favour of this patient. I stated to the gentlemen who consulted me, that I thought the child might be delivered by the forceps; and, as they agreed, I proceeded to the operation.

There was great difficulty, from want of space, in applying the pubic blade: it was at length placed over the ear of the child. The opposite blade was more easily introduced. When the instrument was fixed, the pains, which had ceased, returned with vigour; and, by acting with them, the child was delivered in half an hour. It did not at first inspire, but the heart was acting: by degrees, respiration was fully established, and the child saved. This lady recovered without any unfavourable symptoms.

These cases, to which I might add others of a similar character, convinced me that in these discussions about the comparative merits of the forceps and crotchet in difficult labours when the head was "impacted", we were not speaking of the same thing. When the head is impacted, because the pelvis is slightly distorted, the forceps may and should be used; but when the impaction is caused by the conical cavity of the masculine pelvis, it should be avoided. The former class of cases prevail here in a much greater degree than the latter; and, consequently, the operation of perforation should be very seldom performed. I have stated how it may be avoided in those cases, where it has been performed in consequence of want of space in the conjugate axis of the pelvis. I trust that I have now shewn that it may also (with these few exceptions) be avoided when the head is fixed in the pelvic cavity. If this be granted, an important corollary follows this conclusion; viz., that delays under such circumstances are always dangerous. If I am obliged to perforate, I delay the operation as long as possible, to avoid destroying the child; but if I think that it can be saved, the sooner the mother is delivered, consistently with her safety, the better. Hence, as soon as the disproportion is ascertained, and three or four hours are allowed, in order to estimate the power of the uterus, the forceps may be used: a longer delay exposes the patient to all the risks of inflammation. In fact, many of the bad effects of forceps operations arise from having recourse to this aid far too late, when the passages are inflamed. The action of the uterus is suspended, because inflammation is commencing in the tissues; the head of the child is allowed to remain in the same position for ten, twelve, even twenty-four hours; at length, the forceps is applied, and produces perhaps a slough, and consequently a fistula; the perineum never escapes. Such unfortunate results might all be avoided by more timely interference.

These facts may also shew the importance of a more careful study of the peculiarities of the pelvis and their diagnostic characters. By this means only can we recognize the true character of the difficulty the moment it presents itself. I know of no other way of discriminating cases, which require aid, from those which may be left to themselves. To decide such a question by time alone, exposes the patient to all the risks to which allusion has been made. A previous knowledge of the cause of arrest is absolutely essential, in order to avoid unnecessary delay.

Henrietta Street, Cavendish Square, February 1853.

ILLUSTRATIONS OF DISEASES OF THE HEART AND AORTA.

By R. HUTCHINSON POWELL, M.D.

(Concluded from p. 206 of last number.)

II. ILLUSTRATIONS OF ANEURISMAL DISEASE.

AN extract taken from some manuscript notes of lectures delivered by Dr. Corrigan, of Dublin, in 1838-9, clearly, though very briefly, sums up the pathology, diagnosis, and principles of treatment of internal aneurismal diseases, as exhibited in the succeeding cases; and will prove interesting, from the close correspondence existing between the lecturer's *dicta* and the results of independent and varied observation. I am individually responsible for the correctness of the report.

"Aneurism of the aorta is divided into true and false. In the first variety, simple dilatation of its coats exists; in the second, ulceration takes place through the inner and middle coats, causing rupture; the latter variety is most frequently met with.

"Its pathology essentially consists of disease set up in the lining membrane, and subsequent deposition of lymph between it and the fibrous coat. The latter ultimately gives way, and the areolar tissue alone then forms the aneurismal sac; the opening from the aorta into the aneurism being mostly small. *True* aneurism is never cured when present at the mouth of the aorta; the blood being always fluid. In *false* aneurism, the process of cure consists in the deposition of lymph at that part of the sac which is most remote from the circulation. The lining membrane, which is ultimately formed by, and constitutes the innermost of the fibrous layers, becomes continuous with that of the aorta, and takes on the characters of serous membrane. No deposition of lymph ensues in true aneurism; hence, no reparation is effected, the blood continually circulating through the dilated aorta.

"As to the diagnostic symptoms of aneurism of the aorta, death may ensue without its detection previously. In ordinary cases, a pulsating tumour is observed to the right of the sternum, between the second and third ribs, on the right side of the aorta. Pulsation cannot be detected, if a quantity of coagulated blood intervenes. The pulsation may be rendered more evident by the aid of a prolonged lever; its movements being thus made more apparent, as from the increased movement of the leg in popliteal aneurism. There usually exist dulness on percussion, and absence of the normal respiratory murmur over the affected part of the chest. *Bruit de soufflet* may or may not be present. When organic disease exists in the chest, it is rendered more evident on the patient's "taking cold". The pulse is not to be depended upon. The negative symptoms of the non-existence of other thoracic diseases will much assist in the diagnosis. If the bellows-murmur be heard in aneurism of the aorta, the valves will be invariably found engaged, unless where the murmur arises from depletion. Aneurismal disease is especially indicated by the morbid sound being intense and circumscribed in a place in which it does not naturally exist in the course of the vessel.

"Aneurism of the abdominal aorta is marked by severe pain, intermittent in character: it is usually of the *false* variety. In thoracic aneurism, there is usually but little pain complained of. It is said that aneurism of the aorta produces hypertrophy of the heart; but it never does so, unless when obstruction or diseased valves exist.

"In abdominal aneurism, it is to be observed that the diagnosis is very difficult in the early stage: there are more violent neuralgic pains than in thoracic aneurism. In the erect or sitting posture, no bruit is detected by the stethoscope; but when the shoulders are placed lower than the hip, a loud bellows-murmur is then perceptible. It is a severe disease; and the patient is very liable to sudden death. In chronic enteritis, dyspepsia, and derangement of the nervous system, a bruit is occasionally heard, but along the *entire* abdominal aorta; the aneurismal murmur being circumscribed. Aneurism may be known from a tumour pressing upon the abdominal aorta, by the murmur not becoming inaudible or of less intensity on change of the supine or lateral posture; by the expansive and heaving motion of aneurism; by the constantly recurring and severe pain and bellows-murmur; by the immobility of the tumour; and by the history of the case. Coldness of the extremities is a common symptom, owing to the non-reception of the normal amount of blood, much of which is detained in the aneurismal sac.

"In the treatment of aneurism, the indications are: First, to promote the coagulation of the blood in the aneurismal sac, and thus to diminish the chance of rupture: this may be effected by moderate and repeated venesection, by the use of digitalis, spare diet, and by using but little liquid; the object being to cause the blood to possess a large amount of fibrin, so as to promote its coagulation in the sac.

Second, to relieve neuralgic pains involving the pleura, peritoneum, and the nervous trunks, by sedatives and by local bleeding, occasionally conjoined with the exhibition of mercury to touch slightly the gums. By these means, the inflammatory action, which is liable to arise in the coats of the sac, may be overcome. It should always be remembered, that the pulse in many cases is not a sufficient guide in the treatment, venesection often giving relief when the pulse cannot be felt at the wrist.* The abstraction of blood acts by emptying the sac, and lessening its pressure on adjacent parts. New aneurisms may form in the course of the aorta; those farthest removed from the heart being most likely to take on the reparative process."

CASE VI. TRUE ANEURISM AT THE ROOT OF THE AORTA. (Related by Mr. Obré.) A married woman, 35 years of age, nine months advanced in pregnancy, was observed, half-an-hour after retiring to bed, to become speechless, though conscious. Death ensued one hour subsequently.

On *post mortem* inspection, the pericardium was found to contain about a pound of dark coagulated blood. The heart's tissue was rather flabby. The aorta was externally of a reddish hue, bulging at one part, and partially adherent to the serous envelope. The internal lining membrane was also reddened, and showed three points of ulceration, which had made way through the outer coats of the vessel, and had given rise to the fatal hæmorrhage. The abdominal organs were healthy, excepting the liver, which was slightly enlarged.

This is an instance of the absence of any direct diagnostic character of impending death, resulting from disorganization of the arterial tissues; no bruit, or other sign referrible to the heart or blood-vessels being complained of, or recognisable during life. The probable recurrence of incidental inflammation of the internal vascular coat in this as in other succeeding cases, serves to account for the giving way of the tissues, ulceration being a common sequence, and leading to a fatal issue from extravasation of blood.

CASE VII. ANEURISM OF THE AORTA THROUGH ITS ENTIRE COURSE. J. H., aged 45, a wheelwright of phthisical family, had, about seven years previous to coming under Dr. Hare's notice, fallen from a high loft, and cut his head. He had become emaciated, and had suffered from cough and expectoration for two years. His present symptoms were a sense of oppression when in the recumbent position, especially on the right side; cough, with some expectoration; dysphagia; hoarseness; short breath on exertion; pain in the right shoulder, and on the right side of the sternum; the tongue was furred; he had some thirst; pulse 95, small, easily compressed. A tumour existed between the first and second ribs, close to the right border of the sternum. It was circular in shape, two inches in diameter, and projected from a quarter to half an inch from the chest. Pulsation was very strong, the parietes feeling thin. There was no murmur, but the sounds of the heart were distinct. Auscultation and percussion of the chest indicated some solidity of the lungs, especially the right.

A month subsequently, the patient had an attack of dyspnoea, and inability to swallow, with lividity of the face and hands. The pulse was 100, full. He was relieved by a small bleeding, together with a mixture of digitalis and nitre (previously in use), conjoined with ipecacuanha and squills. The tumour subsequently diminished in size, so that in three months there was merely a slight prominence, and its diameter was reduced to half its former size, with proportional diminution of pulsation. The man became gradually weaker, now suffering, in addition to his other symptoms, from giddiness, irregular pain in the chest, and occasional partial syncope. The left hand and arm had lately become œdematous. He died without a struggle, six months after coming under observation.

* An instructive case is given in the *Lancet* (March 27th. 1852), under Dr. Addison's care, in Guy's Hospital, in which the pulse of the left radial artery from being feeble, ultimately became nearly imperceptible. This was (*post mortem*) traced to obliteration of the left subclavian artery from the pressure of an aneurismal tumour in the arch of the aorta.

A *post mortem* examination revealed tuberculated and excavated lungs. The heart was large; the mitral and aortic valves were thickened, but smooth. Copious deposition of cartilage and bone was found in the lining membrane of the aorta. The aneurism arose from the superior surface of the arch of the aorta, close to the arteria innominate; it was globular in shape, and was filled with large coagula. Besides displacing some large vessels in the vicinity, it had produced absorption of a small portion of the sternum, flattening of the trachea, with slight ulceration, and partial absorption of some of its cartilages. Another small aneurism was found, commencing at the under part of the aorta, at the point of junction of the arch with the descending portion of the vessel; two small bulgings appeared on the anterior aspect of the arch.

CASE VIII. STERNAL TUMOUR SIMULATING ANEURISM OF THE AORTA. (Mr. A. Anderson.) A woman, aged 59, had been under treatment, with little relief, five years previous to her death, for pains at the top of the sternum, supposed to be neuralgic or rheumatismal. Two and a half years subsequently, a small pulsating tumour was observed over the site of the former pain. It was very tender on slight pressure. It increased in size, to the right and left of the summit of the sternum; the tenderness becoming aggravated. Acute pain was felt, six months prior to death, in the lower extremity as far as the knee. She had had slight hæmoptysis on two or three occasions. The tumour followed the respiratory movements; and a bellows-murmur existed over the swelling.

On *post mortem* examination, the heart and arteries were found almost healthy. The calcareous matter of the sternum had nearly disappeared, the bone enclosing, instead, a fibrous encysted mass, about two and a half inches in antero-posterior diameter, which pressed upon the aorta.

CASE IX. TRUE THORACIC ANEURISM OF THE DESCENDING AORTA NOT RECOGNISABLE DURING LIFE: DEATH FROM SECONDARY HÆMOPTYSIS. (Dr. A. T. Thomson.) W. W., of weakly constitution, suffering occasionally from hæmoptysis and dyspnoea, was emaciated on coming under Dr. A. T. Thomson's observation. The pulse was 84; the heart's sounds normal; coarse respiration was heard throughout the right side of the chest; the breath-sound was defective at the summit of the left lung, over which there existed dulness on percussion. Purgatives and gallic acid were given. On the second day, he had copious hæmoptysis. The other symptoms persisting, he was bled. The blood was neither buffed nor cupped. Gallic acid was continued. On the third day, he had further hæmoptysis. Venesection was repeated to eight ounces. On the fourth day, there was still greater hæmoptysis. Refrigerants were substituted for gallic acid. On the sixth day, there was subcrepitant rhonchus under the left clavicle. On the seventh day, he had further frothy hæmorrhage, followed by some mitigation of the general symptoms. On the ninth day, he was dry-cupped, and bled to twelve ounces. Up to this time, the pulse had increased in force and frequency; acetate of lead was now administered. On the twelfth day, all the symptoms wore a less promising aspect, with nocturnal delirium. Pulse 120, irregular; tongue dry; rusty and scanty expectoration; much dyspnoea, anxiety, and jactitation. Wine, beef-tea, and carbonate of ammonia in decoction of Peruvian bark, were given. On the thirteenth day, dyspnoea was very urgent; the physical signs indicated pneumonia. Death ensued at five p.m.

Post mortem appearances. The right lung was congested, and further advanced in inflammatory change. The bronchial membrane was deeply injected; a few tubercles were visible. The upper lobe of the left lung was very firm, and resistant to the knife: its section was of a brownish red colour, and, under the microscope, showed exudation corpuscles, which were not present in the lower lobes; the middle and lower lobes contained patches of extravasated blood, of varying size. The bronchus, where it passed under the arch of the aorta, was not affected. The pulmonary veins, to their minute ramifications, were filled with a dense dark coagulum. The chief bronchi were compressed by an

aneurismal tumour, formed by the entire arch of the aorta ; its ascending portion, one inch from the valves, being also dilated ; and about one inch and a half from the origin of the left subclavian artery, a tumour, of the size of a small apple, was seen. The internal coat of the arch, and that of the aneurism, were studded with a calcareous and atheromatous deposit ; the latter was determined by the microscope to consist of cholesterine and oily matter. The aneurismal tumour was formed by uniform dilatation of the aortic coats. The heart was healthy, excepting an atheromatous deposit upon the aortic valves.

§ This case is suggestive of many reflections. All the symptoms were readily referrible to tubercular disease and its effects. No bruit was audible, in consequence of the comparatively normal condition of the aortic valves ; and the signs usually present in posterior thoracic aneurism were absent, from the tumour just clearing, and not compressing, neighbouring organs. Continuous pulmonary congestion would probably serve to excite suspicion as to the existence of this disease, in the absence of more positive signs, as the buffed appearance of the blood ; which latter sign, though absent in this case, most likely from the cachectic condition of the patient, usually exists in states of the circulatory apparatus leading to aneurism.

CASE X. RUPTURE OF THE DESCENDING AORTA, WITH TRACES OF INFLAMMATORY ACTION. (By Dr. Campbell.) A carpenter, stout in person, aged 38, complained of deep-seated pain in the left chest on inspiration, with dyspnoea, especially at night, and when in the horizontal position. Pulse 80, hard and small ; no palpitation existed. He was blistered, and took tartarised antimony, with relief to his symptoms, the pain being relieved by stimulants. He was found dead by his wife about midnight.

On *post mortem* inspection, the heart was seen to be quite healthy, as were the other viscera of the thorax and abdomen. The posterior mediastinum was torn on the left side, the corresponding pleural sac being filled with blood. The arterial tube was ruptured in various directions, not being enlarged or dilated, but thickened, and having a slight blush of redness, and having its coats infiltrated with atheromatous deposit, from the origin to the seat of rupture.

The order of events in this instance, and in some of the preceding cases, would appear to have been slow abnormal change in the arterial fibrous tissue ; and subsequently, inflammatory action in the internal serous or epithelial lining, terminating in ulceration and fatal extravasation.

CASE XI. TRUE ANEURISM OF THE DESCENDING THORACIC AORTA. (By Mr. Forbes.) The subject was a gentleman, aged 53, previously in good health, and of robust constitution, who had complained, five years before death, of severe dyspeptic symptoms, præcordial pain, emaciation, and great sensibility to cold. No physical signs existed, prior to death, indicative of pulmonary, cardiac, or other thoracic affection ; there being neither cough, dyspnoea, abnormal percussion, nor respiratory or cardiac murmurs.

On *post mortem* inspection, there was found a small basinful of nearly coagulated blood. The lungs, pleura, heart, and its valves, were quite healthy. The escape of blood was traced to an orifice close to the spinal column, connected with a rent in the descending thoracic aorta, nearly three inches below the arch ; it had there become dilated into a pouch, which had contracted adhesions to the anterior aspect of one or two of the dorsal vertebrae, and at this part the sac had given way. No fibrous laminae or coagula lined the sac, but its coats were ulcerated, and nearly perforated in various directions, and the pressure exerted on the vertebrae had caused their absorption to a considerable depth. The ascending portion of the aorta was similarly diseased in its coats, though in a less degree, and was considerably dilated. The abdominal viscera were healthy, excepting the presence of a slight blush in the large curvature of the stomach.

This case is discouraging to the diagnostician ; as not a single *direct* sign or symptom existed which would serve as an index to the formidable disease, insidiously progressing

towards a fatal issue. The præcordial pain was naturally referred to the dyspeptic disorder, there being no physical evidence of cardiac or aneurismal disease present. In similar instances, the persistence and severity of the functional disturbance should excite suspicion, especially if *great sensibility to cold* be present in subjects otherwise in good condition, and free from thoracic or nervous disorder. The indirect method of excluding all other morbid states, may further throw some light on this obscure disease. It will be observed that, in the above case, as pressure was not exerted on the thoracic contents, excepting the dorsal vertebrae, so the corresponding symptoms were absent ; and no murmur was audible, as the aortic valves were unaffected.

CASE XII. ABDOMINAL (TRUE) ANEURISM. The case (under Dr. Stroud's care) was that of a smith, who applied with an epigastric tumour, with impulse, but no sound. Some narcotics were prescribed, to relieve a severe pain complained of about the crista ili, but not in the vertebrae. The man died suddenly, in University College Hospital.

A *post mortem* examination showed an abdominal extravasation of twenty-one ounces of coagulated blood, and forty-eight ounces of serum. The tumour was of the size of the closed hand, and was bounded posteriorly by the vertebral column. The sac firmly adhered to the duodenum, and thus accounted for obstinate alvine obstruction which had existed. Some coloured fibrinous clots were seen in the interior of the sac, and a rent was found of the size of a halfpenny. The dilatation of the artery had begun about two inches below the origin of the renal arteries.

CASE XIII. ABDOMINAL (DIFFUSED FALSE) ANEURISM. (By Mr. Obré.) The subject was a policeman, aged 45. He had formerly suffered from cholera in India, and was a man of resolute character. Three years before his death, he was knocked down, and kicked in the loins, and eighteen weeks ago he was doubled back across a balustrade. He subsequently suffered much from pain in the loins and abdomen. He constantly had to lie down, leaning towards the left side, and was obliged to discontinue his occupation. He had constipated bowels, cough, etc. A tumour was detected, three weeks before death, to the left of the spine, and over the eleventh rib, just underneath the inferior angle of the scapula. It was soft and elastic, about three inches and three quarters in length, by two and a half inches in apparent breadth. The eleventh and twelfth ribs were perforated quite through. The impulse of the tumour, synchronous with that of the heart and the pulse, was inconsiderable, except towards the centre. The tumour probably progressed rapidly just prior to death. No murmur was audible anteriorly or posteriorly. Death suddenly occurred while he was sitting up in bed, and conversing with his wife.

On *post mortem* inspection, the body was found emaciated, the left side of the thorax filled with blood (the bulk of two closed hands), and serum (two quarts). The diaphragm was seen bulging upwards, its fibres being split, and enclosing a clot of blood. The heart was small, and surrounded with fat. The arch of the aorta contained a deposit, consisting of cholesterine and fat. Some effused blood was detected in the descending aorta, where it passes through the diaphragm ; the coats of the vessel were ruptured to an inch and a half in extent, giving rise to the formation of an aneurismal tumour. Laminae existed on the right side, and clots of blood on the left. The tumour had pushed the diaphragm upwards, its coats being partially derived from that muscle. Its circumference was about twenty inches ; its coats being an internal fibro-cellular layer, and the diaphragm and pleura externally. The body of the eleventh dorsal vertebra, and the heads of the eleventh and twelfth ribs, were absorbed ; thus leaving the tumour with but a muscular and tegumentary covering, no fibrous coats existing posteriorly. The abdominal aorta below the rent exhibited bony plates on its internal surface.

It is obvious that any accident would peculiarly tend to rupture a vessel thus predisposed to disease in its coats ; conjointly with the exciting nature of the man's occupation, and strongly acting circulatory apparatus. The

diagnosis was rendered peculiarly difficult, from the tumour being posterior to the diaphragm. No murmur was audible in the tumour, as no blood-current existed therein, nor was there any bruit heard in the abdominal aorta, there being no pressure or other condition productive of murmur, in the calibre or contents of the tube, as was evidenced by the absence of œdema or venous obstruction. The ascending vena cava lay over the aneurismal swelling, but this did not apparently retard its circulation; the pressure of the tumour was directed towards the exterior of the body, and there exhausted.

In the absence of direct signs of cardiac or aneurismal disease, the diagnosis must be guided by collateral circumstances, and by those symptoms which arise from functional derangement in adjacent or related organs or structures. With reference to the former (indirect) source, it is peculiarly significant to note the occupation of most of the above subjects, as implying much and strenuous bodily exertion, prompted by a sanguineous temperament, and, in some cases, great mental excitement or anxiety. As regards functional derangement, this will depend upon the anatomical or physiological relations; œdema, lividity, vertigo, dyspnœa, etc., may or may not exist, according to the interference with, or freedom from pressure on the adjacent structures. The more or less intermittent character of pain or other functional disturbance, is worth observing in these sometimes profoundly obscure cases; the symptoms being for the most part paroxysmal, probably arising from varying conditions of blood-pressure, or other perturbations. Their aggravation at night, and in the recumbent posture, is very characteristic. The contents of the stomach and intestines exert a certain amount of pressure on the arterial tube, sufficient to decide its rupture, in its diseased and weakened state. The sudden and quiescent dissolution of individuals suffering from cardiac or aneurismal disease, is a conspicuous occurrence in such cases. In those cases but little complicated with other structural disease, death took place at night, and in the absence of all excitement. It is probable that the vascular apparatus is unusually loaded and strained at this period, both from this posture favouring accumulation and obstruction, and from the tendency to vascular repletion induced by the abeyance or diminution of functional activity in other organs. This diagnostic mark is of less value in cases associated with disease of the lungs, etc., in which death ensues in a more gradual and less unexpected manner, in consequence of the progressive wearing out of the system, and general loss of power.

In some, if not all, of the preceding cases of aneurismal disease, the blood probably abounded in fibrin, death occurring in one of them (Case VI) in an advanced stage of gestation. This function, it is well known, is attended with a buffed condition of the blood, and in other ways favours the operation of the more immediate causes productive of aneurismal or cardiac affections. In many of these cases, either fibrin, fat, cholesterine, or calcareous salts, more or less conjointly or separately, were found incrusting or replacing the normal tissues; thus indicating a disturbance of the balance obtaining in the healthy nutrition of the organism. Some showed evident traces of inflammation, and others exhibited aberrations of structure less evidently connected with the latter operation, though not the less arising out of malassimilation and loss of equilibrium in the blood-constituents. Of what cases either of these metamorphoses may be respectively predicated, it is impossible at present to affirm with any degree of precision; but a careful collation of all concomitant symptoms, with reference to age, sex, temperament, habit of body, etc., may enable the practitioner to assume, with some probability, the presence and nature of structural disease existing in the heart or blood-vessels.

The preceding cases, though the remarks appended have been of necessity disjointed and inconclusive, have served the purpose of bringing under observation some important subjects involved in the nature, diagnosis, and treatment of cardiac and aneurismal diseases. An extensive collection of similar cases will be required in laying

the foundation of a goodly and unassailable superstructure; so that trustworthy data as to the variation of symptoms corresponding with the site and character of the morbid change may be at length acquired, and acted upon in the diagnosis and treatment of these formidable affections.

21, Edwards Street, Portman Square, February 1853.

ON THE TREATMENT OF DIARRHŒA BY DILUTE SULPHURIC ACID.

By EDGAR SHEPPARD, Esq.

THE prevalence of diarrhœa at this unusual season of the year, in the locality where I reside, leads me to record a few additional cases illustrative of the success of the treatment by dilute sulphuric acid. In the last volume of the *Provincial Medical and Surgical Journal*, (No. 19, p. 471), I had the honour of submitting to the profession some remarks upon this subject; and the cases which I then detailed went far to prove, that when used with judgment and discretion, there is no remedy which can in any disease act more rapidly, or produce more strikingly beneficial effects, than the mineral acid above alluded to, in this common form of bowel affection to which we attach the term diarrhœa. And with respect to this treatment it may be further observed, that the profession has been almost unanimous in assenting to its advantages and benefits. Mr. Rogers of Plymouth* tried it, and came to the conclusion that difference of locality might produce a different type of disease, requiring an essentially different treatment. His cases would not yield to—nay, they were rendered worse by—the acid. This was the only exception to the efficacy of the dilute acid of which I have been enabled to hear. It indeed seemed nothing more than another testimony to the truth of there being distinctive characters, and essentially varying forms, of every disease, prevailing in different localities at one and the same time. Another gentleman, however, practising in the same town, was most successful with the acid, and gave the strongest evidence of its beneficial and rapid action. I thought that Mr. Rogers's doses were too small, and not exhibited with sufficient frequency; but he tried what I suggested (half-drachm doses) with an equal want of success.

How are we to account for this contradictory evidence? Was the acid of one practitioner harmless and inert; or were all the cases which one practitioner met with of that type which would only be aggravated by an acid treatment? The description of Mr. Rogers's cases would not lead to this latter conclusion; the former alone seems to yield the proper solution of such discrepancy in the results. But, be that as it may, Mr. Rogers stood almost, if not quite alone, in the conclusions to which he came as to the inefficacy of sulphuric acid. I proceed now to detail a few cases.

CASE I. J. P., for three seasons had been incessantly troubled with diarrhœa in the hot summer months. He usually applied then, as often as once a fortnight; relief for that short period being afforded—and that often with great difficulty—by chalk, opium, and astringents. When the diarrhœa proved more obstinate than usual, carbonate of soda and chlorate of potash were resorted to. A dry and furred tongue, with constipation and great flatulence, was always the ultimate result of the above treatment.

Last season he first applied in June, with the old train of symptoms; and I gave him the dilute sulphuric acid in half-drachm doses, with compound tincture of cardamoms and sugar. He was directed to call on me again the next day, if he was no better. He did not call; and therefore I could not report his case in my first paper upon the subject. Indeed, I never saw him after that period, until about six weeks ago, when, having chopped off one of his fingers with an axe, he was again brought under my observation. On my making inquiries touching his usual malady, he said that he had never had a day's illness since the "nice sharp"

* See last vol. of *Med. Times and Gazette*, No. 124.