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CASE OF EMPYEMA; PERFORATION OF THE LUNG; OSSIFICATION OF THE PLEURITIC FALSE MEMBRANE; WITH REMARKS ON THE DEPOSITION OF TUBERCLES IN SUCH CASES.

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If the real value of a pathological preparation depends on a full recital of the history of the case, and the train of symptoms to which it gave rise in the living subject, so as to exhibit the cause of the morbid process, its operation, and effect; then is it a matter of the first importance to a Society like the one I have the honour of addressing, to ascertain and demonstrate these particulars.

I would even go farther, and suggest that every well-marked specimen of disease should form the basis of a dissertation on, or be accompanied by, a general review of the class to which it belongs, or with which it is connected. Members would naturally and more profitably select and introduce those subjects with which they were most familiar, and to which they had more particularly directed their attention. By this means, as the mind of each member is, probably, "imprinted with a different bias," would the whole range of medicine and surgery be brought before the Society in its most agreeable and attractive form, and so would its interest and value be most materially enhanced.

With this impression I beg to submit the following case and observations, trusting that many others, much more able, and not less willing, will follow the example:—

Sarah Lukeman, aged 50, married, housewife, living in West Street, was admitted under me, at the Dispensary, July 3, 1843. Her history was briefly this: that nine weeks before, she had been in perfect health; that eight weeks previously, without probable cause, she had been seized with severe rigors, followed by pain in the left side of the chest, beginning at the lower part, and gradually ascending to the upper; she had had fever, frequent cough, some expectoration, but not, according to her own account, of a rusty appearance. During this period she had been in bed, and under occasional medical superintendence.

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Examination.—Left side of chest contracted, and comparatively fixed in respiration. Universal dullness of the entire side, more marked at the apex behind, and the base before. Respiration, anteriorly and laterally, distant and modified, but audible at every part; posteriorly coarse, tubular and in the scapular region with large crepitation. Vocal fremitus exaggerated. Right side percussion clear; respiration puerile.

Lies best on the right side. Cannot lie on the affected side from pain, nor on the back from cough. Cough frequent; expectoration profuse, purulent. Is very feeble; has anorexia, insomnia, but no hectic.

Diagnosis.—Of this there could be no doubt; it was pleuro-pneumonia, with effusion.

Without pretending to diagnose pleuritic effusion in a lesser degree, the symptoms and signs in this case left little room for dispute. It was evident the effusion had once been greater, and that the lung had either partially re-expanded, or that, more probably, it was more or less solidified by inflammation of its own tissue.

The only question was:—Is there the super-addition of tubercles at the apex? Manifestly this was a decision of great delicacy. The auscultatory signs tended to, while the general history forbade such a supposition. Dr. Cowan, on a careful examination, feared that tubercles did exist. She was ordered calomel and Dover's powder, hydriodate of potass, and opium at bed time. After seven days she was admitted into the hospital under Dr. Cowan. She remained three weeks in the hospital, but was discharged at her own urgent request, without benefit, and in a weaker condition. While in the hospital, she was slightly mercurialized, blistered, and then had quinine, wine, &c.

Was readmitted under me, July 31st.

The physical changes were—the contraction of the side was still advancing, the crepitation at the apex amounted to gurgling; and the expectoration was more profuse. Dr. Cowan also directed my attention to abnormal dullness at the apex of the opposite lung behind, and to the coarse character of the respiration in that situation. At his suggestion, I ordered one grain of the acetate of lead, with the sixth of a grain of the acetate of morphia, in a pill every six hours; good food, wine,

and brandy. In a few days she took two pills instead of one. Under this treatment she wonderfully improved in every respect.

August 11th. Yesterday morning, when sitting up, had a sensation as if something burst inside the chest, and immediately expectorated a tea-cupful of nauseous purulent fluid; she coughed incessantly for two hours, and brought up altogether about a pint of the same kind of fluid. Is now much relieved, and since yesterday the cough and expectoration have been trifling. Percussion now gives a tympanitic sound at the upper part of the left side; respiration is more audible at the lower, but gurgling at the apex behind. It was now for the first time observed that the heart's pulsations were much more distinct to the ear and hand at the summit of the left side of the chest, than over its peculiar region. For three or four days at this period, she was astonishingly relieved, and not only got up, but went down stairs, and even walked in the garden.

On the evening of the 14th, after one of these walks, she suddenly experienced a sense of suffocation, and brought up about half a pint of the same kind of offensive fluid. Frightful dyspnoea continued for some hours, threatening asphyxia every moment, but it was ultimately relieved by the free exhibition of stimulants. From this time she did not quit her bed till death, seventeen days afterwards. Every day she suddenly brought up from half a pint to a pint of the same offensive fluid; the cough was constant, the expectoration profuse, and now habitually nauseous. She was unable to lie on her right side; the fluid flowed so copiously into her mouth as to endanger suffocation. She daily became more asthenic, and died by syncope; sixteen weeks from the commencement of the disease, and three weeks after perforation had taken place.

Post-mortem examination, nineteen hours after death. Head not examined. On cutting off the sternum in the usual way, the right lung was seen extending beyond the median line; the left was hidden, and the cavity closed by intimate and strong adhesions of the pleura to the pericardium. On separating these adhesions, the cavity was exposed, containing about a pint of thick, purulent fluid. Lung compressed; not in a round mass to its root as ordinarily seen, but to the vertebræ, the whole length of the cavity being fixed and retained below by adhesions to the diaphragm; more compressed below than above. The costal pleura lined by an adventitious substance of a yellowish colour, firm consistence, worm-eaten surface; double at the posterior part, from one to three lines in thickness; at the superior part converted into bone, and firmly adherent to the pleura. The ossified portion, as large as the palm of the hand, was intimately connected on one side to the pleura costalis, and on the other to the apex of the lung.

Costal pleura much thickened. Pulmonary

pleura also thickened, with a surface irregular and flocculent.

On separating the ossified layer at the apex from the lung, the pleura was torn off, displaying a number of pouches or small cavities, the extremities of enlarged bronchial tubes. The lung was of a dark grey colour, soft, and at the apex in a state of incipient gangrene. Bronchial tubes enlarged, and lung through them receiving air in every portion, but now filled with matter from the empyema. Though now soft, the substance, it was evident, had been firmer than a healthy lung compressed to a similar size, showing deposit from previous inflammation. At the junction of the middle with the inferior third, was an opening or perforation admitting readily an ordinary director, and communicating through a non-tortuous sinus with the left bronchus.

Right lung large, remarkably spongy, and free from congestion. No adhesions. *Not a tubercle in either lung.*

Heart small and feeble—cavities empty. Pericardium and endocardium healthy. Valves normal. No deposit in the thoracic or abdominal aorta.

Abdominal organs healthy.

Osseous Matter.—The deposition of osseous matter in pleuritic adventitious membranes would appear to be rare. I cannot find a corresponding case. Dr. Hodgkin says, in his valuable work on Serous Membranes, "It is a circumstance of no very rare occurrence for the effused organizable matter to assume a semi-cartilaginous, instead of a cellular form;" which description, I think, applies sufficiently accurately to the greater portion of this specimen. Nothing is said about osseous matter. In speaking, however, of serous membranes generally, he says, "The dense and cartilaginous products of inflammation occasionally become penetrated with earthy particles and pass into a state more or less approaching to ossification, but this happens much more frequently beneath the *attached* surface of the serous membranes than on their internal or secreting surface."

Mr. Mayo says, "Phosphate of lime is sometimes deposited in pleuritic lymph."

Dr. Hodgkin also describes the worm-eaten appearance of this dense adventitious structure, (well seen in the specimen on the table,) and offers a very ingenious explanation. He supposes these depressions are filled with a soft inorganizable material, so that this worm-eaten appearance is not produced by ulceration or other destruction of the thickening deposit, but that its deposition or formation is prevented by the presence of a different material.

Cartilaginous incrustations, ossific deposits, bony masses, are mentioned by Laennec, Bailey, Dr. Elliotson, and Dr. Hodgkin, as not unfrequently occurring under the pleura costalis.

With regard to the production or formation of this false membrane, I may safely assert, that lymph was effused on the costal pleura; that it became

organized, and that in one portion ossific matter was deposited. Why ossific matter was deposited in this situation only, I don't pretend to explain, except it might be from the intimate adhesion of both pleural surfaces, which occurred in no other spot; because, if the deposition of bony matter *under* serous membranes—which is much more common than *on* them—is favoured by position, by pressure, here would it most specially be promoted when *under* one and *on* another.

The quantity of solid deposit also might be influenced by the lung being involved, as well as the pleura. Dr. Hodgkin says, "When inflammation of this membrane is associated with that of the substance of the lung, the latter does not collapse as in cases of simple pleurisy, and we find the quantity of solid product of inflammation disproportioned to that of the serum."

Effects of this Adventitious Membrane.—What influence then had this adventitious membrane in the modification of some of the signs, or in the production of others? It is probable the contraction of the side was affected as much by the contraction of this membrane as by the absorption of fluid. It doubtlessly also modified the auscultatory signs. This was more particularly the case at the summit; for here, before a part of the fluid was evacuated, percussion was most dull.

Point of Election of Perforation.—I am not aware that there is anything peculiar in the point of election of the perforation. The occurrence, however, of communication between the cavity of an empyema and the bronchial tubes, is not very frequent.

Dr. Hodgkin says, "Examples are related by Laennec, Andral, and probably many other authors. I saw one, if not more cases of this description, in the Clinical Wards in Edinburgh;" showing that they cannot be very numerous. It was on the left side. Dr. Bird states it is more frequent on the left side than the right in the ratio of three to one.

I will not enter into the question whether pus is ever absorbed from the cavity of the pleura; but I think the fact, that when a communication is established, the contents are invariably puriform, would prove, at any rate, that it is much less frequently absorbed than serum. Perhaps there is some relation between purulent effusion and perforation. Great relief followed the first evacuation of fluid, but this relief was temporary and delusive. The expectoration became habitually nauseous and foetid; suffocation was daily threatened by its sudden irruption; she rapidly declined under its frequent repetition, hastened perhaps by the pestiferous influence of the discharge itself, and she sank by asthenia.

Chemists are not agreed as to the nature nor production of the foetid material; it exhales the odour of sulphuretted hydrogen.

Condition of the Lung.—The heart's pulsations were more sensible to the ear and hand at the

summit of the chest than in their normal situation. This did not depend on any displacement of the heart itself, but on the greater facility of their transmission, through the compressed and solidified lung to the apex, than through the liquid effusion to the parietes of the chest.

State of the Opposite Lung.—It has been stated in the report that percussion was much duller than normal at the apex of the right lung; giving rise to the strong suspicion of the presence of tubercles in that situation. This is a point to which I wish to direct the particular attention of the Society. A great deal has been said about the modification of sonority that occurs by the contact or approximation of a dull and sonorous body; for example, that we may have tympanitic sonority at the summit of the left chest, transmitted through a solidified lung from a stomach distended with flatus; that we may have tympanitic sonority over a lung uniformly solidified, from the presence of air in the bronchia; that we may have normal sonority with a considerable amount of tubercular deposit. Little however has been said about the reverse position, except the detection of the liver, heart, and lobular solidification through intervening portions of healthy pulmonary tissue. If we consider, however, in this case the bony plate, the liquid effusion, the solidified lung, the inelastic and thickened parietes of the opposite side, extending undoubtedly more or less to the mediastinum and parietes of the same side, we cannot be surprised that its sonority should be most materially modified. Normal respiration was masked by puerility, and its sonority modified by surrounding induration. Besides, a considerable amount of deposit would have been required to become cognizable in so voluminous a lung, the existence of which deposit could scarcely be reconciled with the history of the case. I do not think that the modification in the physical signs produced by the contiguity of bodies in an opposite state has yet been sufficiently investigated.

The Diagnosis, as I have said before, was sufficiently obvious. Contraction of the side, I may remark, may in these cases be more apparent than real—may be deceptive, from the increased expansion of the opposite side. The only doubt was the super-addition of tubercles in the apex of the more diseased side, rendered probable by the large crepitation and the greater dullness on percussion in that situation. The event is well calculated to remind us of that which should never be forgotten—"that physical signs are not so much indicative of particular diseases as of physical conditions."

The modification that arose after the first discharge of purulent matter and the foetid state of the fluid itself, were sufficiently characteristic.

Metallic tinkling, succussion, and some other signs, were neither observed nor looked for, as her weakened condition forbade unnecessary manipulations.

Treatment.—I have little to say on this head. The effects of the acetate of lead and opium, were at first decided, satisfactory, and encouraging. When however, perforation occurred, it was manifest after a few days, that all medication was nugatory and abortive.

I will not enter into the question of paracentesis. It is quite clear, that in this case it would have been useless and only have hastened the fatal termination.

In making these remarks, I am fully sensible of the manifold imperfections of my observations and description. When once the mind gets satisfied with the more prominent or distinguishing lineaments of a case, it is apt—too apt—to neglect or regard with indifference its minor, though not less important features. Every discriminating mark of so interesting a case as the one under discussion would require a volume, not a paper, for its complete illustration.

I will now, in conclusion, beg to submit to your consideration, a subject of intense interest and momentous import—viz., the deposition of tubercles in a lung compressed by a pleuritic effusion, or on the opposite side.

Tubercles.—I have stated that there were no tubercles found in either lung in the case just related.

In a discussion at the Westminster Medical Society, (*Lancet*, April 22, 1843,) Dr. F. Bird said, that “one of the most important complications supervening upon chronic cases of empyema, and which he regarded as one of the strongest arguments in favour of the treatment by *early* operation (paracentesis) consisted in the deposition of tubercles in the opposite lung.” Two cases were related, in which the “advanced age of the patients, as well as their previous history, negatived the idea of tubercles having pre-existed the pleuritic effusion, an opinion which was supported by the fact, that no trace of tubercular deposit could in either case be detected in the lung which had been subject to the pressure of the fluid.” “It was difficult,” he added, “to explain the occurrence of tubercular deposit in these cases, but the fact of their being limited to the opposite lung would serve to show their association with, if not their dependance on, *increased* respiratory action.”

Dr. Cowan, in one of his admirable “Contributions to the Diagnosis and Pathology of Thoracic Disease,” (*Medical Gazette*, No. 2, July 11th, 1835,) relates a case of the intercurrent of an empyema on the right side, where the lung was bound down in every part by strong adhesions, the result of a former attack, and in which the parenchyma of the lung was found universally tuberculated. The left, the opposite lung, was much increased in volume, and had only a few isolated granulations. He asks, “To what are we to attribute the striking difference in the condition of the two lungs?” He adds, “We fully coincide with the interesting views of Dr. Carswell on this

important subject, and believe that it was principally owing to the difference in their physical condition; the one bound down and comparatively motionless; the other not only free from adhesions, but its natural movements and functional activity increased.”

Here then we have two opinions apparently diametrically opposed; the one, that the deposition of tubercles depends on increased respiratory action; the other, that it is prevented by an increase of functional activity.

It will be the attempt of the following observations to show that the cause is the same, in the one case and the other.

It will be necessary, however, in the first place, just to review the distinctions and differences, whether natural, or acquired, physical, or physiological, between the right and left sides of the chest: together with the comparative frequency of tubercular deposition in the right and left lung at the summit and the base.

It will be admitted, I take it for granted, that the left side of the chest is normally in a more active state than the right; that on the left side the respiratory murmur is louder, and that percussion is more sonorous; that on the right side percussion is duller, and respiration more feeble; the resonance of the voice greater, and the vocal fremitus exaggerated; that this difference obtains, in a state of health, and that it is a natural condition. This opinion is confidently advanced in the writings of Louis, Clark, Stokes and Gerhard.

On what this difference depends has not been satisfactorily investigated nor pronounced; whether positively on the lung, anatomically, or physiologically, or comparatively on the state of the parietes, as an extrinsic and acquired condition.

Most people are right-handed; and this circumstance, I believe, most materially modifies, not only the physical condition of the parietes, but also that of the contained organ, the lung itself.

From the researches of Woillez, it has been proved that the mean capacity of the right side of the chest is greater than that of the left. This receives a ready explanation from the relative anatomical disposition of the two sides. But he has also most curiously found that the mean capacity of the chest is lowest in persons following those trades which require frequent exercise of the upper extremities. This modification it may be supposed, may be effected in two ways—either by the muscular tension preventing the expansion of the chest, or by positively contracting its parietes.

It is to be inferred, therefore, that the tendency, operation and effect of the muscular exercise in the instances related by Woillez, borrowing an analogy from simple hypertrophy of the heart, were concentric.

In the discussion which followed, the inference

was disputed, as contrary to all physiology, and the legitimacy of the analogy denied.

A correlative confirmation of these views may be deduced from the fact, that emphysematous heteromorphisms are, in a great majority of cases, found on the left side.

It is evident that though this more common exercise of the right side of the body, under ordinary circumstances, will produce increased activity of respiration and circulation on that side, yet it is equally evident that under altered circumstances it will determine increased obstruction, by contracting the thoracic parietes, and thus interfering with the action of the lung in that situation where it least can afford it. The effect of course will most speedily be felt, where the greatest tension is exerted at the apex. Besides, the very fact of its being active, will, "mutatis mutandis," render it more susceptible of derangement. We shall see presently the more extended application of this principle.

Pneumonia.—The production of pneumonia appears to be opposed to that of phthisis. Pneumonia more frequently attacks the lower lobes. This may be influenced by the greater number of bronchial tubes in the lower lobes, and consequently the greater activity of the circulation; for we must remember, that the pulmonary circulation is entirely dependant on the aeration of the blood; that the blood from the pulmonary artery will not, cannot, pass into the pulmonary veins without its due aeration. From this circumstance the causes of inflammation will more speedily operate, and their operation be more quickly manifested in these situations.

The greater activity of the circulation in the lower lobes, from physical causes, may perhaps be in some degree compensated for anatomically by the larger size of the vessels going to the upper lobes.

Tubercles in the Right or Left Side.—Opinions differ as to the relative frequency of tubercles in the right and left sides. Some say the right; others assert with equal confidence the left; the preponderance of testimony is however for the right side. The opinion of Dr. Cowan is, and my own more limited experience fully corresponds, that the right is the rule, the left the exception. This, however, will depend on the causes in operation; in one class it may be the right, in another the left; but, as we have seen, the right from physical causes in almost universal operation, will be more liable; while, perhaps, apart from physical causes, from normal conformation, it may be more disposed to become affected.

At the Apex and Base.—Tubercles are deposited more frequently at the apex than the base of the lung. Why, Dr. Carswell has very ingeniously supposed to be owing to the difference in their physical condition, that the functional activity, the extent of mobility possessed by the inferior is much

greater than that of the upper lobe. The consequence is, that in the lower lobes there is a continual tendency towards the expulsion of tubercular matter; while in the upper there is the same tendency to its accumulation.

This explanation is quite in accordance with the foregoing observations, and I think its correctness receives a convincing confirmation from the fact that in those exposed to the continued inhalation of metallic or stony particles, as grinders, &c., accumulation takes place most in the apex of the lungs. The relative size of the vessels going to the apices must have also a material influence in the facility of tubercular separation.

Nature of Tubercles.—I now come to the important question:—Is the deposition of tubercles a local or a general disease? I think it will be unhesitatingly granted that it is a constitutional affection—a disease of the blood. Tubercle makes its appearance as a secretion on serous or mucous surfaces, or by separating from the blood when it has ceased to circulate. The seat of its election, however, is the free surface of mucous membranes.

Application.—Let us now apply these considerations to the cases with which we started, and from which we have so long wandered.

In Dr. Bird's cases tubercles were deposited in the opposite lung—none in the compressed. In Dr. Cowan's case they were deposited in the compressed—few in the opposite. One thinks they were dependant on increased, the other, on diminished, respiratory action. Now, if, as Dr. Cowan asks, phthisis is a constitutional disease, and not merely a local affection, to what are we to attribute the striking differences in the state of these lungs? Undoubtedly to their altered physical condition.

Let us just bear in mind what takes place when one lung is compressed, and thus spoiled in its office, by a large pleuritic effusion. The consequence must be that the sound lung has double duty to perform; and this it may be able to do under favourable circumstances. To a certain extent, but no farther, this increased activity will be inimical to, and a preventive of, the deposition of tubercles. A rather popular mode of treating phthisis is founded on this fact.

But place such a patient under unfavourable circumstances, where respiration is increased or hurried to the utmost, where there is a continual contest between respiration and circulation, a perpetual struggle for equalization, and then, notwithstanding its augmented activity—notwithstanding its compensatory hypertrophy, one lung must fail in effecting those vital changes which two were intended to accomplish. The blood will become imperfectly aerated, stagnation, or at any rate, detention, will occur; separation take place, morbid secretions form, and tubercles will be deposited.

Nor under such circumstances can we be surprised that deposition should first take place in the

apex of the lung,—that situation where its physical condition is such as to be least able to overcome the difficulties with which it is surrounded; we cannot wonder that disorder should first be evidenced in that situation where there is most *to do*, and the least *done*.

I am taking it for granted in this supposition that a *predisposition* to tubercles existed. For in some cases we find all the physical and physiological conditions apparently necessary for the production of tubercles, and yet none are deposited.

It is an interesting question but one on which I have not time to enter, for my object is to illustrate the deposition, not the formation of tubercles, what influence empyema may have in really forming, in generating, the tubercular disposition. I know none more likely; for it is generally acknowledged, that whatever tends to induce a state of general debility, produces a cachexia, all but universally tubercular.

The importance of the *early* removal of the fluid is immediately suggested by this consideration.

We shall now be able readily to comprehend why, in some cases, tubercles are found only or more numerous in a lung compressed, but not completely so, by a pleuritic effusion. In Dr. Cowan's case the lung was partially compressed by effusion; in the rest of its extent bound down by adhesions, and altogether in a physical and physiological condition, specially favourable to tubercular deposition. Had, however, the effusion been more extensive, and consequently the compression more complete, then tubercles would not have been found in it at all, but in much greater number on the opposite side. Dr. Graves says "Tubercles may supervene, even though the empyema is not absorbed. The opposite side is then the seat of disease." And again, "When absorption takes place, tubercles occur in the affected side;" and also "that rapid absorptions are more likely to be followed by a fatal development of tubercles than those more chronic."

Where the compression is complete, it is evident that the functions of the lung must be destroyed,—that it will only receive blood just sufficient for its bare vitality. For illustration's sake I may mention that the accidental occurrence of empyema and pneumothorax suspends, in a remarkable manner, the progress of tubercular destruction, and that a lung compressed has seldom been known to be attacked with inflammation. On these facts is founded the ingenious proposal to collapse the lung by the admission of air through an *external* opening, for the cure of phthisis.

Following out the same general principle, we find that tubercles are very readily deposited in new membranes, and in recent tissues, where the circulation is retarded, and its current imperfectly formed.

In conclusion, I may add, that whatever tends to derange the circulation in the lungs, that whatever tends to cramp or worst them in their peculiar functions, whether it be internal or external, physical, or physiological, will also tend to the deposition of tubercles in one predisposed.

Conclusion.—These illustrations might readily be multiplied, were I not too sensible that I have already drawn too largely on your patience and your time. I trust that my intention in the preceding observations has not been mistaken, misapplied, or misunderstood. My intention was not to offer a laboured dissertation on phthisis, its causes, its effects, or its mode of formation. My only object was to illustrate the mode of tubercular deposition from one cause, in one disease, that of empyema. The route adopted may have appeared to some foreign, devious, and circuitous, but I considered such a course necessary, in order to obtain and give a connected, satisfactory, and convincing view.

In its accomplishment, if it has been accomplished, I have not pretended to arrogate to myself the discovery of any thing new, but merely to have attempted the application, in some instances may be the extension of a general principle well known and universally acknowledged, and to have connected, harmonized, and simplified its operation.

For this purpose the opinions and writings of Laennec, Andral, Louis, Fournet, Woillez, Gerhard Graves, Stokes, Hudson, Clark, Forbes, Cowan, Carswell, Elliotson, Williams, Walshe, Holland, and Hodgkin, &c., have been consulted and freely laid under contribution.

I have been thus particular in attempting to elucidate the connexion between phthisis and empyema, from a conviction that the *causes* of phthisis have not been sufficiently attended to; from a conviction that not until we observe more strictly the causes, and then endeavour to analyze the operation of those causes, shall we ever be able to, for who will say we shall not, arrive at an accurate knowledge of its true and real nature.

By facts in this way rigidly induced, and slowly accumulated, will at length its state of being—alas! at present hidden—be gradually and insensibly unravelled; or perhaps more fortunately at no distant period, some master-spirit, some heaven-born genius, at one prehensive grasp, will seize the scattered remnants of a thousand minds, evolve its essence, suggest its remedy, and proclaim its cure; and so give by one triumphant effort a bidding arrest to that disease, which numbers in its victims the fairest in the creation, and cuts off in its fell career one fifth of the entire population. To hasten the consummation of such a victory, is the duty, and, demands the ever-riveted attention of the physician, the philosopher, and the man. The name of him shall be immortalized and live for ever, who first can cry "*Ευεμενα*."