On December 13th, 1894, Dr. Sugden, of Aintree, sent me a man, 33 years of age, a locomotive fireman, who had suffered from symptoms of subacute intestinal obstruction, which had commenced suddenly with pain in the left iliac fossa, while he was turning his engine on a turntable twelve days previously. The doctor reduced a left inguinal hernia for him, and, as his symptoms did not improve, naturally concluded that the hernia had been reduced *en bloc*, and sent him to hospital.

The only physical sign of such being the case was a feeling of resistance over a small area to the right of the umbilicus which appeared at the time, and was afterwards proved to be a scybalum.

The patient thus described his pain: "The wind seems to collect in the upper part of the abdomen, and then to run downwards with a gurgling sensation; the pain is most acute when the advancing wind reaches the centre of the belly; it then diminishes as the wind passes on."

While he was starved he got on very well for some three weeks, but as soon as even a little rice pudding was given him his vomiting and other symptoms of obstruction recurred. I therefore explored his abdomen through a 3-inch wound, commencing an inch below the umbilicus, and extending downwards. After a good deal of searching and examining the right and left inguinal canals, the caput cæcum, sigmoid flexure, and pelvic organs, on running my hand along the large intestine I came upon what felt like a large-sized empty cotton reel exactly in the centre of the transverse colon. I was able to pull this out of the wound, the abdominal cavity being protected by means of a sponge placed underneath. The removal of the carcinomatous stricture and approximation being effected, five Lembert's sutures were applied, the transverse mesocolon being adjusted by stitches as far as was possible. The time, including chloroform administration and exploration, was fifty minutes, the actual operation taking under half an hour.

Mr. Thomas, who came into the operation room while I was exploring the abdomen, kindly helped me with the latter part of the operation.

× Carcinomatous stricture of mesocolon. A, Red-frilled edge of new growth. B, Healthy mucous membrane.

The specimen shows a tight stricture half an inch in length, barely admitting an ordinary probe, the red frilled edge of new growth invading the mucous membrane on each side of the stricture being very well marked.

The patient is young for cancer, but it is our experience in Liverpool that general cancer affects both males and females at a much earlier age than was formerly the case. After operation he made an uneventful recovery, was perfectly comfortable, passed his first motion on the tenth, and the button unaided on the twenty-fourth day. I had examined his rectum the same day, and could feel nothing of the button.

His diet after operation consisted of 3 ounces of beef-tea and 3 ounces of hot water every hour alternately for the first

week, after which milk, and at the end of a fortnight rice pudding and biscuits were added.

The case under consideration illustrates what abdominal surgeons in every journal are urging physicians to see, namely, that where an *exact* diagnosis of the cause of obstruction is not made, the symptoms should not be masked by opium, or waiting for a tumour or further distension, but that the surgeon should be consulted.

Murphy states that the so-called conservatism in many cases amounts to criminal procrastination. I am not one of those who have a great anxiety to open the abdomen in all cases of intestinal obstruction; I have seen too many get well without operation ever to make that mistake, but surely the operator who is constantly handling these cases must become more than a mere cutting man.

No case requires more judgment and experience than one of early intestinal obstruction; two opinions are better than one, and chloroform often facilitates the diagnosis. I trust the practice of calling the surgeon in only when some cutting is indicated will soon be a thing of the past. Early excision of carcinoma of the bowel is not such a hopeless operation as excision of cancer in other parts. Bidwell relates two cases where patients are alive after the operation of removing a carcinomatous tumour of the sigmoid and cæcum, the former two and the latter four years ago.

A word in conclusion about the buttons. It has been proved beyond a doubt that they pass even the ileo-cæcal valve without any harm or difficulty. They, in my experience, are a great improvement on the suture, bone plates, or bone tubes. I believe this to be the first case where the one and a-half inch button has been used for the large intestine. It gives no trouble and is very easy to adapt to the bowel. I should advise everyone who is going to use the buttons to practise in the *post-mortem* room, as considerable dexterity can be acquired, and valuable time gained, after a little practice.

I completed the operation in the *post-mortem* room in seven minutes, and after tying up one end of the bowel, put on the full force of the main water pipe, and no leak took place at the button.

THE LETTSOMIAN LECTURES ON THE COMBINATIONS OF MORBID CONDITIONS OF THE CHEST.

Delivered before the Medical Society of London.

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LECTURE III. SYMPTOMATOLOGY.

DR. ROBERTS, in commencing his third lecture, observed that it was a dangerous error to take account only of physical signs, and to neglect to study the symptoms of intrathoracic diseases. In some cases there might be no obvious symptoms, and this negative fact was of importance as giving an indication of the pathological nature of the changes present. The symptoms presented by complicated cases must be studied on a thoroughly comprehensive basis. In acute cases the severity and character of the pain, the kind of disturbance of breathing, and the sounds by which it was accompanied were to be noted. The characters of the cough and expectoration, and the variety of dyspnoea present demanded special study, the more that in some cases the patient's general condition did not permit systematic physical examination to be made. In chronic cases physical examination should be followed by a systematic study of the symptoms. A single symptom might often be of great value in diagnosis—such symptoms as the sudden discharge of a quantity of pus due to the bursting of an empyema into the lung, or of certain kinds of abscess into the air passages. The sense of smell might lead to an immediate diagnosis, as, for instance, the foetid odour of the expired air, especially after a vigorous cough, revealing

bronchiectasis in emphysematous lungs. So the sense of hearing might lead to immediate diagnosis by an observation of sounds associated with the acts of breathing or coughing, or by alterations in the voice, as, for instance, in intrathoracic aneurysm.

The occurrence, type, degree, mode of progress, and associated phenomena of fever were often most significant. Thus we may recognise, Dr. Roberts continued, not only pronounced inflammatory or tuberculous cases, but also those indefinite changes going on in the lungs to which I have previously referred. Moreover, by the presence of fever we may be led to conclude that there must be some obscure condition within the chest, as, for instance, a localised collection of pus which is entirely out of reach of direct examination. In cases of phthisis I need scarcely say that pyrexia is a most valuable indication as to the activity and progress of the disease. But perhaps one of the most striking illustrations of the diagnostic value of this pathological state is when malignant endocarditis supervenes upon old chronic disease of the cardiac valves, which it may be impossible otherwise to recognise.

General wasting is another symptom which is very instructive, as indicating what is going on in the chest, not only in relation to phthisis but also to other conditions, especially obscure cases of malignant disease. Anæmia likewise often deserves thoughtful attention. The phenomena resulting from obstruction of the general venous circulation, especially dropsy, always demand careful study. It is a very common tendency to associate these phenomena simply with heart disease. Let it be remembered, however, that this is by no means their sole cause, and that they may be very pronounced when the heart is really practically normal, while in cardiac cases they are often aggravated by pulmonary conditions. This class of symptoms, especially dropsy, are often of great help in determining what is the actual state of things in connection with the heart, and here it may be particularly noted that functional disorder superadded to organic cardiac disease is often accountable for the occurrence of dropsy, or for its temporary aggravation. I will only further state that general symptoms not uncommonly add more or less to the trouble immediately connected with the chest, especially by disturbing the breathing and the cardiac action.

The relation of the pulse to morbid conditions of the chest opens up a very wide subject, upon which I cannot now attempt even to touch. I will only say that, regarding it merely as a symptom, and without reference to any elaborate methods of investigation, it affords in a large number of instances most valuable diagnostic information about combinations of these conditions which I do not think is always adequately appreciated. I may, by the way, draw attention to the fact that the absence of the radial pulse on one side is another important point to be remembered in relation to the diagnosis of an obscure intrathoracic aneurysm.

I have incidentally referred to certain of the minor structures contained in the mediastinum in my preceding remarks. I wish now merely to point out that interference with these structures, or their implication in actual organic changes, is chiefly indicated by what may be regarded as mere symptoms, as distinguished from physical signs. These may be simply modifications of the ordinary chest symptoms, to which, however, they give special characters, such as pain, cough, respiratory disorders, or cardiac phenomena; but some are of special kinds, such as dysphagia due to obstruction of the œsophagus; or signs of implication of the sympathetic nerve, of certain veins, or of the thoracic duct.

SPECIAL METHODS OF INVESTIGATION.

(A) *Examination of the Sputum.*—While fully recognising the value of a microscopical examination of the sputum if carried out with intelligence and judgment, Dr. Roberts observed that it could not always be relied upon either from its positive or negative aspect, but in any case the naked-eye examination of the sputum should not be neglected.

(B) *Instrumental Examination.*—Dr. Roberts urged the advantage of simplicity in examination, and that no instrument ought to be allowed to take the place of the trained and educated senses of sight and touch.

(c) *Operative Procedures.*—The use of the exploring needle or trocar, and other measures intended to demonstrate the presence and situation of fluid in the serous cavities, or the existence of an obscure abscess in the lung or elsewhere, or of a hydatid tumour, often yielded valuable information.

(d) *Examination of the Larynx and Trachea.*—Laryngoscopic examination might not only reveal associated morbid states in the larynx or even in the trachea, especially tuberculous and syphilitic, but the signs produced by interference with one or other of the laryngeal nerves might be almost the only data for the recognition of an aneurysm or growth obscured by other conditions within the chest. Similar signs might be associated with an adhesion and fibroid thickening in old chronic apical phthisis. "Tracheal tugging" might also be of real service in the diagnosis of deep-seated aneurysm.

(E) *Examination of the Œsophagus* might be useful not only in the investigation of the morbid conditions of the œsophagus itself, but also of diseases in its vicinity.

REMARKS ON TREATMENT.

The concluding part of the lecture was devoted to the discussion of treatment in the following terms:

1. The management of chest affections is far from being such a simple and easy matter as many people seem to imagine, and they certainly cannot, as a rule, be dealt with as individual entities, to be severally treated on a routine and settled system or plan, or with a particular remedy, varying according to the age in which we happen to live, the prevailing therapeutic fashion or fad, or the personal, and it may be very peculiar and original, views of the individual medical practitioner or "scientific therapist." Still less ought we to be content with merely treating symptoms, a practice but too often habitually adopted, sometimes, indeed, with remarkable success and undeserved kudos, for the man who acts on this principle, and who doesn't take the trouble to investigate his cases, will often administer powerful drugs, with benefit it may be, when they are in reality very dangerous, and when a well-informed practitioner, who had ascertained the facts of the particular case, would not dare to use them. In the long run, however, this method of procedure is certain to do infinite harm, and to lead to lamentable results, of which only a very small proportion actually come to light. And not only is it directly mischievous and dangerous, but it does infinite harm by allowing serious morbid conditions within the chest to progress unchecked, which might often be arrested, or at any rate controlled, in their early stages, if their presence had been properly detected.

And here I must enter an emphatic protest against a state of things extensively prevailing, and with which as a profession we are deeply concerned, that not only permits, but encourages in a high degree the evil against which I have been speaking, namely, the prevalence of "cheap dispensaries," where so many patients are polished off within the hour; the employment of ignorant unqualified assistants; and the encroachment of the "prescribing chemist" on the domain of the medical practitioner. We do occasionally see in the newspapers some startling revelations brought out in the coroner's court, but these only give a faint hint as to what is actually proceeding on a very large scale. These revelations, however, do not lead to any change, and things go on just as before.

After this digression I return to my point, and must insist on the fact that a large proportion of chest cases, even when they belong to a particular category, must as a necessary consequence of their combined conditions present more or less difficulty in their management, and that they ought always to receive due consideration from a therapeutic as well as a diagnostic standpoint. Sometimes the difficulties are very great, and we may be able to do little or nothing for our patient. But while fully recognising this aspect of the question, I affirm, on the other hand, that much can often be done, even in highly-complicated cases, in the way of treatment, if we study them adequately and intelligently, and deal with the existing conditions rationally and judiciously.

2. Now the first thing we have obviously to determine in relation to the treatment of combined chest conditions in a

particular case is what we can and what we cannot do. We are bound to face the uncomplimentary fact that there are morbid changes which we cannot influence materially, or perhaps not at all, and we had therefore better leave them alone. Of course there are grave diseases for which we can do absolutely nothing; and then I think we ought to be very cautious in using powerful drugs or practising special methods of treatment, the good results of which are, to say the least, highly problematic, though of course it is impossible to lay down any "hard-and-fast" rule in this matter, and each case must be dealt with on its merits.

There is another class of cases, of very common occurrence, in which permanent changes in various combinations affect the chest and its contents, not necessarily immediately dangerous or serious in themselves, but which give rise to more or less troublesome symptoms, and yet we can do little or nothing for them directly. Under these circumstances our main indication is to try to get the patient to understand the state of things, to learn to put up with them and make the best of them, accommodating himself or herself to existing conditions, and to ward off further evils by judicious care and avoiding doing stupid and foolish acts which are likely to bring on additional troubles. I must say that patients do not like this kind of advice, and as a rule resent our ignorance and incompetency; but really it is often the best and most honest advice that we can give, and in the long run many come to acknowledge this fact. A large number of cases coming under this category merely present the combination of minor changes to which I referred in my first lecture. Others belong to the group—and a very trying and sad one it is—where individuals who have led a too active and energetic life, and who often boast that "they have never had a day's illness," are unexpectedly found out and pulled up by the development of one or more prominent chest symptoms, or by some sudden serious disturbance, and it is then discovered that more or less grave morbid conditions have been slowly but surely progressing for some time, of which these phenomena are the outcome and manifestation. To bring such patients to reason and to make them understand that they must give up their hunting and shooting, their mountain-climbing, their boxing and fencing, their lawn tennis, or even their golf, is anything but an easy task for the medical practitioner. Even the "old man" who has long passed his "three score years and ten," and has had a "real good time" in every respect, cannot understand why he should come to the "end of his tether," and that not even "hypodermic injection of spermine" can infuse new life into him.

There is still another class of cases to which I must allude here, namely, those in which definite and easily recognised chronic morbid conditions exist in the chest in various combinations, but entirely inactive and quiescent, though no remedies or methods of treatment can modify them in the least degree. There are hundreds and thousands of cases of this kind, to which we apply particular names, and which throng our hospital out-patient rooms, where I venture to affirm that no active treatment at all is needed, and indeed such treatment is often worse than useless. And here let me say a word as to the frequent necessity of a more judicious use of applications to the chest. By way of illustration may I call attention to the fact that to go on applying some preparation of iodine, sometimes, too, with not very pleasant results to the patient, day after day and week after week, for the supposed purpose of "absorbing" something which cannot possibly be absorbed, such as a greatly thickened pleura or a densely fibroid lung of long duration, is at least not "scientific therapeutics." Of course this procedure may be of service as a "placebo" or to relieve a symptom, when judiciously carried out, but that is altogether another matter.

A very important matter in relation to the classes of cases I am now discussing is that, although any active treatment is decidedly contraindicated, the prevention of any further chest complication is of the greatest consequence, and more or less stringent measures towards this end have often to be carried out. Obviously climate comes in here as a valuable therapeutic factor, but due care is necessary even under the most favourable climatic conditions. Moreover, the great advantages of "home treatment" must also be duly recog-

nised in this connection, the good effects of which may be very striking. I have already alluded to patients suffering from chest affections who are able and willing to remain indoors all the winter, under comfortable conditions, and thus not only prolong their lives considerably, but often manage to have by no means an unpleasant time. But they are not all so amenable to reason, and what one finds is that not a few individuals suffering, it may be, from even serious chest diseases, want to enjoy all the amusements and fun that are going on in the world, without any regard to the risks involved, and they expect us, in our professional capacity, to avert all the evils which their imprudence brings upon them.

From the point of view I am now discussing, in-patient hospital treatment becomes an inestimable boon, even in a "hospital for consumption," with all its supposed risks, and my personal observation and experience will bear ample and emphatic testimony in support of this statement. At the same time, in the light of modern researches and observations, I fully admit that it is our duty to take every possible precaution to prevent tuberculous infection; and it may be a question whether it is desirable to bring phthisical patients, in whom the disease has been practically arrested and cured, into too close contact with those who are suffering from the complaint in an active form.

The next point worthy of notice is that, in the cases we have been considering, should any complication supervene, even if it be but a slight cold, it ought always to receive immediate attention. Neglect of this principle is accountable for much serious mischief.

3. I now proceed to say a few words about the treatment of combinations of diseases or morbid conditions of the chest in acute cases, as they come before us in practice, and for which we are expected to do something definite. Obviously it is impossible to lay down any distinct general rules, but every case must be studied individually, bearing in mind the recognised principles which usually guide us in dealing with the several acute chest affections. It is especially desirable in these cases to try to realise fully at the outset what conditions we have actually to treat, and what we propose to do by our therapeutic measures. I think the general tendency is to be too active than the reverse, and it is well to lean to the side of discretion. A routine line of treatment directed only to one factor in an acute combined case—say pneumonia—is decidedly to be avoided. The supervision of acute or pronounced chronic conditions often gives us a very trying case to manage, and if the combination is not understood it will probably be a bad time for the patient; if nothing worse happens, he is pretty sure to be subjected to a more energetic treatment than the circumstances of the case demand. Of all the cases that harass the medical practitioner and make him feel his smallness and impotence, I think there are none worse than those complicated acute inflammatory chest cases of rapid onset and progress to which I referred in my previous lecture. Some of them are obviously hopeless almost from the first; in others we feel that we must make a fight for life, and there is no greater satisfaction than when, by sticking to our patient and encouraging others to do the same, we succeed, aided by intelligent, judicious, and devoted nursing, in bringing the conflict to a favourable issue, and, humanly speaking, save his life. Unquestionably the rational administration of medicinal agents becomes in these cases of the highest value, especially of those which affect the functions of the vital organs, or which assist or modify expectoration.

I cannot now refer to other details of treatment, and will only say that it is in grave acute chest conditions that we derive such timely help from active therapeutic measures intended for special purposes, more particularly abstraction of blood, either by venesection or local methods, or even by cardiocentesis—as in a case reported in the *BRITISH MEDICAL JOURNAL* of December 15th, 1894—free dry cupping, inhalation of oxygen, artificial respiration, or subcutaneous injection of powerful drugs, such as ether, strychnine, or digitalin. How far the injection of antitoxins is going to be of service to us in the future in the treatment of formidable acute inflammatory diseases of the contents of the thorax remains to be seen, but, so far as diphtheritic cases are concerned, I can affirm that the results which have been achieved in my

wards at University Hospital, under the active management of my late house-physician (Mr. Bunch), are most satisfactory, and fully bear out the favourable reports from other quarters.

4. The actual treatment of chronic chest cases which come before us, presenting such a variety of morbid conditions, in every conceivable combination, and not uncommonly highly complicated, is a problem that always requires thoughtful consideration, and often gives abundant scope for the application of sound therapeutic knowledge and skill, guided by discretion and common sense on the part of the individual practitioner. Different kinds of cases must of course be dealt with in different ways. As I have already intimated, many cases of even pronounced chronic chest diseases do not require any active measures at all, at any rate as a constant or regular practice; but in others we can do much, by the administration of suitable remedies or in other ways, to influence or control morbid processes, to relieve or help symptoms, or to affect temporary conditions or disturbances which so often form part of the history of these cases.

Of course general or constitutional, as well as climatic treatment, and that directed to the digestive or other systems, is frequently of essential importance; and I must draw special attention to the great value not unusually of more or less prolonged rest in bed from time to time, particularly in cardiac cases. As regards the use of medicines, I think the tendency is to overdo things in this direction in chronic cases, even when they are needed; and I may observe that sometimes we find a condition present which distinctly contraindicates the use of a particular drug, or at any rate should make us very cautious in its administration, as, for example, extensive pericardial adhesion, which certainly is not favourable for the employment of digitalis and allied agents. It is interesting and important to note that if one has the opportunity of watching the progress of chronic chest cases of a combined nature, it will frequently be found that they present exacerbations of symptoms from time to time, which pass away under treatment, but in many of them a period comes when nothing further can be done, and the patient must inevitably succumb. The laity cannot understand this at all, and do not see why what has been accomplished before cannot be done again; and I must say that occasionally even a medical man does not quite realise the state of things under these circumstances, but expects the "consulting physician" to achieve impossible results.

5. I now come to the consideration of a definite principle in the treatment of combined chest cases of all kinds, be they sudden, acute, or chronic, as well as indeed in those of a more simple nature, and one which I regard as of the greatest consequence. It is this—to be always on the look-out for, and prepared to deal more or less actively with, certain morbid conditions, often of a pronounced kind, which we can materially influence by treatment, or even absolutely get rid of, but which, if allowed to continue, are sure to lead to serious results, either immediate or remote. This principle applies also to certain individual diseases of a grave nature, which may in not a few instances be greatly checked, or even entirely cured, by appropriate treatment. It opens up a wide range of subjects, and in individual cases it often gives us occasion for deep and anxious thought in determining what is best to be done for our patient's interests, while special difficulties may face us as to carrying out a method of treatment which we know is clearly indicated. There are some who, in relation to certain of the conditions to which I allude, are, I think, inclined to be too hasty, or even rash, in the employment of vigorous and heroic measures; but the general tendency is decidedly in the opposite direction, and one sometimes sees an aggravating "pottering" about cases when there is really something very definite to be done.

Without any comment, I can now only mention the chief conditions or diseases to which the preceding remarks refer, namely, fluid effusions in the serous cavities; pneumothorax and its effects or accompaniments; purulent accumulations of any kind, whether empyema, pyopericardium, or either of the several abscesses; excessive secretions and morbid products in the air tubes or pulmonary vesicles, especially if of a purulent or foetid character, as well as materials formed in phthisical cavities, special care being taken as far as possible not to allow persistent accumulation of these fluids in

the bases of the lungs; solid inflammatory products in the lungs, the remains of pneumonia or broncho-pneumonia, which, even when very extensive and abundant, and of long standing, may sometimes be got rid of entirely by appropriate treatment, systematically and diligently carried out; syphilitic changes, often markedly benefited by specific remedies; aneurysm, which is in not a few instances remarkably amenable to treatment; cardiac thrombosis; and such exceptional diseases as hydatids or actinomycosis.

6. The treatment of temporary disorders of a more or less serious nature occurring as complications of various diseases or combinations, whether acute or chronic, is another aspect of the management of chest cases which always demands thoughtful consideration as well as often promptness of action. Many of these disturbances yield readily to simple measures, such as rest, warmth, posture, and the use of old-fashioned and comparatively harmless remedies, such as "ammonia with ether." The obvious tendency nowadays, however, is to rush off to certain special drugs or methods of treatment, without at all considering the case which has actually to be dealt with, or making any attempt to understand the conditions present. I allude more particularly to the treatment of attacks of spasmodic asthma and angina pectoris. I have no hesitation in affirming that such attacks or supposed attacks—for the disturbances called by these names are by no means always correctly so designated—are often regarded from too narrow and restricted a standpoint as regards the adoption of measures for their immediate relief, that different cases require to be treated in different ways, and that it is a serious mistake to fly to any one remedy as a routine practice. Further, we must never forget that by the repeated use of these remedies, which are usually powerful and dangerous, we may be doing positive mischief; and especially that we may be laying the foundation for their habitual employment by patients themselves on the slightest provocation, the injurious results of which practice we so constantly meet with at the present time, when all kinds of drugs and preparations in convenient and attractive forms for use can be so easily obtained.

At the same time I fully recognise the remarkable effects which can be produced by certain agents which modern experimental pharmacology has provided for us, as well as their essential value in the treatment of the conditions of which I am now speaking, provided they are employed judiciously, and under the direct supervision of a medical man who knows what he is about. Nor must I forget to note here that some of the very active measures to which I have previously alluded may be urgently demanded in cases belonging to the present category, and that they may be immediately instrumental in averting threatened death.

7. The treatment of symptoms opens up most important questions in relation to combined morbid conditions of the chest, and calls for much consideration in a large number of instances. It is impossible for me now, however, to do more than offer a few general remarks on the point. When in an earlier part of this lecture I strongly condemned the mere symptomatic treatment of chest cases, of course I did not mean to imply that they should not receive due attention when required. As a matter of fact they often need a good deal of consideration, and it is by no means easy to cope with them under many circumstances in which various thoracic changes exist together. But here comes in the essential importance of studying each symptom individually in relation to the conditions present before attempting to influence it. It frequently happens that we then find that little or nothing can be done for a particular symptom which is troubling the patient, and what we have got to do is to enforce the principle to which I have previously referred, namely, that he must learn to accommodate himself to his circumstances. This applies more especially to disturbances of respiration and cardiac action. On the contrary, it may be that there is some state of things within the chest which can at once be recognised as the cause of the disorder, and that treatment directed thereto will immediately relieve the symptom or symptoms thus produced, even when they are of a severe or grave character. To go on pouring in drugs for the relief of urgent dyspnoea and palpitation, so-called, obviously depending upon a large pleural effusion which demands instant removal is certainly not rational treatment, and yet it is pos-

sible even in these enlightened days. Again, it is often not desirable to check a particular symptom even when this can be done, such as cough, provided it serves some useful purpose, though it may at the same time perhaps be controlled and helped in various ways. One general rule at any rate should be followed in dealing with symptoms in combined chest cases, and that is not to give more medicine than is really needed, and to employ simple and harmless remedies as much as possible.

I may draw attention to the great advantage to be derived in relation to thoracic symptoms not uncommonly from the adoption of treatment directed to some particular general condition or conditions, especially anæmia, emaciation, and obesity, though I think the last mentioned is sometimes rather injudiciously attacked. Nor must I overlook the immense relief to be often obtained by getting rid without delay of certain abdominal accumulations which physically interfere with the diaphragm and thoracic contents, as well as of extensive subcutaneous dropsy. The beneficial effects which thus follow tapping for ascites, or relieving anasarca by operative measures of different kinds, have, in my experience of a good many cases, been most remarkable.

8. I now come to my last point bearing upon the treatment of combined chest cases, and that is to say a few words about special therapeutic methods. I need scarcely remind you that we are living in an age when, to say the least, there is no great respect paid to traditional therapeutics, and when active and energetic workers are on all hands trying to discover new systems, methods, or even remedies, which will enable us to cope more effectually and successfully with disease in its varied and complex forms. It behoves us, however, as a profession, to be somewhat cautious in our so-called "progress," and not to be too eager to adopt and practise supposed "cures," which a little consideration may show to have really no rational foundation. Such caution is especially necessary in relation to the treatment of diseases of the chest, and a comparatively recent experience gave us all round a lesson which it is to be hoped will not soon be forgotten.

The more prominent special methods of treatment at present in vogue in relation to chest affections may be summed up as follows: (1) Antiseptic treatment, practised in various ways, including intralaryngeal injections, a method recently brought prominently before the profession by Dr. Colin Campbell. The use of antiseptics may unquestionably be of the greatest value in many combined chest cases, and not merely in those of a phthisical nature. (2) Hypodermic injections of different kinds, which may be rational enough in connection with certain exceptional conditions, but on the whole, as at present recommended and carried out, rather indicate a want of any actual clinical or even pathological knowledge of the grave diseases with which they profess to deal, and sometimes border on the absurd. (3) Climatic treatment, to which is added not uncommonly some particular "cure." About this treatment, which of course is the essential requirement in a large number of instances, I will only say that I find that the "resident doctors" in climatic "health resorts" do not at all like a very advanced or complicated chest case of any kind to deal with, but almost invariably, and for obvious reasons, give their opinion that their particular climate will not be suitable for the patient, and that he had better go elsewhere or stay at home. (4) The use of "respiratory gymnastics," often of the greatest service for various purposes, when properly carried out. (5) Methods connected with the employment of "condensed or rarefied air," especially for emphysematous cases. (6) Treatment directed to the nasal cavities and the throat, which in appropriate cases is of unquestionable advantage. (7) Mechanical or physical methods practised in the treatment of cardiac affections, such as massage, graduated mountain climbing, cycling, or special exercises. With regard to these methods, no doubt they are most beneficial in suitable cases, as I can testify, but each one requires very careful consideration before it is treated in any such way.

The preceding remarks have been intended merely to bring to your remembrance, without attempting to discuss them, certain methods of treatment, one or other of which might appropriately be called for in the management of more or less complicated chest conditions. Their individual

application must be left to the matured judgment, practical experience, enlightened common sense, and honesty of purpose of each member of the profession to which we have the privilege and honour to belong.

And now, Mr. President and Gentlemen, my task is ended. I am but too conscious of the imperfect manner in which it has been performed. One of the greatest and most trying problems which the medical profession has to face at the present day, is how to diminish by preventive measures the enormous number of cases of chest diseases which overwhelm us on all sides; and how most effectually to cope with these diseases, in their many forms and combinations, so as to restore health, to prolong life, or to lessen human suffering, according to the circumstances and conditions with which we have to deal. I can honestly say that my object in these lectures has been to contribute something, however insignificant, to the attainment of these ends. Increasing experience has made me feel more and more strongly that before we can succeed in our aims in anything like a satisfactory degree, we must not be content with a general and often vague or theoretical conception of the maladies against which we have to contend, or of their treatment; and I venture further to suggest, with all deference and respect, that we cannot consent to be guided in this matter solely by the teaching of modern experimental pathology and pharmacology. We are bound to realise things as they actually exist in living patients; and it is from this point of view that I have thought it might be of some positive advantage to bring the combinations of morbid conditions of the chest prominently before the profession, at the same time trying to arrange them under some kind of order, to take a comprehensive survey of their clinical investigation, and to glance at the more important principles bearing upon their practical management.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

CONGENITAL ABSENCE OF KIDNEY AND FALLOPIAN TUBE.

I WAS sent for to see a female child, aged 1 month, who had died suddenly without any apparent cause. She was said to have been quite well in the early morning, when her mother left her in the bed alive, and returned after about an hour's absence and found her dead. The child had two thumbs on the right hand, the four fingers being normal. She had also two accessory auricles in the position of the upper branchial cleft and the intermaxillary cleft. An inquest was held. On making a *post-mortem* examination, I found that the right kidney and right Fallopian tube and ovary were absent, and there were not any rudimentary structures in their place. The right superior angle of the uterus was rounded off, and completely covered by peritoneum. The left kidney was normal in size and deeply congested. The pelvis contained a small quantity of purulent urine; the bladder was quite empty. In this case it appears as if the one kidney had been insufficient for the wants of the body.

Hendon.

F. W. EDRIDGE-GREEN, M.D., F.R.C.S.

THE CONTROL OF HÆMORRHAGE IN AMPUTATION AT THE SHOULDER.

THE method of controlling the main artery on the inner flap by placing a temporary ligature around the vessels, nerves, and muscles, after transfixing the flap by a needle, as described by Dr. Dillon in the BRITISH MEDICAL JOURNAL of February 9th, is no doubt efficient, but I think unnecessary. The text books give four suggestions: (1) pressure on the subclavian with or without division of the skin; (2) elastic ligature carried over the shoulder; (3) trusting to an assistant to compress the flap or catch the vessel; (4) previous ligature of the artery. The three first named are unreliable, the last superfluous. Having in my first amputation learnt the danger of trusting to even a highly-qualified assistant to control the hæmorrhage, I have ever since arranged to keep the