to follow the course of deviation of the parts themselves; and, consequently, it should never be directly lateral. By using extension in the manner indicated, curves, which cannot otherwise be treated, may be unfolded. This unfolding process is slow; and this will not excite surprise, when it is remembered how short are the ligaments, and how closely fitting are the bones which are to be acted on. Rapid changes are impossible, and should not be expected.

When the instrument fits well, frequent changes are unnecessary; great pressure is never required, and it may even be hurtful. Modifications are necessary from time to time, to keep up the action of the instrument, and to vary the pressure, as the curves unfold.

Spinal instruments may be portable, when, if well fitting, they will be worn with great comfort and advantage; or they may be fixed to a couch. In the latter form, being used in the recumbent posture, when the weight of the body is removed from the spine, they are necessarily much more efficient to remove distortion than portable instruments. Not only is the recumbent position most favourable for the action of the instrument, but the instrument itself is infinitely more powerful to remove spinal curvature than any portable instrument can possibly be. The principle on which both of these instruments are constructed is similar; but the couch, acting with powerful machinery, instead of a slight cog and pinion motion only, is so powerful to effect the purpose in view, that it will remove distortion in cases where the portable instrument is utterly useless. In cases of severe distortion, I always recommend the combined use of the couch and the portable instrument, the employment of one alternating with that of the other.

After curvature has been removed, attention should be directed to the development of power by means of exercises which shall bring into action the muscles of the trunk and extremities; such as swinging, dancing, riding, swimming, and the like. These exercises, alternating with rest, will, if judiciously employed, rapidly produce a marked increase of muscular power, as well as improvement in the general health. Friction also, as in shampooing, is very useful, not only in gaining a better condition of the skin, but in conducing to that suppleness of body which, after the removal of spinal curvatures, is most difficult to acquire.

The *palliative treatment* of spinal curvature is applicable to such cases as are not curable. In Lecture v, Figure 16, is an instance of severe curvature, and well portrayed, arising from inflammation within the thorax and its consequences. To attempt to cure such a case would be fatal to the patient; but a support to the enlarged side and to the sunken shoulder will give immense comfort to the wearer.

Again, caries of the bodies of the vertebrae, destruction being irregular, is not unfrequently followed by lateral curvature above and below the seat of disease, after ankylosis is complete. These curves are formed for the sake of equilibrium; and it will probably not often occur that the surgeon shall desire to disturb this effort of nature. I have seen, however, pressure with a spinal instrument made on such curves; the disease re-established; lumbar abscess form; etc. It need not be said here, that efficient support is all the instrumental treatment that ought to be permitted in such a case.

Cases, also, very frequently occur in which, through

excessive distortion, rotation being very great, or ankylosis having taken place, the cure is impossible; yet, where well adapted support gives to the patient not comfort only, but power. Without such support, there may be extreme weakness; but with it, strength to follow the ordinary courses of life.

Lettsomian Lectures

ON

MIDWIFERY AND DISEASES OF WOMEN.

Delivered before the Medical Society of London.

BY

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LECTURE I. (*Continued.*)

ON SOME POINTS CONNECTED WITH THE PATHOLOGY AND ETIOLOGY OF FIBROUS TUMOURS OF THE UTERUS.

Changes undergone by Uterine Tumours.

THE *intrinsic changes* which these tumours undergo in the process of growth are most important; not only because they are of moment in enabling us to judge of the character of the growths, but also because they are useful as indications to guide us in the treatment. These changes, of course, have no relation to the extrinsic changes in the symptoms produced by the growth of the tumours, and by their connexion with surrounding parts.

The intrinsic changes may be classified into three varieties.

I. A process of *softening*, which includes five kinds: *a.* Conversion of the body into a more fleshy mass—a sort of sarcomatous transformation; *b.* Interstitial deposition of watery matter—œdema; *c.* Conversion into a cyst containing liquid matter; *d.* Suppuration; *e.* Fatty degeneration.

II. A process of *hardening*, which depends on the chemical composition of the tumour, and may be peripheral or interstitial.

III. A process of *absorption*, under which a tumour disappears in part or altogether, and this without the assistance of medicine.

I. *SOFTENING.* *a.* The *sarcomatous state* has been usually regarded as the earliest stage of uterine fibrous tumours from the time of Hunter and Bayle, during which period they were spoken of as "the fleshy tubercle". Guyon, however (an excellent authority on uterine fibrous tumours), implies that this softening is not so often an *early stage* as a *progressive stage* or decay; although he admits that it is occasionally also the incipient stage of fibrous tumour. Moreover, in the softening from decay, the feeling of softness is more marked. Such tumours are generally redder in colour and more full of vessels; and the uterine tissue, especially the muscular, is more marked.

b. Softening by *œdema* may come on suddenly; and then, according to Guyon, it is accompanied with great vascularity of the tumour. These cases, he believes, generally prove fatal. The disease is probably inflammatory, and closely resembling acute œdema of the scrotum. Luys gives an example

where a capillary puncture was made, which gave issue to about a tumbler of albuminous fluid. Death resulted two days afterwards, although no peritonitis was observed at the *post mortem* examination. More frequently, however, œdematous softening is a chronic disease. The occasional and temporary growth of fibrous tumours is due to this cause. A tumour will sometimes, if coarsely handled, become larger and softer. This may, it is true, be due to engorgement; but in one case in which this occurred, where I made an exploratory puncture, nothing but serum came away. There was also an absence of inflammatory symptoms. Cruveilhier thinks that in some cases the œdema is dissociated into numerous small masses, which, being congregated together, come to constitute the greatest part of the fibrous tumour.

c. Softening by *cystic transformation* takes place in three ways.

1. *Irregular cavities*, without parietes properly so called, are formed. These are called by Cruveilhier *geodes*, and would probably correspond to the alveolar disease of the ovary. They resemble very closely the last variety of œdematous swelling before referred to, only they appear to be chiefly restricted to the intercellular spaces. The œdema becomes localised, and so constitutes large cavities between the fibroid masses.

2. *Pseudo-cysts* are formed; *i.e.*, the solid fibrous mass itself undergoes local softening or liquefaction. The softening is described by Costello (*Cyclopædia of Practical Surgery*) as beginning (in *fibromas*) in the centre of the tumour by one or more points. This softening is often associated with some degree of transparency that gives to the structure a gelatinous aspect. As it advances, it so entirely puts on the appearance of jelly, that tumours in this state have been designated *fibro-colloids*. But there always remains enough of the external layer to set one right as to the nature of the tumour. Exceptionally, but rarely, they are found in an *hematode* state.

3. *True cysts*, or cavities lined by epithelial membrane, as in cystoid disease of the ovary, may be formed. Mr. Paget describes this change as one of cyst-formation, similar to what occurs in the breast; well defined cysts, lined with smooth membrane, being produced. Accordingly, we read of *fibro-cystic disease* of the uterus as an affection of not unusual occurrence. I believe, however, it is very rare. I learn from a communication made through my friend Dr. Greenhalgh, that Mr. Savory of St. Bartholomew's Hospital (no mean authority) denies the existence of this disease in the uterus altogether; the so-called examples of it in the College of Surgeons being simply pseudo-cysts without lining membrane. Two cases are on record, in which gastrotomy was lately performed by Mr. Brown and Mr. Wells. In the first case, examined by Messrs. Nunn and Holmes, the tumour was stated to be multilocular, and the cysts lined by membrane. It was found incorporated with the fundus uteri, but probably originated in the subperitoneal tissue in the neighbourhood of the uterus. This alone would show that it might have had an origin extraneous to the uterine tissue. The examination was carefully made before the tumour was declared to be fibro-cystic. In Mr. Wells's case, recorded in the same volume of the *Pathological Transactions* (xiv, 198), I learn from inquiry that he is not prepared to say that the fluid was con-

tained in cysts with distinct lining epithelium. Most probably, therefore, it was contained in a pseudo-cyst. One case only appears more difficult of interpretation; and that is Dr. Wilson's case, published by Mr. Hewett, and quoted by Mr. Brown in his work. The disease here entirely originated from the right side of the fundus uteri by a pedicle, and the cysts were lined by a smooth delicate-looking membrane.

Pseudo-cysts may undergo other changes; *viz.*, a salutary one, *i.e.*, where the occurrence of the change is only a prelude to the final absorption of the tumour; or the tumour enlarges, and attains such proportions as to become dangerous to life.

To trace these changes during life is by no means an easy or satisfactory task; because we cannot, in the ordinary run of cases, see them in the earlier stages, and our manipulation and external palpation of them is at most only to be made through the abdominal parietes. If the female be corpulent (a not unusual occurrence in cases of fibroid tumour), but little correct information is attainable. Again, a vaginal examination is often nugatory, if the tumour be in or about the fundus, the most common locality in which they are found. And all this is especially the case at early periods, or when the tumours are small.

But we can get at the fact by collateral and strong presumptive evidence. Fibrous tumours undoubtedly do liquefy, as before stated; and soften in the centre, becoming changed in a pseudo-colloid mass. Usually, also, there is enough of the external fibrous matter to explain the nature of the tumour. But we as undoubtedly find pseudo-cysts about the uterus, occupying the position which fibrous tumours usually do. In nearly every such case, fibrous tumours of the ordinary kind are found in other parts of the organ. Some of these are in a transition state, containing fluids or semifluids in different states of viscosity.

In one remarkable example of fibroid disease given by Atlee, the truth of this proposition was proved by ocular demonstration. The case is important. It is the case mentioned in his interesting paper on the Surgical Treatment of Fibrous Tumours of the Uterus, in the *Transactions of the American Medical Association* (vol. v, p. 586).

The subject of this case was a young lady, who in July 1845 first noticed a tumour in the right side, midway between the ribs and pelvis. It was then as large as the fist, and oblong in shape; could be pushed over to the linea alba, depressed, and elevated; but, upon removal of pressure, returned to its usual position. Three months after this, she was seen by a medical man at Rhode Island, who described the tumour as decanter-shaped, with a narrow attachment to the right side of the uterus. He could play it about, and considered it an ovarian tumour. The succeeding winter (1845-6), it grew to twice the size which it had when Dr. Atlee first saw the patient, having enlarged gradually. The following spring (1846), it again gradually diminished to about one-third of its previous size, without treatment. The next summer, it again increased; and continued to do so until the latter part of the fall, when it again diminished without treatment. It remained stationary now until the next fall (1847), then increased gradually to a greater bulk than ever.

In the spring of 1848, she placed herself under the care of another medical man at New York, who used

chiefly the electro-magnet, and croton oil with other purgatives. The flatulence diminished; the tumour but slightly.

In March 1847, she was under the care of a physician at Albany, who, believing it to be ovarian, tapped her, and came against a hard substance. Nothing flowed except a teaspoonful of blood. The trocar was introduced about two inches, and required considerable force to enter it. On putting a probe through the cannula, it came against a hard unyielding substance. The wound healed kindly.

It was in May 1847 that she came under Dr. Atlee's care. A tumour then occupied the left iliac, hypogastric, umbilical, and right hypochondriac regions, part of the right lumbar, and part of the right iliac regions. It was firm, slightly elastic; did not fluctuate; could be moved in all directions by using considerable force.

On examination *per vaginam et anum*, the patient on her side, it was found to occupy a large portion of the pelvis; the uterus could not be distinguished. It was believed, therefore, that the tumour was entirely uterine. The os could not be felt. The tumour could be played before the finger in the vagina, through the abdominal parietes. When placed on her back, the os could be detected by the index finger placed far back, but not the cervix. The sound penetrated only two inches and a half in the normal direction. But this was, however, accidental; for when, in the subsequent history of the case, she had recovered from gastrotomy, the sound passed a considerable distance. Very little motion could be made with the point of the sound, owing to the fixed position of the uterus at this point. The sound introduced into the bladder took a direction towards the right side.

Owing to the obscurity of the diagnosis and the wishes of the patient, it was thought advisable to try an exploratory incision—i. e., to perform gastrotomy.

The abdomen was opened. Now, gentlemen, I wish you to note the appearance of the tumour. The diseased mass was turned entirely outside the abdominal cavity. It consisted of the uterus itself, which was either hypertrophied or else distended by a solid body within it. The peritoneal coat was elevated in several places from the surface of the tumour into cystiform bodies filled with a yellowish fluid. One of these, of about the size of a walnut, was at the top of the fundus; another, larger and more irregular, on its left side; and a couple of smaller ones lower down. The right ovary was enlarged to the size of a small orange; and the left was about three times its original bulk. Both ovaries were attached low down to the uterus.

In this state of things, nothing more could be done. The tumour was returned. The wound healed rapidly.

The subsequent history relates to an attempt afterwards made to relieve the patient in June 1849, two years afterwards, by enucleation *per vias naturales*. This proved unfortunate in result, for on Nov. 3rd she died. On *post mortem* examination, there were found to be adhesions of the cicatrix to the anterior part of the womb. Purulent serum was effused within the cavity of the abdomen, indicating recent inflammation. The tumour itself had very much the same appearance as when seen during gastrotomy. But all the cystiform bodies had disappeared, save one at the fundus, which was not altered in size, but was less fluid. The ovaries had not changed in appearance. The firmness of the tumour had much diminished; and, when it was cut open, large masses of it had degenerated into a brain-like substance.

Now, the inference I would draw from this case is twofold. In the large tumour, there was the process

of softening in an earlier stage; a brain-like substance took the place of the fibrous tumour—the pseudo-colloid softening before referred to. The more solid cystiform body was, again, in a later stage than the large one, more liquid, and yet less fluid than the other cystiform bodies, which had undergone a process of more decided liquefaction, as seen during the operation of gastrotomy, before their final disappearance.

That these liquefied tumours have a decided relation to the more solid is manifest from the fact, that we scarcely ever meet with the former, unless the uterus contains at the same time some of the more solid fibrous bodies.

The very description of some of these tumours, although made from the naked-eye appearances, is characteristic of their fibrous character. In the case of a fibro-cystic tumour described by Dr. Jackson (*Boston Medical and Surgical Journal*, No. 64), each cyst was said to contain, 1, a pale amber-coloured fluid; 2, a gelatinous substance of the same colour, but varying in consistence; 3, semi-organised masses, varying in different cysts from the colour of cream to that of clots as they occur in the heart, and in size from an almond to that of the female hand.

The liquid contents of these fibrous tumours have, so far as I know, not been very accurately examined.

In one case reported by M. Louis Blin, where the tumour was evidently an hysteria, occurring in the anterior wall, the tumour contained a very brown-coloured thick fluid, and floating within it numerous gelatiniform flakes. The cyst itself was lined by an internal layer of this same gelatiniform matter, and a distinct muscular coating, analogous to uterine muscular fibres. M. Robin found, on microscopic examination, that both in the liquid and solid portions of tumour there were muscular fibres of Kölliker disseminated through an amorphous mass. M. Broca, who also examined the same specimens subsequently with much attention, discovered, besides these muscular fibres of Kölliker, which were long, swollen in certain parts, and containing granular particles, some very short fusiform fibres, not granular, which he looked upon as a form of fibro-plastic element. In fine, it was clear that everywhere here were found the large fibro-cellules (of the Germans), which are evidently muscular fibres; and by their side, which had a very particular aspect, small elongated corpuscles of fibro-plastic tissue, with their central nucleus. (*Bull. Soc. Anat.*, vol. xxviii, pp. 54-56.)

In another case recorded by M. Rotureau (*Bull. Soc. Anat.*, vol. xvii, p. 139), in a pedunculated uterine tumour, the fluid contained a yellowish material, rather offensive, of the consistence of a soft bouillie, which flowed out of the cyst when cut open. This fluid contained, floating in it, pieces of half-fleshy reddish friable fibrous masses, evidently the *débris* of the fibrous mass.

I am fortunate in having obtained some particulars of such fluid contents from so excellent and known an observer as Dr. A. Clark. That gentleman divides uterine cysts into four kinds: 1. Adventitious cysts, or hydatids; 2. Autogenous cysts; solutions of continuity in the uterus, independent of adventitious growths; 3. Glandular cysts; dilatations of the normal gland-follicles, common in the neck of the uterus, and not very uncommon in the body of it just below the mucous surface; 4. Cysts occurring in morbid growths as local solutions of continuity, and named from the

growth which they exhibit, as fibro-cystic, collo-cystic, encephalo-cystic, and so on. I wish only to refer to the second variety—autogenous—corresponding to the alveolar before noticed, or *geodes*, and the fibro-cystic of the fourth variety, as bearing on my subject.

The fluid contents of the second variety, Dr. A. Clark states, have obviously arisen from extravasations of blood breaking up a portion of uterine substance. They have contained serum; variously corrugated and contorted blood-discs, isolated and in heaps; corpuscles like the white ones of blood; granular cells; bits of coagulated albumen, oil-globules, and cholesterine. In an instance which Mr. Defriez of Bethnal Green sent to Dr. A. Clark, there were several cysts of this kind formed by successive extravasations of blood, *said to have been felt by the patient at the time of their occurrence.*

Whether the change in pseudo-cysts is or is not of an analogous character, in so far it is remarkable, that I have found, on microscopical examination, exactly the same bodies mentioned by Dr. A. Clark here in the serum taken from the meshes of an infiltrated fibroid, excepting only cholesterine. I also found crystals of uric acid.

Dr. Clark has also informed me that he has on several occasions examined the fluid of the cysts of fibro-cystic uterine tumours, but entirely without reference to their size. The fluid has been either sanguinolent, serous, or gelatinous.

When *sanguinolent*, he found the elements 1, 2, and 3, before referred to as found in the juice of succulent fibrous tumours, with blood-crystals, *amorphous hyaline* lumps, and bits of fibrillated lymph.

When *serous*, it was coagulable by heat, but very feebly so, compared to ordinary albuminous effusions. The structural elements resembled in character those given in a diagram, with the qualification, that Nos. 1 and 6—*i. e.*, the elements before described as found by him in the same juice of fibrous tumours—were few in number.

When *gelatinous*, the contents were of two kinds. In one, the gelatinous appearance was due to the infiltration of a fine *fibrous* network with ordinary serum; in the other, to the infiltration of a fine network of *mucin fibres* with a very feebly albuminous and somewhat viscid fluid. The *fibrous* network disappeared under the action of acetic acid, while the *mucous* network was unaffected by it, or rendered more distinct.

The structural characters of both kinds of gelatinous contents were much the same, and consisted of the elements already described, with the addition of *mucous vacuolating* and *proliferating* cells. These were the contents of (Dr. Clark's third variety) glandular cysts, which, not forming part of my immediate subject, I did not refer to.

This feebly albuminous character of the fluid, and the absence of hairs and epithelium, together with the presence of fibro-plastic ingredients, are characters which contrast in a remarkable manner with those found in ovarian tumours, and as such may be very useful in a doubtful case of diagnosis.

My friend Dr. Greenhalgh has informed me that Mr. Savory of St. Bartholomew's has also examined the fluid contents of these growths. The cavities contain more or less fluid, which is made up of disintegrated fibrous tissue-cells and oil-globules floating about in serum or dilute liquor sanguinis.

In true fibro-cystic disease, the epithelium-particles found in the fluid are exactly similar to those found in ovarian cystoid disease. The intensely albuminous character of the liquid, and the absence of *débris* of fibrous tissue, would make up the other chief differences.

When the fibro-cystic disease was in the ovary, we might expect to find, in addition, the large compound nucleated cells, and hairs, besides the cholesterine crystals.

Pseudo- and fibro-cysts, however, should not be mistaken for other cysts occasionally found in connexion with the uterus, but which have a different origin. These are cases where a Graafian vesicle has fallen into the cavity of the abdomen, instead of passing downwards into the Fallopian tubes. They appear to contain hairs, teeth, etc., or contents occasionally found in ovarian tumours; or, by falling somewhere within the abdomen, it may be upon the uterus, Fallopian tube, or elsewhere, they may develop true fibro-cystic disease. A remarkable example of the first kind is that which occurred in the Salpêtrière, and was mentioned by M. Blot before the Société Anatomique.

The tumour, which was attached inferiorly to the uterus, and closely adherent to surrounding parts, was found to be partly ossified, and to contain at one part four little bodies ranged in a row, having the aspect of incisor teeth; one of these showed a free tricuspid border, as is often observed in teeth of this kind. They were very hard and ossified, but without enamel. This case was brought before the Société Anatomique, and the discussion elicited a very able paper by M. Pigné, in which he proved that bodies were shown to be monstrosities by inclusion. In a subsequent *séance*, M. Grivot Grandcour exhibited some uterine cysts taken from a woman aged 60. These were placed behind the organ, and formed a tumour as large as a child's head. One of these was partially ossified. The others were soft and transparent. On the opposite side—*i. e.*, anteriorly—a unilocular tumour existed, containing in its cavity hair and a butyraceous-looking matter. These bodies were, however, stated by M. Barth to be only found in the woman, and in the neighbourhood of the uterus, and were attributed by him to the escape, at the moment of fecundation, of an ovule, which then developed imperfectly: in fact, an extrauterine pregnancy. The ossification was a process of age. (Vol. xxii, p. 3.)

It is in this way that I should explain Mr. Nunn's case of fibro-cystic disease before referred to, and Mr. de Méric's late case of cystoid disease, for which he successfully performed ovariectomy, and which grew, not from the ovary, but from the Fallopian tube.

The coexistence of these pseudo-cysts in fibrous tumours is not observed very uncommonly; and their occurrence should be borne in mind in some cases where the diagnosis is difficult. Let me allude to a few examples by way of illustration.

Dr. Tanner has related a remarkable case (*Obstetrical Transactions*, vol. iii, p. 11).

An oval cyst, about nine inches broad, apparently subperitoneal, was stretched upwards from the fundus uteri, containing about a pint and a half of mucous fluid. The cavity of the uterus contained a fibrous tumour, of about the size of the half of a small orange.

Several such are mentioned by Mr. Paget in his

Lectures on Surgical Pathology. Dr. Atlee mentions a very interesting case where this change had taken place in a fibroid.

He first saw the case in July 1852, when a large fibrous tumour, of the size of a seven months impregnated uterus, was diagnosed. In the September following, the tumour had greatly enlarged, and exceeded in size that of gestation at the full period; and the upper part of the abdomen had become elastic, and fluctuation was evident. In the October following, two large cysts were tapped, giving exit in the first to three pints of a dark coloured fluid, with a small quantity of blood. From the second cyst, the same quantity of clear transparent fluid was drawn. On manipulation now, the original fibrous tumour was readily felt. Although several mishaps occurred in the progress of this case—air entering within the sacs, and subsequently fetid serum and gases were drawn out by tapping, it ultimately did well, all traces of the tumour having disappeared. (*Surgical Treatment of Fibrous Tumours, Transactions of American Medical Association*, vol. vi, p. 558.)

Dr. Jackson (*Boston Medical and Surgical Journal*) relates an example of multilocular cyst developed in the fundus of the uterus.

The symptoms during life were those of a fibroid. This patient was tapped several times. The cysts varied from the size of a walnut to that of a foetal head. These cysts contained variously coloured fluids.

The French authors mention several examples of this disease also.

M. Barth (*Bull. Soc. Anat.*, xxvii, 55) found an abdominal tumour attached, and taking origin in the posterior wall of the uterus, which was very large. It was a fibrous tumour, furnished also with a cyst in its interior, and holding within it about half a gallon (3 litres) of a citrinous albuminous liquid. There were two other small fibroids in the anterior wall, one in the fundus.

M. Gaubier (*Bull. Soc. Anat.*, xv, 234) describes a case, also mistaken for ovarian disease, in which a large three-lobed fibroid, of two pounds weight, filled the greater part of the iliac fossa, in which cysts were found containing a bloody serosity. M. Rotureau (*ib.*, p. 135) mentions another case, also mistaken for ovarian disease, where a fluctuating tumour existed in the right iliac fossa, and was found after death to be a pedunculated fibroid, with cysts attached to the fundus. Another is mentioned by M. Icery (*ibid.*, xxviii, 135), where ovarian and uterine cysts coexisted. The uterine cyst was very large, with thick parietes attached to the organ. M. Rieux (*ib.*, xxiv, 19) gives an account where cysts of the uterus were found. The patient was tapped three times. The diagnosis during life was cancer with ascites. The *post mortem* examination revealed a fibrous tumour, with a unilocular cyst, filling the abdominal cavity.

In the table which I have prepared to illustrate the effects of gastrotomy in fibrous tumours, several cases by Messrs. Brown, Wells, Hakes, Fletcher, etc., are recorded, and, with those before given will suffice as examples occurring in British practice.

[To be continued.]

DEATHS FROM FEVER. Within the brief period of seven months three physicians, who have successively occupied the responsible position of medical superintendent of the Dundee Royal Infirmary, have been cut down by fever; and of this disease the matron has quite recently died. The professional loss sustained by the deaths of Dr. Glen Dr. Hamilton, and Dr. Grant is very great. (*Edinburgh Med. Journal.*)

Lectures

ON

CERTAIN MUTUAL RELATIONS OF PHYSIOLOGY, PATHOLOGY, AND THE PRACTICE OF MEDICINE.

BY

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LECTURE III. (Continued.)

On the Pathology and Treatment of Certain Forms of Delirium. Therapeutics. The Physiological and Therapeutic Action of Alcohol. The Present State of Therapeutics, and the Direction which Therapeutical Inquiries should take, etc.

BUT, passing from this subject of pathology, I must come to the more direct object of my concluding remarks, therapeutics; and, perhaps, I could have no better example of the improvement that has taken place, in their practical application, than in reference to the very symptom to which I have just referred. Is it not true that fewer cases of violent delirium are met with at the present day than was formerly the case? that in our surgical wards the occurrence of traumatic delirium is comparatively rare? and are not these results to be attributed to that modification in treatment, which has led both the physician and the surgeon to maintain a due nutrition of the body, wherever injuries are to be repaired, or disease controlled? And here I would remark on the importance, not only in disease, but in the treatment of all accidental lesions, of endeavouring to anticipate symptoms which may arise and complicate the case, by an early recognition of the pathological state of the various organs of the body. In the treatment of all cases of acute disease, a knowledge of this kind is of the greatest importance to the physician, for upon it will depend the nature of the treatment by which the local affection shall be met; and is not this knowledge of equal importance to the surgeon in dealing with an accidental lesion? Do we not sometimes see that a patient, ignorant of some existing organic disease, nay, thinking himself in a state of perfect health, meets with an accident of a more or less grave character, but which necessarily confines him to his house, his sofa, or his bed; that this interference with his usual habits of life, and the depressing influence which necessarily ensues, becomes the means of accelerating the progress of the existing disease, or, if there be a feeble or fatty heart, acts as the determining cause of sudden death. Nor should we forget, in the application of therapeutic measures, the way in which this fatty disease of the heart may complicate certain more chronic ailments. Its frequent association with various gouty affections shows us the importance of caution, in the administration of depressing remedies in these conditions, and the danger we may incur by the sudden withdrawal of their habitual stimulants from those who suffer from these gouty attacks.

And here I would remark that one of the great aims of the practice of medicine should ever be to postpone the approach of death. The modes of dying have always formed a subject, not only of phi-