of a glaucomatous patient, and are probably due to the same cause, reflected in the one case through the optic (ophthalmic ganglia), in the other the auditory (auricular ganglia) nerves; although Mr. Higgins (Guy's Hospital Reports, 1879) reverses the sequence, and states his opinion that the acute inflammatory attacks of glaucoma are due to the loaded state of the stomach, &c., of dyspeptic (and chronic glaucomatous) patients. Be this as it may, there seems an analogy between the two diseases which possibly may be more than apparent. The next symptoms were giddiness and a tendency to fall towards the worse or left side; this accords with Trousseau's views that "the impulsion is always towards the side of the lesion;" but, I think, little importance can be attached to that point in my case, as, although the left was the worse, both ears were very decidedly affected; and I remember hearing Professor Crum Brown explain why an opposite result should be expected by showing that the vertigo was purely sensational, and that the fall resulted from the violence of the muscular effort to save himself exerted by the patient, so throwing his body away from the side affected to the floor or wall, as the case might be. According to Dr. Ferrier, this giddiness depends on irritation in and about the labyrinth by the movements (impetus and inertia) of the endolymph against the ampullæ; and he also places the faculty of coördination and of equilibration in the semi-circular canals, where, according to Dr. Bristowe, inflammatory exudation is the only pathological lesion to be found post mortem. Now, since, according to Dr. Brailey, the tension of glaucoma is due to increased secretion and diminished absorption from (a morbidly damaged) iris, ciliary body, or choroid—in fact, to inflammatory changes of the accommodative or coördinating machinery of the eye,—I think a second analogy may be scored, especially if we compare also the constant halo of lights with occasional flashes, and the diminished field of vision of a glaucomatous eye with the hissings, varied by shriller whistles and screams, and the diminished range of hearing of a vertiginous patient.

To proceed to treatment. My idea of counter-irritation was original and was applied long before I knew that Charcot had used the actual cautery over the mastoids (although I may here parenthetically remark that his faith in quinine received no support from my patient, who became distinctly worse after its administration), still I must now acknowledge that counter-irritants had been used effectively before. The red iodide of mercury had not; but, being so valuable an external application, in many inflammations with effusion of serous cavities, I think its success in this case justifies the presumption of the existence of inflammatory exudation in or about the internal ear, leading to a state of chronic pressure in the cochlea and labyrinth, which may at any time suddenly become acute, after the well known habits of a glaucoma (and with equal rapidity and disaster to the special sense—for Ménière's vertigo is followed by deafness as surely as a neglected glaucoma by blindness); at the same time, if we allow that the treatment acted by absorption and consequent diminution of intra-cochlear tension, we are irresistibly struck with its analogy to the iridectomies, sclerotomies, ice applications, and other means employed for the relief of intra-ocular pressure.

NOTE ON CELLS CONTAINING RED BLOOD-CORPUSCLES.

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DR. RIESS has recently described¹ these elements as specially abundant in the bone marrow in pernicious anæmia. I have also noted their occurrence in the lymphoid marrow in this affection; in three cases very abundant, in two in moderate numbers. An examination of the marrow in over seventy-five persons of all ages and dead of various diseases has led me to conclude—1st, that cells containing red blood-corpuscles are normal elements in red marrow; and 2nd, that it is impossible to connect their presence with any particular disease. I have found them very numerous in cases

of phthisis (2), pneumonia (1), typhoid fever (2), ulcerative endocarditis (1). They were present in the marrow of a foetus at the sixth month, and in that of the sternum of an old man of seventy-six. I do not remember ever having any difficulty in demonstrating them to students in the ordinary red marrow of the rib. Litten and Orth² speak of these cells as occurring in a considerable proportion of the cases which they examined, and they also could not connect their occurrence with any special set of conditions. As in the spleen, they present remarkable variations in number, in some instances being scanty and difficult to find, in others so abundant that each field of the microscope contains several examples. On the structural peculiarities and development of these cells I will not here dwell further than to say that each one may contain from one to ten or twelve red corpuscles, which may have a perfectly natural appearance, or be in every stage of transformation into brown pigment grains. I have notes of the occurrence of these cells in the following localities:—

1. In the connective-tissue cells of the embryo and newborn animal. Here, in all probability, the red corpuscles are in process of development (Schäfer).

2. In red marrow, of which they form a normal constituent, but, like the myeloplques, occur in very variable numbers.

3. In the spleen pulp, normal element (Kölliker), they are particularly abundant when the organ is rich in pulp, as in the acute swelling of fever.

4. In lymphatic glands, when in a state of congestion and tumefaction; not a constant feature, but sometimes very numerous.

5. In brown induration of the lungs, part, at any rate, of the pigment in this condition results from the ingestion of red corpuscles (which leave the engorged vessels by diapedesis or extravasation) by the cells of the alveolar stroma, in which they gradually undergo transformation into brownish-red grains.

6. In the neighbourhood of extravasated blood the connective-tissue cells, fixed and amœboid, are often found to contain red blood-corpuscles, which can be traced in all stages of degeneration into pigment granules.

Artificially, I have seen these cells produced by feeding lively white blood-corpuscles of the newt or frog with human red blood-corpuscles; I have a sketch of a colourless blood-cell of the newt distended with four red corpuscles which it had eaten.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. THOMAS'S HOSPITAL.

CASES OF TUMOUR OF THE BREAST TREATED BY OPERATION.

(Under the care of Mr. SYDNEY JONES.)

THE following is a brief record of the breast tumours that have been removed during the past year at St. Thomas's Hospital by Mr. Sydney Jones. The notes of cases have been furnished by Mr. Battle, surgical registrar. All cases were operated on and treated antiseptically. Alternate silk and catgut sutures and drainage tubes were used.

CASE 1. *Scirrhus of breast*.—E. P.—, aged forty-three, single, admitted on Jan. 6th, 1881. Family history good. Catamenia ceased twelve months since. She received a blow on the breast three years ago. Much family trouble two years since. Eight months back she noticed a lump the size of the little finger in the right breast; this increased gradually, and for two months she has had shooting pains, increased by pressure or handling. Hard, somewhat rounded tumour in the upper part of the breast; outline below indistinct, but clearly defined above; surface rather irregular. Tumour movable, but pressing part of the mammary gland.

¹ Centralblatt f. d. Med. Wissenschaften, No. 48, 1881. THE LANCET, December 17th, 1881.

² Berliner Klin. Wochenschrift, 1877.

Skin normal, non-adherent. Nipple on each side flat. No retraction; no apparent enlargement of the gland in the axilla.—Jan. 8th: Amputation of breast was performed under ether, with antiseptic precautions.—14th: Wound dressed; almost healed. The patient left well on Feb. 2nd. Highest temperature 99.2°.

CASE 2. *Scirrhus of breast*.—E. G—, aged forty-nine, married, no children, charwoman, from Devizes, admitted on Jan. 3rd, 1881. Four months ago she noticed a hard lump the size of a walnut in the left breast near the nipple. For two months she had had shooting pains, which increased after handling. The left nipple was slightly retracted, the breast hard, but the skin nowhere adherent or discoloured. Mammary gland irregular on the surface, very hard, especially below the nipple, where, it was stated, the tumour had commenced. No tenderness. One enlarged and slightly tender gland in the axilla. No loss of flesh. Catamenia regular.—Jan. 8th: Removal of breast and gland by antiseptics, ether, scirrhus, cupping on section, with numerous globular epithelial masses easily shelling out on pressure. The temperature after operation never went beyond 99.4°. The patient left hospital on Feb. 1st, 1881.

CASE 3. *Scirrhus of left breast*.—M. D—, aged fifty-two, married, was admitted on February 16th, 1881. No family history of malignant disease. No previous history of disease or injury to breast. Eight or nine months ago a swelling about the size of a nut appeared in left mamma. Two months ago there were more rapid growth and more pain, which was usually in paroxysms, especially at night. Does not suffer in general health. The left breast has a tumour movable with gland tissue, and the size of a walnut. Growth hard, nodular, very tender. No affection of skin or of nipple; no discharge from nipple. Three slightly enlarged glands in axilla.—February 19th: Operation under antiseptics; ether; removal of breast and axillary glands. The patient went out well on March 19th.

CASE 4. *Cystic adenoma of breast*.—E. L—, aged thirty-five, married, from Sunbury, admitted March 29th, 1881. No history of malignant disease. Enlarged glands on both sides of neck, and scar of abscess opened thirty years ago. Swelling, size of a walnut, noticed on right mamma last summer, said to be hard and painless. In right mamma, at lower part, is a growth about the size of two walnuts, which seems separated by a slight interval. Growth appears attached to gland, and very movable. It is rather hard and nodular; no fluctuation detectable. Skin and nipple quite free; occasional yellowish discharge from nipple; had had this long before noticing growth. No affection of axillary or lower cervical glands. Patient has no children, and has had no miscarriages. Catamenia scanty for seven years.—April 23rd: Tumour operated upon antiseptically. Cyst opened and a tumour, the size of a walnut, of kind described as cystic adenoma, removed. Some of the cysts found to contain intra-cystic growths. Dressed on 26th. On May 7th the antiseptic dressings were left off. Discharged well on the 14th of May.

CASE 5. *Intra-cystic papilloma*.—M. C—, aged sixty-eight, a widow, from Holmwood, Dorking, admitted April 12th, 1881, with cancer of the breast. For twenty years has had yellowish discharge off and on from left nipple, continuing up to a year last Christmas, when a small swelling was first noticed in the breast, and the nipples became gradually flattened. Last summer she was struck by a calf's head in the breast; aching pains felt occasionally in the tumour shooting to the back; always tender on pressure; circumscribed tumour in left breast to left side of and beneath nipple; moves freely over subjacent tissues, and at centre is adherent to skin; fluctuation detected; nipple much retracted; glands in axilla not enlarged.—29th: Cyst tapped; tumour almost entirely disappeared; fluid straw-coloured, rather thick and viscid.—May 10th: Tumour smaller than on admission; fluctuation; recovered under antiseptic spray; chloroform; cyst rather larger than an average walnut; skin adherent to cyst wall; intra-cystic growth the size of a nut; cyst filled with bloody fluid; temperature never above 98.4° after operation. Went out well on May 25th. Mr. Anderson's report stated: Intra-cystic papilloma growing from a basis of fibrous and connective tissues, with glandular vestiges.

CASE 6. *Adenoma of breast*.—A. S—, single, aged forty-five, admitted on April 21st, 1881. Tumour of the left breast; lobulated; non-fluctuating; freely movable over subjacent tissues. The skin moves freely over it. There appears to be three hard masses, one below and to

the outer side, one on the outer side, and one above. No swelling of the lymphatics. Fourteen or fifteen years ago had a blow. Mother died of cancer.—April 30th: Mamma removed antiseptically by ether. The cysts varied in size from a pin's head to a walnut. Several scattered through the gland. The cysts contained some grumous fluid, fluid-like serum, and jelly-like fluid of dark colour, as well as some hard solid material. The highest temperature after the operation was 99.6°. On May 17th a swelling formed about one inch and a half above the line of incision. The abscess was opened. The patient left the hospital well on May 28th, 1881. Mr. Anderson's report stated: The firm portions of the growth are purely glandular; the rest a loose connective tissue of very delicate structure. There is no trace of sarcomatous element.

CASE 7. *Carcinoma of left mamma*.—E. D—, aged forty, admitted May 27th, 1881. Swelling in left breast, very hard; feeling like scirrhus nodule. Skin non-adherent, painful; but more pain down the left arm; one gland in axilla. Right breast removed by Mr. Sydney Jones in November last. Cicatrix of right breast looks well.—May 28th: Operation under antiseptics and ether. Small tumour removed by oval incision; but as it presented characters of carcinoma, whole breast was removed. Drainage; silk and catgut sutures. Patient left the hospital on June 15th, 1881.

CASE 8. *Scirrhus of left breast*.—Mary M—, aged fifty-six, cook, admitted May 31st, 1881. Father and mother dead; one sister dead, two living; one healthy, the other suffers from fits. Eighteen months since she noticed a small lump in her left breast above the nipple—at first the size of a pea, but it has gradually increased. She has had no pain. Small ovoid tumour in upper part of the left mamma, irregular, hard, indistinctly margined above and on sides continuous with gland tissue. Skin over it puckered; and slight enlargement of gland in axilla, attached to skin over it, and not freely movable over subjacent tissues. Breast and gland removed, under ether and antiseptics; drainage. Patient left hospital, well, on the 22nd of June, 1881.

CASE 9. *Adenoma of breast*.—M. H—, aged twenty-two, admitted May 27th, 1881. Swelling for three months in the right breast. No knowledge of injury. Pain for twelve months previous to swelling. Catamenia every fourteen days. On the upper and inner side of the right breast there was a small lump of the size of a filbert, hard, and freely movable. Skin not adherent; no axillary glands.—May 28th: Tumour removed under antiseptic spray, ether, drainage-tube, silk, and catgut sutures alternately. First dressed on the 21st, on account of some pain. On June 14th the patient left the hospital well.

WANDSWORTH AND CLAPHAM INFIRMARY.

TRAUMATIC RUPTURE OF ANTERIOR WALLS OF RECTUM;
HERNIA OF INTESTINE; PERITONITIS; SEPTICÆMIA;
DEATH; NECROPSY.

(Under the care of Dr. J. B. NEAL.)

FOR the following notes we are indebted to Mr. James Allan, late assistant medical officer.

Agnes J—, aged twenty-nine, was admitted at 3.30 A.M. on August 7th, 1881. She was under the influence of drink, excited, and apparently in great distress, and stated that soon after midnight she had been outraged by three men, who held her face downwards. She was scantily clad and her underclothing was blood-stained. There were recent bruises and scratches on her body, lower limbs, left arm and face. From the anus there protruded a loop of intestine, over a foot in length, distended with flatus, though otherwise empty; not strangulated, and showing appendices epiploicæ. There was no mark of injury about the genitals. The gut, having been smeared with carbolic oil, was returned without difficulty by manipulation. The rectum was very patent, and had in its anterior wall a solution of continuity of considerable size, within easy reach of the examining finger. Pain was complained of, and referred to the lower part of the abdomen. Immediate microscopical examination of the rectal and vaginal mucus for spermatozoa gave a negative result. The pain was relieved by subcutaneous injections of a grain and a half of morphia. Small doses of tincture of veratrum viride were given every four hours,