pains, like those of rheumatism, which set in soon after a confinement. It very seldom affects the pelvis of women who have had no children; hence it may happen that a female, who has been delivered of full-sized infants without any particular trouble, becomes the subject of this disease, and suffers increasing difficulty at each succeeding labour, owing to the growing deformity of the pelvis, till at last delivery by natural means becomes quite impossible. The Cæsarian section has been performed in several instances of this kind. These casts show the extent which the deformity sometimes reaches. The proper circular shape of the pelvis is quite lost; the acetabula and the promontory of the sacrum almost meet in the middle, the rami of the pubes are in contact, and the tubera ischii approximated.

Mollities ossium, as has been already said, is a disease of rare occurrence, and happily so, for it is very little under the control of art. When it has once commenced it generally proceeds unchecked either by medicine or therapeutics, reduces the patient to a most distressing state of deformity, and terminates only in death. Various remedies have been tried, but it is useless to enumerate them, for they have all failed. Mercury, as might have been anticipated, when given in sufficient quantity to affect the system, has only made matters worse. Dr. Good relates, in his "Study of Medicine," the case of a lady, aged 28, in whom both thigh bones broke spontaneously, and other bones became soft and compressible, there being at the same time great debility. Under tonic regimen the bones united by callus, she appeared to be in a fair way of recovery, and was in full hope of regaining her former health, when she was suddenly carried off by an attack of pleurisy.

The facts which have been brought under your notice in this day's lecture serve to illustrate the close relation that exists between diseases apparently different, and the great difficulty of fixing their boundary lines with precision. Such lines, it is to be remembered, scarcely exist on the field of nature, and though it may be desirable to draw them artificially for the purpose of systematic teaching, it is evident that we only fall into error when we endeavour to make the distinctions accurate or clearly defined. Here we have a passive affection—rickets—occurring in childhood, and dependent upon an imperfect appropriation of earthy salts by the bones; secondly, an active disease—mollities—appearing in the adult, and attended with deterioration and absorption of the animal as well as the earthy constituents of the bones; and, thirdly, the atrophy of old age. One might have imagined that these three affections would be sufficiently marked to render it an easy matter to distinguish them in practice; but we have found that a very slight cause, a scarcely perceptible amount of inflammation, is sufficient to induce, either in rickets or in senile atrophy, a state closely corresponding with mollities; hence the confusion that has always prevailed in this department of pathology, and the difficulty of forming a decided opinion in each particular case.

We cannot also fail to remark the frequent connection between atrophy and inflammation—a connection proved by every-day experience, no less than by the examples adduced in this lecture. Whatever has the effect of depressing the physical energies or lowering the nutritive powers is almost sure to render the person or organ impaired an easy prey to inflammation, and not to inflammation only, but to many other diseases. The weak frame is most susceptible of cold and malaria; the cautious experienced operator dreads the loss of blood, because he knows that it will render his patient liable to erysipelas, secondary abscesses, and a variety of complaints which militate against the chance of success; and we constantly find that the sufferers under cancer or other serious malady have been getting thin and weak for sometime previous to the attack. I again revert to this point, though your attention has been directed to it before, because it is a fact of the highest practical importance,—one which cannot be too frequently impressed upon you.

BRIEF NOTES OF

MEDICAL CASES,

SELECTED FROM HOSPITAL AND PRIVATE PRACTICE.

By C. M. DURRANT, M.D., IPSWICH.

HÆMORRHAGE FROM THE MOUTH.

AN officer in a Dragoon regiment, aged 26, on awaking, found his mouth partially filled with blood, which upon examination by his medical attendant, was found to exude from the mucous membrane, between the cheek and upper jaw of the left side. The hæmorrhage was very readily restrained by pressure, and the quantity lost did not exceed ten or twelve ounces. He had been much exposed to cold, wet, and great fatigue in salmon fishing, grouse shooting, &c., in Scotland, often standing for some hours in water up to the waist. In addition to this, he had suffered while in Scotland from a severe attack of the then prevailing English cholera.

Prior to my seeing him the hæmorrhage had ceased; his countenance was pale and anæmic; pulse between fifty and sixty, his natural pulse being forty-five: tongue clean; evacuations clay-coloured, the liver having for some years been inactive; urine clear and natural in quantity; abdomen yielded a doughy sensation, with some fulness about the course of the colon. No enlargement of liver or spleen. He is of a consumptive family, but the lungs and heart were both healthy.

Treatment.—Free action upon the liver and bowels by alterative aperients; salines, with the syrup of the iodide of iron. There was no return of hæmorrhage.

Remarks.—The above case affords a good illustration of passive hæmorrhagic exudation from the mucous membrane. The habitual inactivity of liver, the naturally slow and languid circulation, together with the depress-

ing influence of cholera, coupled with reckless exposure to wet and fatigue, will at once indicate the more than sufficient predisposing cause of hæmorrhage, viz., a disordered condition of the blood itself, producing cachexia, and a laden condition of the portal system, favouring irregular circulation, which, in its turn, was still further kept up by the naturally slow and languid heart.

Upon this view was grounded the treatment, viz., free stimulation of the liver by alterative aperients, increasing the secretions from the skin and kidneys by salines, and improving the deteriorated condition of the blood by the exhibition of the iodide of iron.

In the treatment of passive hæmorrhage, free and repeated purging, and the specific action of mercury upon the system, are often signally beneficial. Too frequently, I believe, are astringents at once had recourse to upon the supervention of the hæmorrhage, and they check for a time the flow; but in a great majority of instances a more certain and permanently good result will be obtained by active derivation from the bowels by means of blue pill and neutral salts. Indeed, few affections bear free purging with such advantage as this class of hæmorrhages, and in the more severe cases in which the drain has been very profuse, and considerable apparent debility has ensued, the most gratifying results have again and again attended the adoption of this practice.

PUERPERAL ASTHENIC PNEUMONIA.

I was requested to meet in consultation upon the case of Mrs. —, a delicate anæmic female, aged about 30, of an hysterical temperament, and hereditarily predisposed to phthisis. She had been confined three weeks with a still-born child, but every circumstance connected with the labour had been natural and satisfactory. At this period, she was somewhat suddenly seized with acute pain in the right side, accompanied by great and distressing dyspnoea. On examination, the body was semi-recumbent; countenance anxious; skin clammy and perspiring; respiration quick, short, and with a painful degree of dyspnoea, but unaccompanied either by cough or expectoration. The pain in the side was increased by inspiration, or upon attempting to recline in that position; tongue coated; bowels confined; evacuations healthy; urine normal; pulse 130, small, and irritable; lochia ceased. Percussion yielded a flat sound, which ultimately became completely dull over the posterior and lower third of the right lung. Small crepitation, with occasional large bubbles over the same spot, which, in its turn, was followed by loud tubular breathing and bronchophony. The anterior portion of the lung was but slightly implicated; the left lung healthy, with some amount of exaggerated respiration. At no time was there either cough or expectoration.

Treatment.—This consisted of blisters, the iodide of potassium, with salines, and ultimately, the ammonio citrate of iron; supporting the strength by a liberal allowance of beef-tea.

Remarks.—The general character of this variety of

pneumonia is essentially asthenic, occurring usually in the second or third week after confinement, and it is apparently caused by the absorption of morbid secretions into the blood, which, by infiltrating the pulmonary tissues, induce a low degree of inflammatory action in the parts with which they come in contact. This affection presents phenomena which do not commonly obtain in the more regular and sthenic form of the disease.

In the cases which have fallen under my notice, the attack has been more or less sudden. The patient has not been exposed to cold, but the system has been invariably in a delicate and cachectic condition. The peculiarities of the symptoms are the comparative suddenness of the attack, evidencing the absorption of some deleterious matter into the system; the great degree of dyspnoea, beyond what the amount of inflammation would lead one to expect; the quick, small, and irritable pulse; anxious countenance; clammy perspiring surface; absence of cough; or, if any exist, it is short, hacking, and *dry*; the latter feature, viz., the want of expectoration, is very characteristic. The premonitory rigor is by no means a common symptom in this form of pneumonia, and the pain felt in the affected lung is rather described as a sense of weight and oppression. The acute pain in the accompanying case must be attributed to pleuritis rather than to the deeper-seated disease of the lung itself.

The physical signs are valuable, and are in general well marked. Thus we have in succession the characteristic small crepitation (if the case be examined at its onset); the gradually increasing dullness on percussion; the tubercular respiration, with bronchophony, succeeded as the result of treatment by the gradual return of healthy vesicular murmur, unaccompanied by the “*redux*” signs, occasionally discoverable in the other forms of the disease.

A large extent of inflammation is by no means necessary or common to this variety of pneumonia, and indeed the reverse generally obtains. In cases which terminate fatally, we find patches of inflammation in various stages of its progress; here a spot of dark congestion; there a circumscribed hepatization, while, intermingled with these, we have local purulent deposits, and morbid infiltrations, all more or less surrounded by healthy portions of lung.

In the treatment of these cases, depletion even in its topical form, is seldom required or to be advised. Blisters repeated according to circumstances, with the iodide of potassium and salines internally, followed by steel, and perhaps ammonia, are the remedies chiefly indicated. Mercury may occasionally be desirable; but it must be administered cautiously, and the system requires support from the first.

EMPHYSEMA AND PNEUMOTHORAX FROM A PUNCTURED WOUND OF THE CHEST.

Physical Signs.—An upholsterer, in the act of cutting a piece of cloth with a pen-knife, fell, and punctured the chest between the third and fourth ribs of the left side. The wound was small, and attended

with very slight hæmorrhage; but the external air passed audibly into the cavity of the left pleura. On examination about two hours after the occurrence of the accident, the left side was found to be nearly immobile, loudly tympanitic on percussion, and the vesicular murmur over the entire side greatly diminished in intensity. On the right side, the breath sound was exaggerated. These signs were followed by emphysematous crackling over the left mammary region, more particularly around and above the wound. With each pulsation of the heart was heard a moderately loud and peculiar flapping sound, influenced solely by the position of the patient, it being continuously audible during the horizontal, but becoming at once lost upon his taking the erect posture, and did not again recur until the former position was resumed. From this circumstance, it was evident that the peculiar sound in question originated from the vibration caused by the action of the heart upon the portion of the air within the pleura, located during the horizontal posture of the patient between that organ and the parietes of the chest. Under bandaging, rest, and simple treatment, the patient speedily recovered. The air becoming absorbed, all physical signs vanished, and the lung resumed its healthy function.

Remarks.—Although not a strictly medical case, (for it was not under my care) yet I had an opportunity of examining the physical signs daily, and from this well-marked development, and the rare vibratory sound which existed, I have thought it of sufficient interest to extract *verbatim* from my note-book.

The absence of the flapping sound when the patient was erect may be readily explained by the displacement of the air during the approach of the heart to the parietes when in that posture; and its persistence during the horizontal position will be rendered equally evident by the falling back of the heart, and the consequent admission of a certain portion of air between it and the surface, and which was rendered vibratory by each pulsation.

The emphysematous crackling was the simple result of contained air within the parietal cellular tissue.

(To be continued.)

ON THE PROPRIETY OF EXCISION IN MALIGNANT DISEASE.

By THOMAS PAGET, Esq., F.R.C.S.,

SURGEON TO THE LEICESTER INFIRMARY.

To the Editor of the Provincial Medical and Surgical Journal.

SIR,—In malignant disease I imagine no one will contend we have yet attained the knowledge which enables us to select the cases to be operated upon with success, or dictates to us that we discard from operation all of decidedly malignant character. Each, then, must be judged by its own circumstances, its present state, and past history. Some will at once, though with pain,

be consigned to their fate with only the poor consolation of palliatives; others present themselves in a nascent undeclared state, or at all events, in so early a stage, that we conclude without hesitation, “in these excision must be tried, or in all abandoned.” I need scarcely say there is a third class, in which time and progress have placed the case in the region of doubt; and it is for the surgeon to pass through a course of anxious thought to decide, and then to open his mind to his patient, without the slightest appearance of indecision.

If in the present era of numerical statistics and microscopic demonstration, any value will attach to mere convictions resulting from observation, I would suggest a guide in these distressing cases, and you will add to obligations of the kind already conferred, if you will find me a space in your columns for the purpose.

In considering, then, the propriety of operation, I would to the more ordinary and obvious guides add and rely much upon *the comparative rapidity or tardiness shewn by the disease in attaining its present state*. My experience alone cannot establish this as a practical point, and others may have arrived at a different conclusion, or, without my knowing it, may have published their ideas in accordance with my own. Cases have, however, occurred under my notice in numbers sufficient to impress it as a principle that *the chance of relief from operation is in inverse ratio to the rate of progress shewn by the disease*. By relief, the least that is intended is decrease of pain and arrest of diseased action.

Among such cases the following are perhaps the most significant, and at least will serve to illustrate my meaning:—

George Lee, aged 19, was admitted into the Leicester Infirmary with his left eye protruded from its normal situation at least three inches. It is worthy of note that, though the optic nerve was stretched to this length between the foramen and the globe, vision was not destroyed. He could see with either eye singly. There was at times much pain deep in the orbit and on that side of the forehead. This mischief was effected by a tumour, which filled and projected beyond the orbit, thrusting the eye before it. It was of lobulated form and shewed in parts a livid tinge. He came with a full determination to have it removed if possible.

I find the entry made on his admission runs:—“Hydatid, encephaloid, or botryoidal tumour, arising within the orbit;” and on consultation, as the nature of the case could not be more definitely settled, it was decided not to refuse an operation, but to dissuade the patient from it. With this view I kept him in the house more than a month, trying my best from time to time to ward off the responsibility of surgical interference; I had, however, promised him to remove it, if he wished, and he was firm in insisting upon my promise. I never saw more firmness of purpose.

The orbit was emptied by excision. All present concurred in the malignant nature of the tumour, which now forms a fine specimen in our museum (bottle 47.) It is now five years since the operation,