question, very rare indeed, and I have not the least doubt that what is commonly called a "recurrence" is in the enormous majority of cases in reality "incomplete operation." One must have seen such cases shortly after operation in order to be enabled to judge in what an incredibly slipshod manner the operation is nowadays but too often done and how the cry "recurrence" has come to be raised. A whiff of gas, a little scraping with the finger-nail, and behold! the "operation" has been performed, and the parents are left in the belief that all has been done that could be done. A few months, nay, even weeks, after the "operation" the old symptoms come on again; the parents in distress seek another opinion, and, when they are told that the operation has to be performed anew, ask in despair: "But don't they always grow again?"

Against this class of "recurrences" there is only one safeguard, but it is a very efficient one: thoroughness of operation, and this thoroughness must be preached until it is generally practised. I need hardly say that this thoroughness is not equivalent to violence. Unfortunately, whilst one very frequently meets with instances of under-operation, one occasionally comes across sad examples of the other extreme. I have seen cases in which the operator had so proceeded that the ugliest adhesions had formed in the naso-pharyngeal cavity and between the soft palate, the pillars of the fauces and the posterior wall of the pharynx. An aspect, in fact, resembling that of cicatrization in congenital or tertiary syphilis, and in these cases the articulation of the victims was materially and lastingly impaired. That certainly is not the kind of thoroughness I recommend. But the desirable thoroughness I have in view can only be obtained, so far as I can see, by the operator being in the position of not being hurried unduly by the brief duration of the anæsthesia, nor by the fear of any untoward event during the operation itself.

Personally I have not the least doubt that these conditions are most ideally obtained by (a) chloroform being selected as an anæsthetic in these cases; and by (b) the patient being operated upon in the recumbent position with his head well bent over the back of the operation table. If chloroform be quietly and slowly administered by a competent anæsthetist, and never pushed to the abolition of the cough reflex, it introduces, to the best of my conviction and experience, no amount of danger into the operation, and it gives the operator time to remove the growths thoroughly. If the recumbent position be adopted, with the head well over the table, there is no danger of blood or a loose fragment of adenoids penetrating into the larynx or lower air passages. These—as I consider them—most essential conditions having been secured, the operator can then at his ease thoroughly remove the growths, by whatever instruments he prefers (personally I almost always use the two models of Gottstein's curette, the curved and the straight one, and Hartmann's laterally-cutting curette, whilst in exceptional cases only I employ Woakes's modification of Loewenberg's forceps). The operation ought not to be considered as finished until the operator, by thorough digital exploration, has convinced himself that not a vestige of lymphoid tissue projecting over the surface of the mucous membrane has been left behind. Should the tonsils have to be removed at the same time, I usually remove the adenoids first and the tonsils afterwards. Only when the tonsils are so large that it is impossible to introduce instruments into the naso-pharyngeal cavity, without impeding respiration, I remove them first. I have heard my method described as "fussy," but it is safe, and it certainly yields infinitely fewer recurrences than that of the lightning operator. No after-treatment of any kind is necessary beyond keeping the patient in bed for twenty-four hours, and in the house for two to three more days, an aperient being given the first evening, if there should be a rise of temperature. I warn especially against any "antiseptic" injections being made through the nose. It is many years since I gave them up completely, and I am glad to be able to state that I never since have had an acute ear complication.

Others may prefer other methods. I have not the least wish to assert that the method I recommend is the best, or the only one by which success may be secured, but from long and ample experience I can honestly state that it

answers all reasonable requirements, and if you proceed by it, selecting suitable cases only for operation, you may be confident that you will maintain the prestige of one of the most salutary operations of modern times.

If, in conclusion of this lecture, I were to briefly summarise the advices given in it, I should say this: In all purely local affections of the upper air passages there are certain cases in which all reasonable men will agree that local treatment is required, and others in which the moderate section at any rate will be unanimous that it is not. Between these two classes there is the very large intermediate one in which everything is a question of "degree," and in which opinions may legitimately differ as to whether local treatment should be adopted or not. Far be it from me to assert that occasionally mischief may not be done by doing too little, but if I endeavour to judge impartially the current of opinion at the present moment, I have no hesitation in stating that if at all, we err at the present moment in the opposite direction, and I cannot better sum up the advice which I think should at this juncture be given, than by reminding you of Talleyrand's celebrated counsel to a young diplomatist who for the first time was sent on an independent and responsible mission: "Above all, not too much zeal!"

A REMARKABLE CASE OF AORTIC ANEURYSM OF SIXTEEN YEARS DURATION: DEATH FROM RUPTURE EXTERNALLY.

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THE patient, a builder's foreman, was born in 1844, and came of a rheumatic stock. He himself had had occasional joint pains, and had suffered at times from "fever and ague," contracted in Mexico in 1866. No history pointing to syphilis could be elicited. In 1884 he began to suffer from an incessant cough and indefinite thoracic pains, accompanied by loss of flesh, but it was not until a week before his first admission to St. George's under Dr. T. T. Whipple in April, 1886, that he noticed a swelling on the right side of the sternum; for two months previously, however, anginal pains had been very severe.

When first seen there was a "rounded, regular, smooth tumour," $3\frac{1}{2}$ inches in diameter, occupying the first and second right interspaces and the adjacent edge of the sternum. It was expansile, but no *bruit* was heard over it, though one was present in the right subclavian and carotid arteries. The aortic second sound was accentuated. The voice was hoarse and the cough suggestive of pressure, and there was also inspiratory stridor. Air entered the right lung much more freely than the left, but there was no dysphagia. The right pulse was slightly the weaker of the two, and the pupils were equal. Pressure on the carotid and subclavian vessels on the right side greatly diminished the pulsation in the tumour, and distal ligature was proposed, but the patient declined operative treatment. During his first three weeks in the hospital the aneurysm increased rapidly in size till it eroded the whole of the upper part of the sternum, measuring $6\frac{1}{2}$ by $4\frac{1}{2}$ inches. Two eminences made their appearance on the surface, and the skin over it was tense, shiny, and discoloured. The patient at this time was described as being "weak, ill, and hopeless." Treatment consisted of a scruple to half-drachm doses of potassium iodide, with morphine, for the relief of pain, and the fluid part of the diet was restricted to a pint in the twenty-four hours. No further extension took place; on the other hand, the tumour began to steadily decrease in size and seemed to consolidate, while the prominences disappeared. The patient was kept in bed for eight months, at the end of which time the pulsating area measured only $1\frac{1}{2}$ by $1\frac{1}{4}$ inch. There was no paralysis of the vocal cords, and no *bruit* had at any time been audible over the aneurysm. The patient's condition had much improved, and he experienced no ill-effects from getting up. He was discharged in January, 1887.

A year later he returned to work, and followed his employ

ment, which did not involve manual labour, with intervals of rest until the early part of 1892, when he caught a violent cold and cough, which was followed by shooting pains in the neck and left arm, and a rapid bulging of the aneurysm at the site of the episternal notch. Since his discharge he had had no medical treatment. He was admitted again in May of that year, the tumour being then of the size of a tangerine orange. The pupils and pulses were equal on the two sides, and the vocal cords wanting in tension, though not paralysed. The temperature became elevated, and the patient dyspnoic and dysphagic, so that his condition was regarded as "imminently serious." The iodide treatment was resumed, with the result that the pressure symptoms gradually became less marked, and in three weeks the man was able to take solid food. The prominence at the episternal notch decreased, and after two months rest in bed the patient was allowed up, and a little later discharged. He continued under the care of Dr. T. T. Whipham until February, 1895, when he had an attack of pleurisy and pneumonia, and was laid up in the hospital for a period of six months. From this time the aneurysm became markedly worse.

In February, 1897, he returned, having been at work on and off, and was admitted under Dr. Isambard Owen with an increase in the size of the tumour especially on the right, where it projected for $2\frac{1}{2}$ inches from the normal level of the chest wall. After five months rest he was again discharged improved, and continued at work till the beginning of 1899. In August of that year a swelling as large as a hen's egg appeared in the course of a week on the left of the original tumour. The skin became discoloured, but the protuberance disappeared as rapidly as it came, leaving two leaking areas. In the following month he was again taken in, the prominence on the right being then $1\frac{1}{2}$ inch high, while from the other side there oozed a thin watery discharge. There was still no *bruit* to be heard over the aneurysm, and there were no pressure symptoms beyond slight stridor and a brassy cough. The discharge soon ceased and the patient was sent home after a month.

He was admitted for the last time in February, 1901, the aneurysm having increased during the previous year to the size of a man's closed fist, and presenting three lateral projections. The centre of these was the most prominent, and the skin over it was tense and shiny. Between the middle prominence and that on the left was a small ulcerated surface where pulsation was marked, and from which there oozed a small quantity of blood. Anginal pain had been severe, but not so marked as in 1886, and pressure as shown by the voice, cough, and dyspnoea was more in evidence though no difference in the pulses could be detected. Venesection relieved the symptoms to some extent, and potassium iodide and calcium chloride were given internally. The temperature soon became irregular and the patient had much pain in the neck, possibly caused by ulceration, for occasional hæmoptysis took place. After a month the temperature subsided to normal; the aneurysm became more conical in shape, and the leakage of blood, which had ceased, recommenced. The superficial ulceration gradually extended though without pyrexia until April 8th. On the following day the patient had a rigor, and sixty hours later a large conical mass of laminated fibrin, the whole of the superficial part of the aneurysm, became detached leaving a considerable cavity in the chest in which no definite pulsation could be seen. There was only slight leakage, and the patient continued fairly comfortable with the exception of pain for another nine days. The aneurysm then suddenly burst externally, and the man died in about a quarter of an hour.

At the necropsy the whole of the ascending and transverse portions of the arch were found to be greatly dilated and very atheromatous. From the upper and anterior aspects of the arch there arose a sacculated aneurysm as large as a cocoanut, three parts full of laminated clot, which passed forwards and communicated with the exterior. The trachea was eroded about three-quarters of an inch above its bifurcation, and the lungs showed signs of bronchitis. The heart was slightly dilated, but not obviously hypertrophied, the aortic valves alone being a little thickened. There was no evidence of pressure on any part of the neighbouring structures, and nothing worthy of note in the other thoracic or abdominal viscera.

The remarkable points about the case are (1) the length of time during which the patient was known to have had an aneurysm. For full fifteen years he was kept under observation, and during the whole of that time he had a large external tumour, though the aneurysm had evidently been forming a year, and perhaps more than a year before that. The longest recorded case that I know of is one mentioned by Sir W. Gairdner, which was known to have existed for twelve years, and that under circumstances entailing considerable cardiac strain; (2) the frequent and at times rapid variation in the size of the aneurysm, which on several occasions seemed likely to cause an abrupt termination to the patient's life; (3) the marked benefit which accrued from prolonged periods of complete rest and treatment, both medicinal and dietetic; (4) the recovery from an intercurrent attack of pleurisy and pneumonia; (5) the fact that the entire external portion of the aneurysm sloughed and came away, after which the patient lived for nearly nine days; (6) the termination by rupture externally, which is by no means a common cause of death in these cases, even though such a contingency may appear imminent.

It is only fair to the patient to state that he was a very sensible man and realised the gravity of his condition. He bore his periods of enforced rest cheerfully, and voluntarily restricted his diet both in the hospital and out, the amount of fluid ingested being left largely to his own discretion. To the extension of the aneurysm in a forward instead of a backward direction must be attributed of course in great measure the possibility of such prolongation of life as occurred in the present instance.

REFERENCE.

¹ Allbutt's *System of Medicine*, vol. vi.

A CASE OF ULCERATIVE ENDOCARDITIS, WITH RECOVERY.

BY
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It is always satisfactory to be able to report the details of a case in which the symptoms were such as to render it certain that the malady was of a very serious nature, and yet recovery has ensued. And when the disease is one that is admittedly almost invariably fatal, either during the acute stage or shortly afterwards, it is of special importance that a case of recovery be put on record. For when recovery follows, it leads to some modification of our views as to the invariable outcome of the malady, and at the same time causes us to reflect as to the possibility of the happy result being due in any degree to the treatment, either generally or by drugs.

The following case was one of undoubted malignant endocarditis, and the account of the clinical features of the malady is as given below:

The patient, a man aged 35, had always been in good health, and was a total abstainer.

On October 22nd, 1900, he complained of earache, and was treated for this. He was up and about as usual, but on the 25th he suffered from attacks of shivering, and at the same time it was noticed that his urine was dark and thick.

He was seen on October 29th, being then in bed. The urine was of a dark mahogany colour, and contained a granular detritus, but no complete blood corpuscles. The temperature was now 103° , and a distinct systolic murmur was audible over the aortic area. He remained in much the same condition until November 3rd, when marked rigors set in, and the urine became even darker than before.

On November 5th the right parotid gland was observed to be slightly swollen. There was no tenderness over the mastoid region. The *bruit* in the aortic area was now more distinct, but the discoloration of the urine was somewhat less marked. From this time onwards the temperature presented the most characteristic features of septicæmia, very marked evening ascents being followed by extreme falls the following morning. Thus on two occasions an evening rise to 105° was registered, and the next morning the temperature was 97° and 96.2° respectively.

On November 8th his condition was very unsatisfactory; the afternoon temperature was 103.2° , the right parotid region was the seat of a prominent and tender swelling, and there was evidence of œdema of both lung bases, the crepitation being most marked on the left side. The temperature now began to show very marked daily excursions, and the feebleness of pulse and general debility became very severe. On November 12th the size of the parotid swelling diminished somewhat, and a discharge from the mouth, purulent in character, was noticed. From this time onwards the parotid inflammation gave no further trouble, but the general condition of the patient was in no respect more satisfactory at this date. On the contrary, he was distinctly weaker, and lying lower in the bed.