degeneration. Staining by Ziehl-Nielsen and Gram's methods failed to demonstrate any tubercle bacilli in the sections.

Fig. 2.—From a photograph by Dr. R. A. Fleming. About 750 diameters magnification. Part of the same section as photograph No. 1, showing giant cells.

The pharyngeal adenoids on section were found free from tubercle, and consisted simply of lymphoid tissue, covered by a layer of the columnar epithelium of the nasopharynx. Some enlarged cervical lymphatic glands were subsequently removed from the same patient, and these on section showed typical tuberculosis in various stages of advance, from simple enlargement to caseation.

This case seems to show that the tonsil is more important as a channel of tuberculous infection than has hitherto been supposed; and when we regard the frequency with which it is attacked, and attacked successfully, by pyogenic organisms, it is not to be wondered at that the tubercle bacillus sometimes enters it and flourishes in its lymphoid tissue, a tissue which is *par excellence* a seat of tuberculous deposit.

THE TRANSMISSION OF DIPHThERIA BY NON-SUFFERERS.

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THE following series of cases is of interest, as showing the possibility of the conveyance of the diphtheria poison by persons who do not themselves suffer from the disease:

HOUSE A.—Case 1.—R. H., aged 45, began to be ill on October 4th, 1894. The case was typical, and was followed by double "drop-wrist." No other person in this house suffered from sore throat.

HOUSE B.—This is half a mile distant from A. There was no communication between the houses till December 26th, when the occupier began to work for R. H. Case 2.—E. J., aged 7½ years, had a sore throat on or about January 2nd, 1895. The case was a typical one, followed by paralysis of both legs. The patient died from cardiac syncope. Case 3.—E. J., aged 4 years, began to be ill on February 6th. This was a typical case, and resulted in death from asphyxia. Case 4.—J. J., aged 12 years, had a sore throat on February 16th. The case was typical, and was followed by dimness of sight and strabismus. Bacteriological examination of cultures from the throat showed the presence of large numbers of diphtheria bacilli.

HOUSE C.—This farm house stands on a peatmoss, and is 1½ mile distant from houses A. and B. Case 5.—R. J., aged 18, brother of the last three patients, worked here from

January 15th. His mother stated that he was at home for a few minutes on the days his sisters were buried, but at no other time. He himself admitted having been home on each Sunday to change his shirt, which he did in the room occupied by the patients. He stated that he did not suffer from sore throat at any time, but bacteriological examination showed typical diphtheria bacilli in large numbers to be present in the throat. There is no history of his ever having had diphtheria. Case 6.—J. C., aged 18, began to be ill on February 26th. He worked on the same farm as the last youth, and slept with him. He went home to House D. on February 27th, being then "full of cooth," and suffering from sore throat, and unable to work. Typical diphtheria bacilli were present in great abundance on March 15th.

HOUSE D.—This is 1½ mile distance from House C., two miles from B., and 2½ miles from A. Case 7.—J. C., aged 13, slept with the last patient, his brother. He came home from chapel on March 3rd, complaining of sore throat. On March 8th he was seen for the first time by his medical attendant, and was then dying. No bacteriological examination was made. Case 8.—E. C., aged 3 years, sister of the last two patients, began to be ill on March 12th. The case was a typical one, and an abundance of typical diphtheria bacilli was found on bacteriological examination.

REMARKS.—House B. was probably infected by the father of the family, who himself did not suffer from the disease. His son, Case 5, did not suffer from the disease, though he was proved to have its germs in his throat, but he was the means by which it was carried to House C., whence it was taken to D.

AN UNUSUAL CONDITION OF THE PILLARS OF THE FAUCES, PROBABLY CONGENITAL.

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THE following case presents certain features which may be deemed sufficiently interesting to warrant publication:

The patient, a married woman, 29 years of age, consulted Dr. Monro at the Medical Dispensary of the Glasgow Royal

Infirmary in March last year, on account of a catarrh of the

chest and throat, evidently the result of a cold. Upon the abnormal condition of the throat being discovered, she was sent to me for examination, and subsequently the case was placed at my disposal.

A simple cough mixture had been given to her on the medical side, and when I saw her a few days after the first examination she expressed herself as feeling practically well. Upon examination only a slight catarrh of the larynx was found to be present. The view of the fauces, however, was so unusual as to induce me to take full notes of the case. These notes, together with a tolerably accurate drawing of the parts, I now submit.

Mrs. W., aged 29, has been married for ten years, her husband being a labourer. She has had four children, three of whom are alive and healthy; the fourth died of whooping-cough when 18 months old. She had a miscarriage five years ago. Her father, she states, is still alive, and 85 years of age. Her mother died at the age of 39, from bronchitis. The family consisted of three sisters, all of whom are alive.

The patient is a healthy-looking, well-developed woman, of medium height, with thick dark brown hair and bright intelligent eyes. The teeth are less decayed than usual in women of her age, and the sound ones remarkably white and well-formed. There are two short perpendicular scars through the mucous membrane of the upper lip, but scarcely involving the skin, one being situated near the middle line, whilst the other is removed a short distance to the right side. She ascribes the presence of these scars to "hacking" when suffering from scarlet fever, and states that they formerly used to open afresh in cold weather. A scar about the size of a three-penny-piece, said to be the result of a boil, is found on the calf of the right leg. With these exceptions, I have been unable to find any other cutaneous scars, nor are others admitted to be present by the patient. There are no indurated nor enlarged lymphatic glands to be felt, and the general aspect and examination yield nothing which points definitely to syphilis. When a child she had measles and scarlet fever, and at the age of 12 was very ill with what she calls "brain fever." This illness appeared to follow a blow on the head from falling against an iron bedstead, and she was said to have remained more or less unconscious for three or four weeks. She is not subject to fits. She has no recollection of ever having had a sore throat, and has always been very healthy.

On examining the fauces, an opening is seen in each of the anterior pillars. On the left side the soft palate is found not to divide in the usual way into an anterior and a posterior pillar, but passes down as a single band in the position of the anterior. Towards its lower attachment it becomes somewhat expanded and slightly directed backwards. Separating this band from the buccal wall is an elongated opening, which begins above on a level with the base of the uvula, and extends downwards almost to the gums. The posterior pillar on this side appears, therefore, to be absent.

On the right side of the fauces we have a similar condition of parts, but here the band representing the anterior pillar is somewhat broader, and the opening external to it rather larger, than that of the opposite. Moreover, there is in addition a narrow strip of mucous membrane which arises above from about the usual point of attachment of the posterior pillar with the soft palate, and passes downwards to its insertion below. On the soft palate being raised and the parts rendered tense, separation takes place at the point of junction with the soft palate as in the normal state. The edges of these bands are soft, smooth, and even, and no cicatricial tissue can be made out either on their free edges or surfaces, the mucous membrane over which appears to be entire. The external boundaries of the above-mentioned oral openings formed by the buccal walls and part of the soft palate are smooth, and show no remains of a former attachment. Both tonsils are absent.

On examining the pharynx the mucous membrane is found to have been destroyed over a very large area. Inferiorly this destructive process is met with a short distance above the œsophageal opening; spreading as it passes upwards, it involves to a certain extent the edges of the epiglottis, pushes laterally over the usual site of the tonsils, extends up into the naso-pharynx and over the upper surface of the soft palate, where it is gradually lost. Generally speaking this

process appears to have been of a superficial character, for with the exception of one or two somewhat dense-looking fibrous streaks on the posterior wall of the oro-pharynx, the look presented is that of a destruction of the mucous membrane proper, leaving bare the fibrous layer. There is no distortion of parts, there is no destruction of the cartilage of the epiglottis, and even on the upper surface of the soft palate the process appears to have been confined to the superficial covering, scattered patches of which still remain. In the oro-pharynx it extends forwards till about the level of the opening in the anterior pillars, but does not go beyond; and here the line of demarcation is so ill-defined that it has almost the appearance of gradually blending with the normal mucous membrane. The anterior surface of the soft palate and uvula appears quite normal. The larynx, tongue, and nasal cavities do not seem to have suffered in any way. The voice is clear and free from any nasal quality. There is no trouble during deglutition, and previous to examination the patient was unaware of anything unusual being present in the throat.

The questions which one is here inclined to ask are: At what period of the patient's life did this destructive process take place? What was its nature? Has it any bearing on the anomalous condition of the pillars?

In answer to the first question, inasmuch as the patient positively denies any knowledge of having had a sore throat, nothing definite can be stated. As to its nature, when the patient was shown at the Glasgow Medico-Chirurgical Society on February 8th, one member thought the whole condition due to syphilis, but a consideration of the history and features of the case tend to disprove this theory. No more definite facts than have been given could be elicited in connection with the "brain fever." That being so, we are constrained to regard the scarlet fever from which she suffered at an early age as being the most probable cause of the ulceration in the pharynx. As to the third question, the general opinion of those who examined the patient, both at the meeting and elsewhere, was that the openings in the pillars did not look as if caused by ulceration. I think I am also right in stating that none of them had seen a similar condition of parts, and those gentlemen who had an opportunity of making a prolonged examination in a good light agreed with me in looking upon it as congenital. I must say that after repeated examination, and with every desire to arrive at a correct conclusion, I can only view the condition in this light, and consider it of a character similar to certain cases reported by Schmiegelow,¹ Claiborne,² O. Chiari,³ Schapring,⁴ and others. It appears to resemble especially Schapring's case, in which there were cicatrization of the pharynx and absence of one tonsil.

REFERENCES.

¹ *Monatsschrift für Ohrenheilkunde*, 1885, p. 35. ² *Amer. Jour. Med. Science*, 1885, p. 490. ³ *Monatsschrift für Ohrenheilkunde*, 1884, p. 142. ⁴ *Ibid.*, p. 204.

HYSTERICAL OR FUNCTIONAL DISEASE.

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THE interesting remarks which my account of a case of functional deaf-mutism led Sir William Dalby to send to the *BRITISH MEDICAL JOURNAL* of March 16th emphasise the necessity of precisising our ideas as to what we mean by the terms "hysterical" and "functional," and the desirability of establishing a uniform nomenclature for diseases of this group. Are the two terms synonymous, or should they be applied to cases in different categories?

Sir William Dalby narrates the case of a girl who was thought to be deaf by her friends, but whom he judged (by the modulations of her voice, among other signs) really to have perception of sounds, though the usual responses were apparently without motive or effort suppressed. Taking this view of the case, we cannot call it one of functional, or even hysterical, deafness. The patient may have been, in popular phraseology, hysterical, but the loss of function was that of reaction to auditory stimuli, not loss of reception. This is a distinction which should be drawn between this case, and those who, like the professional subjects of popular "mes-