constitutional idiosyncrasy capable of developing the one or the other. Inquiring into the family history of the patient, I could not hear of any member who had suffered from cancer in any form, but there had been gout, an attack of which manifested itself during the progress of this case.

Since reading Mr. Hutchinson's admirable Bowman Lectures, in which he traces a very intimate connexion between gout and various diseased conditions of the eyes, I have been impressed with the thought whether a similar relation may not be found to exist between that disease and other maladies, such as the one in point and others of a more malignant character. Additional force has been lent to the thought by the following circumstance. A family with a long history of gout has in the last two generations suffered but little inconvenience from it. The grandfather of the present generation was the last who experienced any violent attack. He was a "martyr to it," and crippled by it. He had four children, two sons and two daughters. Of these one of the sons only had two sharp attacks in middle life, remaining free up to the time of his death, which occurred at the age of seventy from cancer of the pylorus. Not one of his six children had any positive attack of this complaint (gout), although two of the sons had enlargement of the great toe-joint, but one daughter died of cancer of the breast, two sons of cancer of the bowels, and one son of cancerous ulceration of the leg. Cancer was unknown in this family when gout was in the ascendant. I can relate another case of a lady having gouty ancestry who became the subject of scrofulous ulceration of the glands of the neck. Some time after these healed a fibrous tumour formed in the uterus attaining a large size, unattended with pain or hæmorrhage, the health remaining unaffected. Sir James Paget also in his Bradshawe Lecture, "On Some Rare and New Diseases," like Mr. Hutchinson, tracking certain of them, more perhaps by history than pathology, discovers gout to be the source whence they spring, suggesting that as the typical form becomes less common, others hitherto unknown, or but little recognised, assume a prominence and attract attention by their increasing number, and though presenting at the first glance scarcely any feature by which their relationship would be suspected, yet, as he observes, "types vary in diseases as in species," and "the certainty and probable extent of this variation must seem the greater if we consider the mingling of diathesis in transmission from and through both parents." Thus he says, "In phlebitis we very often trace a variation from the customary type or standard of the very old and heritable disease—gout; in short, all the evidence of being one of the many forms of what is called incomplete gout." Osteitis deformans, rickets, and mollities ossium appear to have some relation to gout, "for some of the cases have known inheritance of gout," and are sometimes seen in "typically gouty persons."

It must be allowed that in searching after an "unknown quantity" a certain amount of guessing is permissible, and I think, with Sir J. Paget, "that it is a legitimate use of the imagination which may happily discern a way towards the truth." Hence, when we find fibroids and cancer associated or separated, yet blastemal formations developed in individuals of a typically gouty descent, it can scarcely be called "using the imagination to the furthest bounds of propriety" to suggest that they both owe their existence to the same dyscrasia. As one swallow does not make a summer, so deductions made from one or two cases may perhaps be regarded as only hypothetical, yet they may serve as a basis on which co-operation may establish a substantial structure of facts confirmatory of the view here suggested.

St. Mark's-square, West Hackney, E.

THE BRITISH OPHTHALMIC HOSPITAL, JERUSALEM.—On the 27th ult. a meeting in furtherance of the interests of this hospital was held in the Jerusalem Chamber, Westminster. The chair was taken by Sir A. H. Layard, and amongst those present were Sir Edmund Lechmere, Bart., M.P., Hobart Pasha, Sir Richard Temple, and Mr. Mocatta. The hospital was founded in 1882 by the English branch of the Order of St. John, and is chiefly intended to provide proper treatment for the peculiar diseases of the eye prevalent amongst the population. At present the hospital contains only four beds, and is maintained at an annual cost of £300, but double the amount is needed to carry on the work effectually.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

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

CHARING-CROSS HOSPITAL.

CASE OF LATE CONGENITAL SYPHILIS OF THE THROAT;
TREATMENT WITH MERCURY AND RECTAL ALIMENTA-
TION; CURE; REMARKS.

(Under the care of Dr. BRUCE.)

THE diagnosis of the later manifestations of congenital syphilis is sometimes extremely difficult, especially when, as in the case which we publish, there are few, if any, signs in the patient himself of previous disease. In the absence of personal and family history in such cases it is sometimes necessary to wait until the effect of treatment has been tried. Although congenital syphilis at the age of this patient is not often fatal, still from the situation of the local lesion it may become so, and the treatment by nutritive enemata which Dr. Bruce adopted had without doubt very great influence in producing the cure of the case.

W. D—, aged thirteen, from Kent, was admitted into Charing-cross Hospital on Sept. 2nd, 1884, suffering from severe ulceration of the throat.

History.—He stated that his illness commenced about a month ago with inflammation of the lungs, followed within a week by the sore-throat, which has persisted ever since. From the first there was pain on swallowing and discharge from the mouth, and he immediately began to lose flesh. Previous to this illness the boy had been fairly healthy, but not robust. It was ascertained that as a baby (? aged two years) he suffered from rash and snuffles, and was treated at King's College Hospital. He has recently been living in an isolated house, in a healthy district, and the drains have been in good condition. He is the second of nine children; the eldest is alive and well, but all the others snuffled as babies, and several are dead. His father is alive and well. His mother miscarried five times.

Condition on admission.—The patient is a wasted, fair-complexioned boy, confined to bed. He lies with the mouth open, in obvious distress in the throat, and speaks with a very indistinct nasal voice. The skin is of an earthy tint and very dry, without rash or oedema. The uvula and posterior border of the soft palate have entirely disappeared, leaving an ulcerated margin; anterior to this the palate is red and shiny. The posterior wall of the pharynx is entirely occupied by a foul greyish-yellow slough, which extends upwards and downwards as far as the eye can reach. There is no swelling of the glands of the neck. The patient takes food indifferently, owing to dysphagia; part returns through the nose, and part is rejected by vomiting. The liver and spleen are not enlarged; bowels confined. A hacking cough ends in expectoration of mucus and sloughs detached from the pharynx, which contain no tubercle bacilli. The physical signs connected with the lungs, heart, and abdomen are normal. Pulse 74, regular, weak; urine scanty, sp. gr. 1033, without sugar or albumen. Sleep good.

Diagnosis.—Syphilitic ulceration of the throat, congenital.

Treatment.—Mercurial ointment (half strength), a portion as large as a hazel nut to be rubbed into the adductor region of the thigh daily. Pharynx to be rubbed with solution of nitrate of silver, twenty grains to the ounce. To be fed by nutrient enemata of beef-tea, yolk of egg, and brandy, four times a day, whilst allowed to take what food he cares to attempt by the mouth.

Progress of the case.—Sept. 12th: Very little but still decided improvement; rectum becoming irritable. Two minims of tincture of opium added to each enema. Little change in throat. Strength of silver solution increased to forty grains to the ounce. A little brandy taken by the mouth.

16th.—Marked improvement; the patient looks more lively and the throat is less foul, the soft palate looking more healthy, its posterior margin more raw, and the pharynx less thickly covered with sloughs. The enemata are better

retained; a little food, both solid and fluid, taken by the mouth. Urine very scanty and high-coloured.

19th.—Strength increases; but little change in throat since the 16th. Most of the enemata retained; very little food can be swallowed. Spirits improving; voice still thick and nasal. Throat to be swabbed out twice a day with silver solution, sixty grains to the ounce.

24th.—Marked improvement. He sits up for an hour, and is more active and cheerful. No dysphagia; no regurgitation of food; enemata all retained. Back of pharynx presents only a thin slough; posterior part of soft palate merely reddened.

26th.—Moves about the ward. Throat greatly improved, the red base being seen through the grey surface of the pharynx, and the edge of the soft palate looking healthy. Can take most of his food by the mouth, but has still four nutrient enemata daily. Strength of silver solution reduced. Gargle of chlorate of potash ordered. Urine more abundant.

30th.—The slough has entirely disappeared from the pharynx. Strength increased, but three pounds weight said to have been lost within three days.

Oct. 3rd.—Throat now clear. Further loss of two pounds, but strength increased. Slight salivation. Mercurial reduced to one half.

7th.—Weight has increased two pounds. Salivation continued. Mercurial inunction stopped.

10th.—Nutrient enemata stopped. Meat diet by the mouth.

14th.—Steady increase in body weight. Still salivation.

17th.—To take syrup of iodide of iron.

21st.—Has gained two pounds weight in three days. Great improvement in general appearance. Adhesions forming in pharynx, with small points of ulceration.

Nov. 19th.—Discharged cured.

Clinical remarks by Dr. BRUCE.—This case was of considerable interest from its nature, and from a certain degree of difficulty attending its diagnosis; chiefly, however, in connexion with the details of treatment. Active congenital syphilis at the age of thirteen is not so common but that it deserves record, and its diagnosis as a matter of fact may be very far from easy at first. In the present instance the previous personal history and the family history of infantile snuffles were not obtained for several days after admission, and during this time the true nature of the illness was the subject of some discussion. The question of tubercular ulceration was raised, but the absence of swelling of the neck alone went far to dispose of the suggestion. The best immediate evidence of the correctness of the diagnosis of late congenital syphilis was the result of the severe treatment to which the patient was subjected. He was at once put upon mercury. But here a great difficulty arose; the patient could not swallow. Dr. Bruce urged upon the students the absolute necessity of ensuring an abundant supply of nourishment to the tissues whilst a powerful alterative like mercury is being allowed to act upon them. It was contrary to all sound clinical rules to administer mercury to a starving child, and a patient unable to swallow was virtually starving; but just as certainly the patient would shortly die of syphilis. Feeding *per oram* was therefore given up definitely, and regular nutrient enemata ordered instead, whilst the patient was permitted to attempt to eat occasionally small portions of nutritious food. The method proved successful. A stronger solution of nitrate of silver might have been used from the first for swabbing out the throat, but the shock attending free cauterisation of the whole pharynx might have been too great in the prostrate condition of the patient. As occasionally happens, the rectum, which was irritable at first, came to retain the nutrient enemata very well. There was free salivation for a time, although the mercury was reduced, and soon omitted when the mouth became tender. Another curious fact was that the boy continued to lose weight, whilst his general appearance and strength and the local disease were all steadily improving.

DUNDEE ROYAL INFIRMARY.

ABDOMINAL SANGUINEOUS CYST; ASPIRATION; RECOVERY;
REMARKS.

(Under the care of Dr. SINCLAIR.)

J. G —, aged fifty-one, flaxdresser, was admitted on May 14th, 1883, with the following history. About two months previously he observed a smooth round swelling just below the umbilicus, which rapidly increased in size; it caused no discomfort except that arising from its rapidly increasing bulk.

On admission, a rounded swelling, quite smooth to the touch, could be made out in the umbilical region of the abdomen, but extending slightly into the other regions. It was of firm consistence, and appeared to be adherent to the anterior wall of the abdomen (the umbilicus not being movable over it). No fluctuation or impulse could be elicited. There was no bruit on auscultation. The tumour occupied the umbilical part of the epigastric, hypochondriac, and right lumbar regions, and a very small portion of the hypogastric region. It was clearly separable from the hepatic dulness by a narrow resonant line, and it did not move with respiration. The hepatic and splenic dulness were of normal extent; no abnormal signs were discovered in the lungs; the cardiac dulness was normal, but the sounds were weak; tongue slightly furred but moist; appetite good; bowels constipated; temperature 99°; pulse 70, weak; respiration 28; urine pale, slightly acid, sp. gr. 1018, no albumen.

17th.—Hypodermic needle was inserted into tumour, and a syringeful of dark sherry-coloured fluid was readily withdrawn. The fluid contained nearly 50 per cent. of albumen, abundant red blood-corpuscles, and some amorphous masses. No echinococci or hooklets. Sp. gr. 1020.

21st.—The tumour was aspirated in its centre, and sixty ounces of fluid were withdrawn, of the same character as that removed by the hypodermic syringe.

22nd.—The patient complained of sickness yesterday after the operation. No trace of tumour.

June 2nd.—Patient got up.

6th.—He was dismissed in good general health, the tumour having entirely disappeared.

Remarks by Dr. SINCLAIR.—I can find no description of a similar cyst in Bright's classical memoirs. One, in some respects similar, is described by Bauer in Ziemssen's Cyclopædia.¹ It terminated fatally after two tapplings. In THE LANCET of May 5th, 1883, Dr. Bristowe described two cases of abdominal cysts which resembled the one just described in the rapidity of growth and sanguineous contents. The first he concluded to be probably either a simple cyst of the spleen or a distended kidney, more probably the latter. The second had a much larger history, and was found on post-mortem examination to have been a sanguineous cyst resulting from a round-celled sarcoma. Dr. Clifford Allbutt has described a case² presenting some points of resemblance to mine as regards its contents; but it had a rather higher situation, required three aspirations, re-formed subsequently, and then disappeared after an attack of diarrhoea and colic. Dr. Oliver's case,³ which occurred in a female, yielded 148 ounces of blood-red fluid on the first, and 84 ounces of similar fluid on the second, tapping, made a much slower recovery than mine, and was considered by him to be probably a hæmatocele of ovarian origin. The case described by my friend, Dr. Reid, and which was watched with great interest by us all, was clearly, I think, unconnected with any of the solid viscera of the abdomen. That it was not hydatid was evidenced by the absence of hooklets on careful microscopic examination. I can see no ground for considering its origin malignant. The impression is that it was a cyst of peritoneal origin, possibly owing to a traumatic cause, as the patient is a man of intemperate habits. I saw the man some time ago, a year after dismissal, and found him in good health, and quite capable of performing his usual work; but I thought I discovered some traces of reaccumulation. As cases of this kind are of great interest and rarity, I shall keep a watch on the patient, and report his further history should the disease return.

DOUBLE THORACIC ANEURYSM; DEATH; AUTOPSY.

(Under the care of Dr. SINCLAIR.)

For the following notes we are indebted to Mr. J. Mackie Whyte, M.A., M.B., house-surgeon.

J. W —, aged forty-nine, a tall well-built man, employed as a labourer in a jute works, was admitted on Feb. 14th, 1884, as an urgent case. His history was that he had been subject to pain in the chest since the middle of December, 1883, when he fell downstairs while drunk, and received a scalp wound, but no other external injury. The wound healed, but the pain in the chest became worse, catching his breath. For the past fortnight his voice had been hoarse, and he had had a troublesome cough, with inability to expectorate the mucus, which caused a disagreeable rattling noise. Had been in the army; while there he had acquired syphilis; otherwise previous health had been good.

¹ Vol. viii., pp. 338-39.

² THE LANCET, July 7th, 1883.

³ Ibid., Oct. 11th, 1884.