symptoms present, which leave no doubt in my mind of the existence of this evil; but the difficulty which invariably presents itself in arriving at the truth, proves oftentimes a serious obstacle to our progress in forming a correct diagnosis. In her statement to me, she positively denies having had at any time a venereal sore, or anything approaching to it, but admits the irregular habits of her husband; and, further, that after a former confinement, an eruption, evidently rupia, appeared over the surface of her body, followed by a scaly eruption on the child, with ulcers and fissures at the anus. We must, therefore, form our opinions and definite conclusions from circumstantial evidence; at the same time cautiously watching the result of our treatment. In the case now related my opinion justified the remedies adopted, as was proved in the final result; but the question arises, as regards the foetus in utero, what was the cause of the death of the child? She had no mercury administered internally, and the iodide of potash, from which agent I have seen very powerful effects proceed, was omitted two months previous to the uterus expelling its contents. Could it have been from the nightly administration of morphine to procure sleep, and ease from pain? I think not; but I am disposed to agree with the patient herself, that the excessive pain she endured, and her anxiety and depression of spirits, were the immediate cause of her misfortune.

Woburn-place, Russell-square, April, 1854.

A Mirror OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

Nulla est alia pro certo noscendi via, nisi quam plurimas et morborum et dissectionum historias, tam aliorum proprias, collectas habere et inter se comparare.—MORGAGNI. *De Sed. et Caus. Morb.* lib. 14. Proœmium.

GUY'S HOSPITAL.

*Large Ovarian Tumour; Tapping with imperfect results;
Death; Autopsy.*

(Under the care of Dr. OWEN REES.)

THE general public have but a very slight conception of the amount of responsibility and unavoidable anxiety connected with our profession; nor do medical men receive half the credit they deserve for the devotion and solicitude with which they rack their brain, in order to find alleviation to human suffering. It is especially with such diseases as ovarian dropsy and tumours that the surgeon is severely tried; for whatever course he takes he seldom succeeds in escaping blame. If constitutional remedies fail, and the patient dies, he is reproached with not having operated; if he has recourse to the knife, and the result be unfavourable, both the public and his professional brethren find fault with him. In this dilemma he consults the statistics of the operation: these he studies with care; but the more he becomes acquainted with the facts bearing upon this fearful disease, the more embarrassed he feels. Some operations he finds have been crowned with success; but the patients have been so lost sight of, that no certainty exists as to the ultimate results. In some cases the abdomen has been laid open, and such firm adhesions found that no removal of the tumour could be attempted; but no clue is given as to the means of ascertaining the existence of these adhesions before any operative measures are attempted. As to milder means, no authentic and satisfactory records meet his eye respecting the effects of pressure or tapping.

And yet it is very melancholy to say to a patient seeking relief from ovarian disease: I dare not act with decision, because I am beset on all sides with doubts and misgivings. There is, however, one point which is not very difficult to clear up, and the elucidation of which should engage the attention of medical men—viz., the diagnostic signs which will aid us in making a distinction between a semi-solid tumour, a congeries of cysts filled with gelatinous fluid, and a *bond fide* membranous bag filled with serous fluid.

We have now on several occasions seen the trocar plunged to dense tissue, or a thick gelatinous fluid, to the surprise of

the operator, and we are inclined to think that the collection of a set of symptoms indicative of this state of things would be of some value; for in such cases interference with the knife would either be set aside or the complete excision of the mass considered.

As to the latter operation, it will be conceded that the main point is the distinction between the subjects who are likely to be benefited by it, and those whose fate may be hurried by the use of the knife; and here is the rock upon which split those surgeons who are most expert at performing the operation; because we seem in some degree to acquire a liking for certain operative procedures which we have the consciousness of having as it were, at our fingers' ends. Thus it would appear, in this instance, (and it is perhaps so in a few others,) that the very man who operates the most skilfully is not always the best judge of the more or less advisability of the operative interference. We are, however, free to confess that a few successful operations may very easily bias the mind of a surgeon, and we must say that we bear a lively recollection of those cases where we saw excision performed, and followed by the most favourable results.

The cardinal point of the question seems to be the *diagnosis*; but we do not possess sufficient data to diagnose properly; the unsuccessful operations seldom see the light, and the history of all the cases published is not given with sufficient minuteness. We would not be understood, however, to set a light value on the tables given by Dr. Lee and others; nor on the straightforward accounts such as those given in this journal by Dr. Tanner; nor on the cases brought forward with such candour by Mr. Childs, at a late meeting of the Medical Society of London, (*THE LANCET*, vol. i. 1854, p. 420;) but we would merely express a wish that some surgeon, well acquainted with the subject, would take the trouble of handling the question in as complete a manner as our records will allow; and that after the publication of a comprehensive work on Ovarian Tumours, practitioners through the length and breadth of the land might be induced to acquaint their professional brethren, through the press, with the results, whatever they be, of their practice respecting this disease.

Perhaps we might suggest that the tapping of ovarian cysts through the walls of the vagina has not been tried to a sufficient extent. We are acquainted with one case, in which Dr. West, at St. Bartholomew's Hospital, succeeded in establishing a permanent discharge through the vaginal canal, and the disease has for several years been kept in abeyance. What more common than discharges from the vagina? If it could then be proved in practice that the abnormal activity of one ovary can be so guided as to spare the patient the misery of accumulation, without impairing her health or endangering life, a great step would be made in the therapeutical part of the question. We shall soon have to revert to this subject, and desire, on the present occasion, to confine our attention to those cases in which the secretion of the cysts is of a highly fibrinous kind—in which, in fact, the irregular generative efforts of the ovaries are of a vigorous kind, and followed by the pouring out of thick, gelatinous fluids. Here we must not think of tapping, and if we cannot conscientiously excise, we should be content with palliative measures. No doubt, as has been very properly said by Mr. Childs, at the meeting referred to above, that there is great advantage in adopting a decisive course *sufficiently early*; but there are few surgeons who feel inclined to advise an operation when there is still a chance of controlling the disease by pressure, constitutional treatment, or tapping; or whilst there remains a hope of a spontaneous cure, examples of which have been recorded; and yet it stands to reason that operations are performed at great disadvantage when all the above means have been tried in vain through a series of years, and the patient's health has been brought to the lowest standard.

We now beg to offer a few details of the case lately treated at this hospital, as obtained from the notes of Mr. Cheek, one of the clinical clerks:—

Ann R—, aged fifty-four years, a laundress, who has been a widow for eighteen years, and is the mother of three children, was admitted Jan. 18th, 1854, under the care of Dr. Owen Rees.

The patient states that she enjoyed good health till within two years prior to her admission, though she always worked very hard, without, however, being in want of any of the necessaries of life. At the period just mentioned the catamenia ceased, and thereupon one of her legs swelled considerably; inflammation and circumscribed ulceration took place, and when the healing process commenced, the abdomen began to swell, in consequence, as she thinks, of a severe cold. A tumour first appeared in the right iliac region, and gradually

involved the whole abdomen. The swelling then remained stationary for a little while, and increased very rapidly a short time before admission. The patient has repeatedly sought professional advice, but counter-irritation and various medicines did not procure any relief. The poor woman now began to experience much inconvenience from the bulk of the tumour, and was therefore tapped three days before applying here. From some cause or other, no fluid but a little pus was evacuated.

State on admission.—The patient has now much difficulty of breathing; she cannot lie down, and gets no rest at night. The abdomen presents an enormous size; the protruding mass is very hard, and does not distinctly yield the sensation of effused fluid.

Mr. Stocker, the resident medical officer, ordered half a grain of elaterium, to be repeated if necessary.

On the third day after admission, the patient was tapped by Mr. Hilton, but the withdrawal of the trocar was not followed by the escape of fluid. The symptoms for the next two days became extremely distressing, when, on the second morning after the first operation, paracentesis abdominis was again performed, Mr. Callaway being the operator. The instrument was introduced just above the umbilicus, about six inches higher than the spot where Mr. Hilton had perforated the abdomen. Nearly a bucketful of fluid was evacuated with great relief to the patient, but directly afterwards she fell into a very low state, the pulse was hardly to be felt for a long time, and she complained of being very cold. Large quantities of wine and brandy were administered, warm water was applied to her feet, and blankets placed over them; these measures soon restored her, and the flannel roller was put on.

In the evening the patient complained of the tightness of the roller, which was accordingly slackened. Bowels opened twice on the day of the tapping.

Jan. 23rd, the day after the second operation.—The patient has had a bad night; she was repeatedly sick, and brought up everything she swallowed; she has severe pain in her legs, great difficulty of breathing, and has passed but very little urine; tongue furred and dry; pulse weak. She has been taking beef-tea through the night.

The poor woman died the next day at four o'clock, and had not passed urine for the last twelve hours.

Post-mortem examination, twenty-two hours after death.—Legs dropsical; the abdomen contained a large quantity of ascitic fluid, in which were shreds of lymph, the result of recent peritonitis. Extending upwards, above the umbilicus, was a large tumour, quite detached, and springing from a peduncle by the side of the uterus, being, in fact, the left ovary enormously enlarged. The tumour was made up of cysts, the upper one having been tapped before death; its cavity was now filled by a quantity of coagulated blood, which had poured out after the operation. The other cysts contained the peculiar gelatinous fluid generally found in cystiform disease of the ovary, and their walls consisted of hard tissue, which was thought to be malignant, but that point was not satisfactorily determined. The left kidney was distended by a white fibrous mass, the right was quite healthy, and the other organs were in a normal condition.

ST. GEORGE'S HOSPITAL.

Empyema; Thoracentesis repeated several times; Partial Recovery; Spontaneous Discharge of Pus through the Parietes of the Chest.

(Under the care of Dr. BENGE JONES.)

THE subject of the present case is now in the hospital, and affords a most striking example of the very severe thoracic derangement and pleuritic effusion from which a patient may recover. It is principally in cases like this that the advantages of decisive measures are clearly seen, and it then becomes strikingly apparent how beneficial an operation is tapping of the chest. It must be confessed, however, that the cases which are likely to embarrass the physician are not those in which impending suffocation points distinctly to the necessity of the operation, but rather those in which the disease has become chronic, where the symptoms are not clearly defined, and there is no impending danger. We have seen several of this latter kind of cases within the last twelvemonth, and could not help noticing that thoracentesis is now a more common operation than it was in former times. And it may well be looked upon with less dread at the present period, as the manner of performing it has been so improved as to expose the patient to very little danger as regards the operation itself. We now no longer make a large gaping opening

to be subsequently distended with tents and pledgets; but the wound is small, and every precaution is taken to prevent the access of air and the renewed inflammation of the pleura.

Very valuable hints have been given as to this operation by M. Trousseau, up to a recent period physician to the Children's Hospital in Paris; and it is not a little strange to English practitioners to hear of an hospital physician not only practising thoracentesis, but also giving rules respecting it, and recording numerous cases wherein he had met with considerable success by following them. We find that M. Trousseau combined in his operation the steps advised by Récamier, and modified pretty recently by Reybard. M. Trousseau, who has performed upon a great many children, not only thoracentesis, but also tracheotomy, divides his operation into two parts. The first consists in making in the skin an opening with a lancet, just large enough to allow of the passage of the trocar, the incision to be in the eighth intercostal space, and in a line parallel with the rib. Before introducing the trocar, an assistant should cause the skin to glide upwards on the ribs, so that the aperture made with the lancet may correspond with the seventh instead of the eighth intercostal space. The trocar should then be thrust in, and made to run close to the upper border of the lower rib. The instrument must be very sharp, and pushed in with a certain amount of force, until the resistance is overcome. As soon as it is removed, the liquid flows out, and the valve begins to act. This valve should be composed of some membrane which may be easily driven by the pressure of the atmosphere upon the external opening of the canula. The valve, which may consist of several layers of the membrane, is to be fastened around the head of the canula in the form of a tube, reaching a good distance further than the handle of the trocar. Thus, when the latter is drawn out, the valve is seen at each act of inspiration to become tightly pressed by the atmosphere against the external opening of the canula. The use of this valve entirely precludes the necessity of placing the tube, or a bag attached to it, under water.

As to the circumstances in which the operation is advisable, and likely to be useful, it is generally admitted that two great divisions should be made—viz., cases in which the patient is being suffocated by excessive effusion of liquid (serous or purulent) into the pleura, and cases where there is no immediate danger, though the quantity of fluid effused is considerable.

In the first division the operation is almost always called for, except there be, as remarked by M. Trousseau, some organic lesion which is likely in a short time to destroy the patient. In the second division may be noted acute hydrothorax; here the operation should not be delayed, as patients have been known to die in a few days by the rapid increase of the fluid, and the complete abeyance of the function of absorption. In these cases the dulness reached to above the clavicle; the whole side of the chest was raised; the intercostal spaces bulged out, and the thoracic organs, especially the heart, were displaced. There are, however, chronic effusions which do not evince a tendency to sudden and dangerous increase; but here the compression of the lung against the spinal column should be taken into consideration, and the organ not be allowed to become glued and permanently confined by fibrinous layers. In two of the cases of M. Trousseau the effusion had existed two months, but the fluid was found quite clear, and the lung expanded again upon the evacuation of the serum. This was also the case with a patient of Dr. Risdon Bennett at St. Thomas's Hospital, whose chest we saw tapped by Mr. Simon. And it is very probable that such is also the state of things in a patient of Dr. Wilson, at this hospital, who has now been tapped five or six times, and is able, between the operations, to engage in very toilsome labour. This man was discharged from the army when still very young, for chronic effusion in the chest. In fact, we well remember hearing Dr. Wilson mention that he has resorted pretty largely to thoracentesis in these later times, and generally with favourable results.

As to empyema, it is not an easy matter to say, in a given case, whether the effused fluid is still serous, or whether the purulent transformation has taken place. No doubt that pus frequently forms after the accession of air when the operation of tapping the chest has been performed; but it is not quite certain, so far as we have seen, whether pus may be primarily secreted by the pleura. There is another serous cavity, if we mistake not, which never secretes pus—viz., the tunica vaginalis testis.

It is in the meanwhile interesting to notice what a large proportion of recoveries take place after tapping for empyema. Dr. Thomas Davies, quoted by Dr. Watson, gives a table, from which it appears that out of 16 cases of empyema in which thoracentesis was performed, there were 12 recoveries.