earlier stages, when alone it could conceivably be extirpated.¹⁵ It must, however, be stated that in two cases of phthisis parts of the lung have been actually removed by Ruggi, one of the patients dying in a few hours, and the other on the ninth day. And not only so, but tumours of the lung also have been removed, though it must be owned that the experience of the surgeons who undertook the operation is not very encouraging. Weinleicher, in 1882, removed a round tumour as large as a man's head from the thoracic wall of a man aged thirty-seven, leaving a huge gaping opening into the chest and taking away a part of the lung to which it was adherent; the patient died twenty-four hours afterwards. And Kroenlein also removed a recurrent sarcoma in the same situation from a girl, aged eighteen, taking away part of the sixth rib and some adherent lung. The end of this case is not reported in the interesting article of Albert's from which I take the reference.¹⁶

Lastly, to complete this branch of the subject, must be mentioned a method of treating tubular lung, whether containing cavities or not, introduced by Guérin in 1830, and more recently modified and extensively practised by Vidal—viz., the puncture by means of the actual cautery. Vidal reports forty-four cases, thirty-seven of whom improved under treatment; and I believe that this method has also been employed in Australia.

Gangrenous cavities.—It must be remembered that gangrene of the lung may follow wounds of the chest, and in the old days of duelling empyemata and pulmonary abscesses from such a cause seem to have been common. Now, however, this is not the case in civil practice. Gangrene of the lung is said also to be caused by the presence of a foreign body in the air passages; but as from the present point of view the dilatation of the bronchi, which I believe invariably follows, is the more important lesion, I shall discuss this question under the head of Bronchiectasis; and will pass on to gangrenous cavities resulting from some form of pneumonia. These cavities are perhaps the most promising with which the surgeon is called upon to deal, especially if operation be not too long delayed. In the course of time, if the patient survive, the surrounding lung becomes condensed and inelastic; but in the earlier stages of the disease it retains more or less its normal characters, and the walls of the cavity are able to fall together like those of an abscess in the soft parts elsewhere. But delay is often almost unavoidable on account of the great difficulty of localising the position of the cavity with precision, and the still greater difficulty of ascertaining the absence or the presence of adhesions. I do not think that the second point should be allowed to influence the surgeon in the direction of delay, and certainly should not interfere with an exploratory puncture, because, in the first place, experience shows that even adhesions which have been accurately diagnosed by the most competent observers may, after all, be found to have no existence, and, in the second place, it seems clear that exploration with an aspirator needle may be safely made through a patent pleura, even if the instrument pass into a collection of putrid pus. I do not say that mischief will never follow this procedure, and I am sure that it is wise to ascertain for certain the condition of the pleura before making a free incision into a lung containing septic pus, for if the non-adherent pleura be opened, and through it a drainage-tube be passed into a putrid cavity, very serious symptoms may result. This was well illustrated in a case of bronchiectasis (which will be referred to again), where we had ascertained a week or two previously that there was some clear fluid in what was thought to be merely a remnant of the pleural cavity. On cutting through the intercostal space, it was found that the two layers of the pleura had become adherent since the preliminary puncture, but only by very weak adhesions, which easily broke down under the pressure of the finger and the expiratory efforts of the patient whilst the opening was being made into the bronchiectatic cavity. This led to the opening up of a large remnant of the pleural sac, the walls of which were non-adherent, and the consequence was that the pus from the bronchiectasis escaping into the pleura set up a septic pleurisy, from which the patient nearly died.

It will be well, therefore, to consider at the outset what should be done when these adhesions, so commonly but yet not invariably found, are wanting. One plan would be that mentioned above as recommended by De Cérenville as a precautionary measure—namely, to pass needles armed with silk through the pleura into the lung; but as in almost all cases the lung is solidified, and will therefore not fall away to any extent from the thoracic wall, even if no adhesions at all be present, I do not think that this, though quite unobjectionable, can be considered to be a necessary precaution. The right method of procedure, though I confess it is not a very easy one, is carefully to stitch the lung up to the opening which has been made in the chest walls. It is a difficult proceeding, because the parts are in a constant state of movement from the act of respiration, and because the lung itself is but ill suited to retain the stitches that are placed in it, and also because the hole in which the manœuvres have to be carried on is a rather deep one, and mostly obscured by the presence of blood. I have only once had to put this plan into practice, and though here it was only partially successful, it was sufficiently so to show that, with a little more care, the closure of the pleura might have been effected. We found, in this case, at the end of a few days, that a part of the stitching had given way, but as no cavity was reached, no evil consequences as regards the pleura resulted, the wound remaining aseptic. Of course, after the stitches have been placed, the attempt to open the cavity must be postponed for at least a week, and at the end of that time the instruments used must be sharp, and their employment gentle, lest the accident which it is intended to avoid may, after all, happen.

(To be concluded).

An Address

DELIVERED AT THE

OBSTETRICAL SOCIETY OF LONDON,

On February 2nd, 1887,

By J. B. POTTER, M.D., F.R.C.P.,

PRESIDENT OF THE SOCIETY.

GENTLEMEN,—I have again to congratulate the Society on its prosperous and healthy condition. Our numbers at the close of the year were 736. We have lost by death, resignation, and erasure 40 Fellows, but during the year we elected the large number of 72. Including the 25 new members that have been already elected this year, the Society at the present time stands with a total of 761, the highest number that has been reached since its foundation. Our financial position is good. As you have heard from the report of our excellent treasurer, another £100 has been added to our invested funds, making the amount of our capital £1500, and we commence the year with a good balance at our bankers. Our library has been increased by the addition of 156 volumes, bringing up the total to 3690. These are all proofs of our popularity and prosperity; but the success of the Society depends more upon the work done, and we can show continued good results in this. Our midwifery board reports good and still increasing work. The number of women examined reached the large number of 102, of whom 80 were found qualified to receive the Society's diploma; 395 women are now on our register. This gratuitous and honourable work, as was stated last year, causes considerable strain on the Society and its unpaid examiners, and, as the numbers are continually increasing, some scheme will have to be devised to meet the difficulty. It is curious to notice how the value of the Society's diploma has increased when we observe that, whereas in the first eight years only 47 names appear, during last year 102 women presented themselves for examination. The unsettled state of politics still prevents this burning question from coming to the front, as sooner or later it must do; but the Society, if it had no other work to show, may well be proud of having taken in hand this duty, so long neglected by the State. The attendance at our meetings has been good, and the work of the session well

¹⁵ These experiments have also been carried out in Germany, by Th. Gluck, in 1881 (twenty cases, some successful removals of the entire lung), Dr. Hans Schmidt (three out of eight survived), and Dr. Block, in 1882 (fifty to sixty cases done without removal of rib).

¹⁶ Ueber Lungen Chirurgie. Wien. Med. Presse, 1884, p. 887.

maintained. The publication of the Transactions in portions has been undertaken for the first time, and, although the circulation has not been large, it has been a boon to those who have availed themselves of it, and an advantage to the Society in bringing its work more rapidly before the notice of the profession.

[Dr. Potter then entered into an enumeration of the more remarkable of the specimens shown and of the chief papers read at the meetings of the Society during the past session.]

I have attempted no more than a slight summary of the work of the Society during the year, and the quality of the papers is an evidence that its scientific standard has been well maintained, and that it has fulfilled its function as established for the promotion of knowledge in all that relates to obstetrics and the diseases of women and children. It may be contended by some that we have not the records to show of great improvements in the practice of our art during the past year—no striking novelties in treatment; but it is the function of the Society to maintain a judicial attitude, and, while assisting progress when the progress is real, to check or arrest this when it tends to danger. In other words, it welcomes improvement, but avoids destruction. One of the highest points that we should aim at is the prevention of disease, and this, though well worked out in the practice of obstetrics, has not received the same attention in the diseases of women. Much has been done at different times to solve the important question, Should any death occur in or after natural labour? And the answer to this question has been each year more favourable, as evidenced by the improved record of our lying-in hospitals. Even in difficult labour mortality has been much reduced, and though the wish expressed by Dr. Tyler Smith in his paper in the first volume of our Transactions for the abolition of craniotomy from obstetric practice in all cases where the foetus is living and viable has not yet been fully realised, the more frequent induction of premature labour and more timely use of the forceps have conducted much in this direction. In our present state of knowledge we are not yet prepared to accept abdominal section as its alternative in all cases, still holding to the English axiom—the safety of the mother before that of the child. Again, by the use of chloroform and the more frequent application of the forceps we have means of preventing laceration and sloughing of the soft parts, thus rendering far less common the miserable after-effects of a lingering labour. But the prevention of diseases of women has not received the same attention: the effects of cold, damp, climate, occupation, imprudence and want of care at the menstrual periods, the effect of excessive child-bearing, abortions, the prevention of impregnation, and many other causes of disease, deserve and require our careful consideration; and he who can prevent the occurrence of the diseases of women will be a greater benefactor to his race than the operator, however skilful he may be, who treats them.

The whole question of uterine pathology is far too large a one to enter into here, even had we the requisite time at our disposal. To attempt to enter into the various theories that have from time to time given rise to different modes of treatment would be a perplexing and unprofitable task; each seems to reign for a short time only to be cast aside and replaced by some other, and now the tendency seems to grow more and more surgical, until at last to some minds abdominal section and the removal of internal organs seem the panacea for all the evils that woman is heir to. To the indiscriminate use of these procedures we cannot give our adhesion, and especially do we object to the heroic surgical treatment of hysteria—that chameleon disease which still claims so much sympathy and treatment at our hands. Even statistics on these matters, however carefully tabulated, have to be received with caution; the distinction between cases that have recovered or become well and those that can be truly said to have only just escaped death or have lived too frequently with their suffering unrelieved has not always been clearly shown. In estimating these matters much must depend on character. A reputation for truth and logical precision is of more permanent value here than the statement of brilliant results that will not bear the test of investigation. If I have spoken strongly on this matter, it is owing to the fear that some may be apt to forget the sacredness of human life in their zeal for operating, and this must be my excuse.

One task yet remains to me, and that a sad one. We have always to deplore the loss of some of our members by death. This year fortunately the number has not been so great as

on many occasions. Eight have passed away: two of our honorary Fellows—viz., Dr. Simon Thomas of Leyden, and Dr. Courty of Montpellier; and six of our ordinary Fellows. Of the former, Dr. A. E. Simon Thomas of Leyden, whose death was announced so recently as December last, we have not yet been able to find any obituary notice. He was elected an honorary Fellow of the Society in 1866. Many of his works are in our library, one of the most important being his great work on the Oblique Pelvis. For the following notice of M. Courty I am indebted to the memoir published in the *Annales de Gynécologie*, of which journal he was one of the original founders:—

Professor Amédée Courty was born at Montpellier on Nov. 2nd, 1819, his father and grandfather having also followed the profession of medicine. After receiving the usual classical education he threw himself with zeal into the study of medicine, and at the same time devoted himself to the pursuit of science. After taking a licence in Science he became Doctor of Medicine in 1845, the subject of his graduation thesis being “*Sur le Développement de l’Œuf dans l’Espèce Humaine*.” He now gave himself up to the study of physiology, and published several memoirs on this subject, also teaching the subjects of anatomy and surgery until his appointment as a professor in the Faculty of Medicine in Montpellier in 1849, when he wrote a thesis on the use of Anæsthetics in Surgery. In 1854 he wrote a memoir on Cauterisation of the Cervix Uteri with the Actual Cautey during pregnancy. From this time he devoted himself to the special study of the diseases of the genital apparatus in women, and, dissatisfied with the knowledge that he found in the text-books of his time, began to collect materials for the great work on which rests his title to fame, named “*Traité Pratique des Maladies de l’Utérus et de ses Annexes*,” the first edition appearing in 1866, followed by a second and third in 1873 and 1879. This work was translated into English in 1882, with a preface by Dr. Matthews Duncan. Though no doubt largely indebted to the works of German and English authors, still throughout we find the impress of his own mind and the result of his long and patient researches. The great secret of Courty’s success in his department of practice was that he became a specialist only after long study and a familiarity with medical and surgical work of many years. On this foundation he grafted his special studies, this being the way in which he understood the term specialty, not following, as is too often the case in the present day, the plan of calling himself a specialist and therefore considering himself one—such a specialist as might be defined as one knowing a very little of one subject and nothing at all of the science and art of medicine. He obtained a large practice in Montpellier, and was largely consulted throughout the south of France. His professional duties obliged him during his later years to pay frequent visits to Paris, and advantage was taken of his presence by many to avail themselves of his matured knowledge and skill. He took great interest in the French Association for the Advancement of Science, and also in the International Medical Congress. He was a regular attendant and frequent speaker at these meetings. He died on March 2nd at Montpellier. His loss is felt by all the medical world, and especially that part of it devoted to the study of the diseases of women. He was elected an honorary Fellow of this Society in 1875.

Of our ordinary Fellows, John Archer, F.R.C.S., practised in Birmingham, his native town, upwards of fifty years, and was one of the early Fellows of this Society, having been elected in 1859. He was senior surgeon to the Lying-in Hospital, and was an able obstetrician. He was a good type of the general practitioner—honourable, hard-working, and successful. A past president of the Birmingham Medical Institution, he held a most respected professional position in the town. He died on March 8th, at the age of seventy-seven, of angina pectoris.

In speaking of the lamented death of Dr. Alfred Wiltshire, which occurred on the 4th of December, at a comparatively early age, I refer to a loss which is specially felt in our Society; a regular attendant at our meetings, and one who had taken an important part in its management.

[Dr. Potter gave a sketch of the career of the deceased physician, particulars of which were published in our issue of Jan. 1st of the present year.]

Dr. J. Macgrigor Croft, of Abbey-road, practised for many years in St. John’s Wood, and died on Jan. 1st. He was elected a Fellow of the Society in 1859.

John M. Burton, F.R.C.S., of Lee, died on Feb. 10th. He

was a well-known and respected practitioner in that neighbourhood, where he had passed the whole of his long and industrious life. He became a Fellow of the Society in 1862.

Henry Albert Lovett, M.R.C.S., of Tasmania, died in July, 1885, but his death was only reported to us in 1886. He entered the Society in 1876.

John Gittins, L.R.C.P., of Horselydown, was elected in 1867, and died on July 27th, aged forty-five.

Whilst closing these brief and imperfect records of our departed friends, I cannot but feel how often it has been scanty and insufficient, but this has been due, not to a want of respect and appreciation on our part, but to the absence of knowledge and details at our disposal. It may perhaps be said of them as of many other silent workers—

"The noblest service comes from nameless hands,
And the best servant does his work unseen."

It remains to me before leaving this chair, to which I was elected by your kindness two years ago, while apologising to you for my many shortcomings, to thank you for your patient consideration and courtesy to me on all occasions; and especially must I thank our secretaries for the help and assistance they have accorded to me at all times. The work of our secretaries, often laborious and self-denying, is known to few; and I can only say that, as long as the Society is served by such officers as Drs. Herman and Champneys, we need have no fear either for its future prosperity or the promotion of obstetric science. Of my successor whom you have elected unanimously to-night, Dr. John Williams, I need say but little; his name is a household word in the Society. Beyond his other and many qualifications, I know of no one who has its interests more thoroughly at heart, and I can only congratulate the Society on the wisdom of its choice.

CASES OF PERITONITIS.

By JAMES F. GOODHART, M.D., F.R.C.P.,

PHYSICIAN TO GUY'S HOSPITAL AND THE EVELINA HOSPITAL FOR CHILDREN.

(Concluded from page 410.)

Now another point. In some cases suppurative peritonitis is marked by all the severity of symptoms found in acute plastic peritonitis, and in such there will necessarily be the small, thready, wiry pulse, the collapse, and the depressed temperature seen in the more rapid form of the disease. But I am now concerned with the cases of more insidious onset, and in these another negative symptom, in addition to the absence of fever, is quite likely to deceive—viz., the absence or comparative absence of pain. Many years ago I remember examining a man, the other details of whose malady have now escaped me, but as regards whom this has remained firmly fixed in my memory, that he allowed the freest possible manipulation of his abdomen without evincing any pain, and yet within a few hours he was dead, and I found the peritoneum to be full of pus. That was an extreme case, but many times since then I have seen this: that the abdomen has been soft, not markedly distended, and the tenderness, although not absent, has been of the slightest; conditions, in fact, which would of themselves seem to negative rather than to suggest the existence of peritonitis.

Next, a word as regards diarrhoea. Constipation is the symptom of peritonitis, not diarrhoea. So constantly is this the case that, as I have just said, one of the great difficulties of practice is to say whether we are dealing with mechanical obstruction or the obstruction wrought by paralysed peristalsis. I am sure it is quite impossible in some instances to be certain of the nature of the case without having surgically a finger in the pie. Peritonitis is far the more common. But what about diarrhoea? That may well seem to negative peritonitis. It by no means negatives *suppurative* peritonitis. But more than this, I wish to insist that when it exists with any symptoms of peritonitis it is, in my experience, an omen of the gravest, I would almost say fatal, import.

Some have laid stress upon the position of the pain in peritonitis associated with caecal inflammation. Some have said that it is very liable to be referred to the

left groin, others to the umbilicus; I would venture to assert, on the other hand, that the peritoneum is very treacherous in this indication. I remember some years ago making a post-mortem for Sir William Gull and Mr. Bryant upon a lady who had died with an illness of much obscurity; and Sir William Gull said to me before commencing: "I want the liver examined very carefully. I am sure there is some disease in that neighbourhood; there was always so much pain in the right shoulder." This opinion was so far correct that there was a considerable collection of pus between the liver and the diaphragm; but the real disease, of which I believe there had not been a suspicion, was a sloughing caecal appendix and suppurative peritonitis.

This case leads me to remark upon the very insidious nature of some of these cases. In the two cases I first narrated there were pains in the abdomen, which, had they been more carefully attended to, might possibly have enabled one to avert the disastrous result. But I remember two other cases, which occurred to me some time ago, which well illustrate this point. I was asked by Mr. Alexander to see a policeman, not far from the hospital, because he was having nearly daily repeated rigors of severity associated with a temperature of 103°, and during the attacks his condition seemed to be a very alarming one. He had had a severe attack of epigastric pain and jaundice five months before, but had been well in the meantime. When I saw him he was apparently pretty well, his temperature normal, and all that I could detect was a little tenderness of the abdomen near the gall-bladder. He remained thus without any severe symptoms till the Monday, when he was suddenly seized with intense epigastric pain, collapse, and feeling of impending death, and he died within two and a half hours of his attack. We made a post-mortem examination the next day, and found the caecal appendix twisted and adherent to the caecum, dilated into a sac of considerable size near its termination, with smooth abscess-like walls, an ulcer into the peritoneal cavity, and a small concretion escaping. There were extensive adhesions between the liver and the diaphragm, and a large abscess between them and in the right lobe of the liver. Another very similar case, I believe, for there was no post-mortem, I saw with Dr. Boothroyd of New Cross, only a month or two ago, in the person of a healthy-looking man, aged twenty-five. He had had a severe attack of abdominal pain and frequent vomiting four months before, had been very ill at the time, but got quite well. He had been ill nine days when I saw him with remittent attacks of fever, sweating, and rigors. He had a normal temperature, was sweating profusely, his tongue a beefy red, and a rather full abdomen, but nothing capable of localisation. Remembering my former experiences, I could not but fear that there was some deep-seated supuration about the mid-rib, but in the absence of any indication of its exact seat, and having a dislike to bootless prodding, we decided to wait for further knowledge. I did not see the case again, but Dr. Boothroyd told me that the temperature continued to rise almost daily; the sweating continued, a little more fulness appeared in the epigastrium, and the lower lobe of the left lung became consolidated. Dr. Boothroyd still felt sure that there was an abscess high up in the abdomen between the liver and diaphragm, or in the liver itself, and I have not yet recovered from my disgust at the stupidity of the poor man's friends in refusing any further aid, and in subsequently refusing to let us make an inspection of the body.

One other word about these cases, which always seems to me worth while to insist upon—viz., the frequency with which pleurisy spreads from peritonitis, and peritonitis from pleurisy. I was once in frequent attendance upon a case of empyema with another medical man. It was in an only boy, and anything the matter with him, or rather, in his then condition, any variations in his progress, were the causes of repeated panics. I had left the house one morning, the child doing perfectly well, for the rest of the day, and returning at night found the whole place in a turmoil—another doctor called down from London, whispers of some serious fresh complications, and so on. The child had suddenly been seized with fresh pain in the upper part of the abdomen, and was consequently in great distress for the time; but I believe it was nothing more than the extension of inflammation through the diaphragm, calling for the exhibition of opium. At all events, that treatment was adopted; all the pain subsided, and no further evil happened.

I do not think the freedom of communication between the serous sacs of peritoneum and pleura is sufficiently well reco-