followed with a syphilitic taint.

In June 1870, he began to suffer from hoarseness, loss of voice, and dysphagia. These symptoms were followed by the formation of a large abscess in front of the neck. He described this swelling as having been as large as his closed fist, and occupying the space between the lower jaw and the middle of the thyroid cartilage, and bulging as far forward as the chin: it was extremely tender and painful. This abscess was opened in two places. One incision was made to the right of the thyroid cartilage, on a level with the pomum Adami; the other opening was made at the inner edge of the right sterno-mastoid muscle, near the sternal end of the clavicle. A large quantity of pus was discharged, the tumour rapidly disappeared, and the incisions healed up; but the opening of the abscess was not attended with any alleviation of the symptoms of aphonia or dysphagia.

His condition on arrival at Netley was as follows. He had great

dyspnoea, evidently produced by mechanical obstruction to inspiration; each effort to inspire was accompanied by a harsh stridulous noise; the voice was reduced to a whisper; he was unable to lie down; the countenance was anxious, but there was no abnormal rapidity of pulse or increase of temperature. On examining the neck externally, there appeared some thickening of the skin over the thyroid and cricoid cartilages; the space between the thyroid and cricoid was diminished, and the crico-thyroid membrane shortened. On placing the finger on the cicatrix of the upper incision already alluded to, a distinct depression in the right ala of the thyroid could be felt, indicating loss of substance at that point; but no pain or tenderness on pressure could be detected over any part of the cartilaginous skeleton of the larynx.

On examination with the laryngoscope, the ary-epiglottidean folds were found swollen; the left one was displaced and pushed over to the right side. The vocal cords appeared healthy; but immediately below the left vocal cord a whitish tumour appeared protruding into the cavity below the cords occupying the posterior third of the opening, and partially blocking up the rima.

As the case was urgent, everything was prepared for the operation of tracheotomy, in case any alarming paroxysm of dyspnoea should supervene. A violent paroxysm having set in at 1 o'clock next morning, the trachea was opened by Surgeon-Major Mackinnon, C.B. The operation was followed by instant relief to the patient; he breathed quietly and easily through the tube, and there was a cessation at once of all dyspnoea.

For several days the patient progressed most satisfactorily; but, on the morning of the seventh day after the operation of tracheotomy was performed, he was suddenly seized with a violent fit of coughing, which lasted for about two minutes, and during which he brought up into the mouth a piece of bone; the paroxysm of coughing ceased immediately afterwards. This fragment was very foetid, light, and friable, and had somewhat the conformation of the inferior and posterior angle of one of the alae of the thyroid cartilage. It was at first conjectured that it might possibly have been a piece of mutton-bone, which might have been accidentally lodged in the larynx when the laryngeal symptoms first appeared. But the patient positively declared that no such accident could have happened without his cognisance; and the shape and appearance of the fragment gave no support to this conjecture. The question was, from what bony structure could this have been detached. The os hyoides was examined and found intact. The spine was examined from behind, and no tenderness could be discovered indicative of disease of any of the cervical vertebræ; and, in addition to this, it was unlikely that a necrosed portion of the body of a vertebra would find its way into the larynx, on account of the strength of the structures lying in front of the spinal column. Besides, the sequestrum did not present the large cancellated structure characteristic of the body of a vertebra. There appeared, therefore, to be but one solution of the question—namely, that ossification of some portion of the cartilaginous frame of the larynx had taken place, followed by necrosis, and resulting in the large abscess already alluded to. Separation of this sequestrum most probably took place then, which, failing to find its way through the incisions in the neck, became fixed in the larynx, and produced the urgent symptoms which rendered tracheotomy necessary.

The patient is now convalescent; the opening in the trachea is completely healed up; he speaks no longer in a whisper, but with his natural voice; the swelling of the ary-epiglottidean folds has disappeared; the rima is, however, slightly narrowed, and there is a little stridor on deep inspiration.

It is possible, although I think very doubtful, that the pathological conditions existing in this case may have had a syphilitic origin. It appears to me more probable that the affection is one more allied to those described by Dr. Wilks at page 205 of his work on Pathology; where he remarks "that, although many chronic affections of the larynx have a syphilitic origin, there is, however, an affection independent of syphilitic taint attended with pain and swelling about the larynx, followed by abscess either within or without; very commonly one ala of the thyroid becomes converted into bone, dies and exfoliates, originating probably first in perichondritis, then ossification, and finally necrosis."

There can be no question that in this case the patient, on admission to Netley, was in imminent danger, and that the promptitude with which the operation of tracheotomy was performed by Mr. Mackinnon saved his life.

Note.—Since the above account of this case was written three weeks ago, the patient has been again attacked with urgent laryngeal symptoms, and it was considered desirable to open the trachea a second time, which has been done to his great relief. Most probably there is still another sequestrum making its way into the larynx, although nothing can be seen by the laryngoscope to indicate its presence.

* See Robin's *Végétaux Parasites*, 1853, p. 370. He adds: "Après l'opération le malade se trouva bien, et continua ses occupations sans gêne." Robin also mentions a case (p. 364) in which a larger though somewhat similar growth was met with by M. Gubler growing beneath the skin of the back of the hand of a young man suffering from a gun-shot wound. Several white bleb-like elevations of the skin were produced, which were found to have been occasioned by the growth in question.