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CLINICAL LECTURES,

DELIVERED IN

ST. GEORGE'S HOSPITAL.

By Sir BENJAMIN C. BRODIE, Bart.

ABSCESSSES.

GENTLEMEN,—I propose to call your attention to-day to a very ordinary subject, but it is, nevertheless, a very important one. It will meet you at every corner of your practice, and it is, therefore, one which involves many important considerations relative to your future success in your profession. I allude to the subject of abscesses. By an abscess, I mean a collection of pus in a cavity. It is not my intention to enter fully into the pathology of suppuration or abscess. It is true that I might say much to you on this subject, but it is my wish to give you practical information in these lectures, and I shall limit myself to that part of the subject on which practice may be said to bear more fully. You know that much difference of opinion has been manifested relative to the nature and process of suppuration. It used to be supposed formerly that suppuration was a melting down of the solids; and Mr. Hunter imagined that it was a secretion from the blood. No one can be found to doubt this fact; a single case of gonorrhœa would make it clear. There are, however, some modern pathologists, who think that, in addition to a secretion from the blood, there is combined with it a melting of the solids as well. But, however this difference of theory respecting suppuration may be, it makes no difference whatever in the process itself. I have seen an old laminated coagulum filling up the auricle of an enlarged heart, and in the centre of this coagulum there was some fluid of the consistence and colour of cream; but I do not know whether such a deposit as this has ever been subjected to the close inspection of the microscope. It would, therefore, appear that blood escaping from a vessel may be converted into pus. In gonorrhœa, the pus secreted escapes freely by the canal of the urethra, but in an abscess the pus is collected in a cavity. The lymph poured out around an abscess generally becomes organised, and forms the walls of the abscess; and this deposition of organising material applies to many abscesses. In the formation of abscesses in the cellular texture of the thigh, you have first an early and incipient vascularity, afterwards a villous surface, which eventually secretes pus. But there are abscesses which form in the cellular membrane without having any defined walls—as, for instance, a man may die of erysipelas, and after death you may find large quantities of pus effused into the cellular texture of the part affected by the erysipelas; now, this is an abscess also. Or, again, a man may have a hydrocele, which may be injected; the inflammatory symptoms may run high, and end in the

formation of pus; you open it, and the matter discharges freely; now, in this case the cavity of the abscess is a natural one, and is formed by the tunica vaginalis of the testicle. Where you have matter formed in the cavity of the pleura, you have an abscess also, and the walls of it are formed by the natural walls of the pleura. The secreting surface of the cavity of an abscess is formed by ulceration, and this process goes on from the moment that one single drop of matter is formed.

You will thus see that, in the formation of an abscess, ulceration may be concomitant with suppuration, but not necessarily so. They are sometimes connected together, but not always. You may have the bones of a carious joint destroyed by ulceration without suppuration being present. There is no doubt but that mucous membranes secrete pus, and you may find this exemplified in examining the body of a person who has died of gonorrhœa. In purulent ophthalmia, likewise, you have an inflammatory state, producing purulent secretion. When you have suppuration in a cavity lined by a serous membrane, there is in the first instance a layer of lymph thrown out, which becomes organised; and it is from this organised lymph that pus is secreted, and not from the membrane itself. This point has been very clearly stated by some, but in my opinion it is one not very easily determined.

Abscesses are of many kinds; you may have a phlegmonous abscess, where its formation is preceded by acute phlegmonous inflammation; or you may have a chronic abscess, where the inflammation accompanying it is of a slow and chronic character. These terms serve to express the two extreme points occupied by purulent formations; but between these two extremes there are many varieties. An abscess is always the result of previous inflammation, though there are some who deny the truth of this proposition. For instance, the knee joint may swell and inflame, and it may be opened, and pus may be poured out; and this may arise from some local deposition of pus elsewhere, which may have been taken up by the blood-vessels and deposited in the knee. On examining such a case as this after death, the parts where the pus was originally deposited may bear the marks of inflammation, though this may have been present without pain. Cases like these, however, do not contradict the general rule. It may be difficult to prove the negative of the above proposition.

There are abscesses which we call secondary, and these may exist without suppuration in the primary locality of their formation. A boy was admitted some years since into this hospital with fracture of the skull and the femur. The pericranium was separated from the bone, and in three weeks he died. On examining the body, the dura mater was found in a sloughing state, and separated from the inside of the

bone, opposite to the spot where the pericranium was separated on the outside, whilst around the edges of the fractured femur there were found depositions of pus. A girl had some caustic rubbed on the pericranium; she had also a severe cough, and she soon died. On examining the body, the dura mater was found separated from the inner table of the skull, opposite to where the pericranium had been destroyed, and in a sloughy state; secondary abscesses were also found in the lungs. I could, if our time allowed of it, prove to you that these secondary abscesses may occur where suppuration exists in the primary locality, as well as where it does not so occur.

Is an abscess ever cured by the matter being absorbed, and afterwards thrown out by secretion? This is a very important question. Dr. Macartney states that he has seen the matter of a psoas abscess absorbed, and it has been said that the matter of a bubo has been also taken up. I recollect the case of a gentleman who had an abscess presenting over the ileum. I diagnosed that there was dead bone; but in time the tumour, or abscess, or whatever else it was, entirely disappeared. A young man had scrofulous disease of the knee; it was packed up in splints and bandages, and in time all trace of the tumour disappeared. A young lady was affected with disease of the spine, and there was a hard solid tumour discoverable in the abdomen; this is now many years ago, and the last time I heard of her all trace of the tumour had disappeared, and she had quite recovered. Such facts as these would lead to the belief that the purulent matter poured out in these cases had been absorbed. I consider the point to be a very doubtful one on which to pass a certain decision. A man was in this hospital with lumbar abscess; in course of time it disappeared, and reappeared again in its original situation. I have opened many suppurating buboes, but without meeting with any pus; and it frequently happens in these cases that the soft fluctuation felt under the skin arises from a collection of serum between the gland and the skin, and nothing more. A girl had a tumour over the sternum, which inflamed; I pierced it with a lancet, and a large collection of serum escaped; this got quite well; by and by another tumour formed in the same place of a similar kind. I did not open this one, and in process of time it disappeared spontaneously; and, if I had not opened the first tumour, I dare say that it would have been absorbed.

I believe we do not possess sufficient knowledge to enable us to pronounce with certainty as to the power of abscesses becoming absorbed. There are certain symptoms which attend upon the permanent progress of an abscess, and upon its progressive retrocession. A young gentleman had some symptoms of disease of the bladder; I passed a bougie, and discovered that he had curvature of the spine. He died in a few months, and after his death an abscess was discovered, but he had no symptoms of abscess during life. When an abscess is once formed, it generally has a tendency to come towards the surface of the body; and in his works, Mr. Hunter draws a comparison between this progressive tendency of an abscess towards the surface, and the disposition of plants to shoot upward towards the surface of the earth. This analogy, however, does not hold good; the truth is, that an abscess makes its way in that direction where it meets with the least resistance; as, for instance, an abscess in the liver may burst into the colon, and an abscess in the colon may burst into the bladder. An abscess in a fascia will burrow under it; whilst an abscess over the fascia will come towards the skin, as the skin gives way rapidly under the process of ulceration. A phlegmonous abscess comes more speedily to the surface than a chronic one. Now, when the matter comes thus to the surface, there arises a very important question—are you to let the matter out or not? There are some surgeons who

will recommend you to leave these cases to nature, whilst there are others who will as strongly recommend you to open them by artificial means. I always prefer the latter to the former, as the opening is larger, and the abscess is thereby more readily emptied.

Causes of Abscesses.—These may differ very materially from each other in different cases. It may arise from a local cause; a man may, for instance, get a piece of glass imbedded among the muscles of the arm, and suppuration and abscess dependant upon a local cause may be the result; or a man may receive a punctured wound in the thigh through the fascia, and abscess may occur from a local cause. There may be inflammation in one of the glands of the groin, and abscess as the result dependant on a local cause likewise. Again, you may meet with a case of ulceration of the rectum, and a small portion of feculent matter may irritate the denuded mucous membrane, and inflammation and abscess may be the result, and the cause be a local one at the same time. A man may have a stricture of the urethra, and the bladder may be constantly forcing a stream of urine against the posterior surface of the stricture; ulceration and suppuration may ensue, and an abscess may be formed arising from a local cause. In a very large majority of abscesses, however, the cause of the abscess is a constitutional one. A man with a disordered and diseased state of constitution may receive a severe blow on the head, and disease of the liver or the lungs, with abscess in these structures, may be the result; or if, with such a depraved state of constitution, a man have a simple fracture of the femur, matter will most probably form around the fractured ends of the bone. It is in such constitutions as these that you meet with what are termed critical abscesses, occurring after fevers. Boils do not arise from any local cause, but from a depraved and unhealthy state of the constitution, and carbuncles likewise. In many other cases, besides those which I have narrated to you, this rule will hold good.

NOTES FROM CLINICAL LECTURES,

DELIVERED IN

ST. GEORGE'S HOSPITAL.

By Dr. SEYMOUR.

PHTHISIS TRACHEALIS.

This disease affects the cartilaginous portions of the trachea in a similar manner to that with which phthisis pulmonalis affects the deeper seated pulmonary apparatus—the patient, in the one affection as in the other, being consumed and destroyed by the ulcerative processes of the disease. Now, this affection of the trachea may exist alone by itself, or it may be in combination with phthisis pulmonalis. Where it exists alone, there is much frothy expectoration, and great pain on making pressure over the anterior cartilaginous surfaces. There are evening exacerbations of hectic fever; the pulse is weak and languid, the voice extinct, and the patient decays and loses flesh rapidly. Such are some of the symptoms which you will meet with where this disease occurs uncombined with any other; but where, in addition to this, you have phthisis pulmonalis superadded, you have all these symptoms much increased in intensity, and a dark, thick mucous expectoration as well. Now, there is a case of this kind in Buxton ward, and you will soon have an opportunity of judging, by the post-mortem examination of the case, whether my diagnosis of it be a correct one. I have seen some of these cases in which the ulceration was so extensive that you could pass a probe along it to some extent. In the case of this patient the catamenia are absent, as they almost always are; the pulse is slow and weak; and