3rd.—Passed a good night; no pain nor tenderness; felt hungry; took some fish. Bandage and dressings removed; wound looked healthy, with a slight discharge from the lower end of it; bread poultices applied. Towards evening she had pain and spasm at the chest, which were relieved by ether and ammonia.

4th.—Slept well, and expressed herself as very much better; very little pain; wound looking well, and discharge increasing.

5th.—Had less pain; pulse 120; tongue furred; wound healthy, and discharges freely a grumous-looking matter (which Mr. Adams believes to be broken-up placenta), the cord having come away in the poultices. Took six ounces of sherry wine, beef-tea, and fish; often feels very hungry.

6th.—Passed a good night as usual; tongue rather dry. The bowels not having been relieved since the operation, Mr. Adams ordered two drachms of castor oil, which operated very freely.

7th.—Took some jelly, and a chop; wine increased to eight ounces, none of the ligatures having come away. The whole length of the wound had now healed by the first intention, with the exception of the lower end, where there is a sinus, of the size of a threepenny-piece, out of which the ligatures hang, and the discharge freely escapes.

8th.—The sutures were now beginning to irritate the bond of union. Mr. Payne removed them. Her pulse sank to 100.

10th.—Continues to improve.

12th.—Mr. Adams removed some of the ligatures, when the discharge of about half an ounce of offensive grumous fluid followed.

17th.—Continues to improve in every respect.

19th.—Mr. Adams removed the remainder of the ligatures, and there again ensued the same offensive discharge. He has ordered her to sit up for a few hours daily.

It is now the twentieth day since the operation. She takes four ounces of wine, and a pint of porter, with a chop, daily, and has not the slightest feeling of uneasiness, except from the annoyance of the discharge, which is, however, slowly decreasing.

July 11th.—She is still going on well, gets up, and walks about the ward daily; but there are no signs of a placenta or membrane coming away, although the offensive discharge continues.

KING'S COLLEGE HOSPITAL.

ANEURISM OF THE ABDOMINAL AORTA, PRODUCING EROSION OF THE VERTEBRÆ; FATAL RESULT SLOWLY INDUCED BY GRADUAL HÆMORRHAGE BEHIND THE PERITONEUM.

(Under the care of Dr. JOHNSON.)

OF the various kinds of tumours which arise in the abdomen, perhaps there are none of more serious import than aneurisms, whether springing direct from the aorta or from some one of its numerous branches. If the sac should burst into the peritoneal cavity, death very quickly ensues. On the other hand, should the aneurism open into the cellular tissue without or externally to the peritoneum, the extravasation of blood goes on slowly, and a fatal result will gradually take place. This form of extra-peritoneal hæmorrhage has been known to give rise to pulsating tumours in the iliac, hypochondriac, and lumbar regions.

The slowness of death in the following case is clearly accounted for by the gradual hæmorrhage which occurred between the peritoneal layers of the transverse and ascending meso-colon, and which was found to extend to the cellular tissue of the pelvis. The situation of the tumour was below the origin of the superior mesenteric artery, where it had already produced erosion of the bodies of the contiguous vertebræ. As might be expected, its pressure on the vena cava caused the prominence of the abdominal and the varicosity of the superficial crural veins; whilst the albuminuria was wholly attributable to the obstruction of the left renal vein from the same cause. It is extremely probable that the paroxysmal pain denoted a rupture of the aneurismal coats; but from the circumstance of the blood escaping between the layers of the meso-colon, it quickly coagulated, and impeded further flow.

For the notes of the following case we are indebted to Dr. A. Ernest Sansom, house-physician to the hospital:—

Henry P—, a carpenter, aged thirty-eight, was admitted May 18th, 1860. He has had to lift heavy weights constantly; had no serious illness till three months before admission, when a sudden and severe pain occurred one morning as he was going to his work, and caused him to return home. The pain was between the hypochondria; it passed off, but recurred at in-

tervals. He suffered besides from pain in the back. Some time afterwards he felt a throbbing at the pit of the stomach, which he thought to be palpitation of the heart. Coincident with these symptoms were general malaise, sickness after meals, and considerable loss of flesh. Latterly he passed but small quantities of urine, and the pain in the back was increased by micturition.

On admission, he complained of pain in the back, varying in severity, causing him frequently to change his position, but not increased by pressure. He presented the appearance of a strong, healthy man, who had been debilitated by disease. The superficial veins of both legs were seen to be varicose, and those of the abdomen were tortuous and enlarged, especially on the right side. From the ensiform cartilage to within an inch of the umbilicus was felt a distinctly pulsating tumour, which communicated a thrill to the fingers and a rasping bruit to the ear, synchronous with the pulse at the wrist. A small, movable swelling was felt in front of the tumour. The bruit was heard, though somewhat faintly, behind on either side of the spine, chiefly on a level with the ninth dorsal vertebra. There was an exaggerated curve in the lumbar region, and the ribs bulged very much. Breathing pure; heart sounds natural; bruit not heard above the diaphragm; pulse 62. The urine was albuminous; specific gravity 1018, of a rather deep sherry colour, containing some small waxy casts. Ordered a compound soap pill and compound magnesia mixture twice a day; soap plaster to the back.

The pains were relieved, and he continued better until the 24th, when, about six P.M., immediately after he had had an evacuation, he had an epileptic fit. After emerging from this, he fell into paroxysms, to all appearance, of violent pain, to such extent that it required three men to hold him. An enema of warm water was first administered, and then, soon after the commencement of the muscular contortions, Dr. Sansom administered chloroform. Just previously, the pulsation of the tumour was found to be diminished, and pressure over its situation seemed to cause pain. Chloroform soon brought about a perfect calm, which continued for half an hour, when it was re-administered; and so, at intervals, throughout the night. At half-past six the following morning the patient was sensibly calmer. At ten A.M. forty minims of solution of acetate of morphia were given by the mouth, which failed, however, to produce the desired effect, so chloroform was continued, but at longer intervals. At two P.M. twenty minims of solution of acetate of morphia were injected beneath the skin of the right upper arm, which soon produced a manifest and continued quieting effect. Soon the paroxysms ceased. On the 26th he had a threatening of their return; but morphia was administered, and he became quiet. The tumour was now felt to pulsate over a wider area. The bowels were relieved by an enema.

On the 31st the patient died. No change was noticed till two hours before death, when the face became pale and gradually completely blanched; the heart's beats were very feebly felt, and after a short time were imperceptible. Occasionally, however, after all pulsation had ceased, a sigh was heaved.

At the post-mortem examination, an aneurismal tumour, of about the size of two fists, was seen to involve the abdominal aorta below the origin of the superior mesenteric artery. The aneurism had burst between the layers of the peritoneum in the transverse and ascending meso-colon, the blood being traced downwards to the cellular tissue of the pelvis. The bodies of the last dorsal and first two lumbar vertebræ had been much eroded, the intervertebral substances standing out nearly a quarter of an inch from the corresponding vertebræ. The small swelling felt in front of the tumour was found to be the pylorus. The aneurism had stretched the vena cava on its surface, and the left renal vein was flattened by it to a riband-like band. The kidneys, especially the left, were enlarged and congested.

UNIVERSITY COLLEGE HOSPITAL.

SEQUEL TO A CASE OF EMBOLON IN THE CEREBRAL ARTERIES, WHICH HAD PRODUCED HEMIPLEGIA, THE RESULT OF RHEUMATIC ENDOCARDITIS.

(Under the care of Dr. JENNER.)

MANY physicians are sceptical as to the possibility of diagnosing the existence of embolon during life, and it therefore becomes a matter of importance to give the sequel to any case that we have thought of sufficient interest to record in our "Mirror." Of three instances which appeared in the first volume of this journal for the present year (pp. 466-7), the

second was discharged relieved from University College Hospital. The patient (Charles S—) had been under the care of Dr. Jenner, and not of Dr. Parkes, as was stated, and was readmitted a month after his discharge, under the former gentleman, and he died from uræmic poisoning.

In the notes of the examination made after death (kindly furnished by Mr. Philipson, of Caius College, Cambridge), it will be perceived that the absence of a clot, or of softening, or of any amount of disease in the arteries near the brain, tends very much to exclude the general causes of the symptoms shown by him during the first attack. On the other hand, the condition of the mitral and aortic valves confirms the diagnosis of embolon very strongly, because sufficient time had elapsed before death to allow the detached piece of fibrine to become completely absorbed. The minute vegetations on the borders of these valves were so slightly adherent, that they could be scraped away with but little force. We stated in our former remarks, that although the symptoms were not very clear, yet, on analysis, they pointed to embolon, and we think the sequel proves such to have been the case, for there is nothing else to account for the varying paralysis.

Post-mortem examination.—The arachnoid was slightly thickened, and in places opaque. The brain, on section, was less studded than natural with red points; there was no softening of any part of its substance, nor was there any appearance found of altered or recent clot. The arteries at the base were in some places atheromatous, but this alteration had not at any place undergone ossific transformation. No clot was found in any vessel. The pericardium was not adherent. Heart much enlarged, and the wall of left ventricle much thickened. The mitral orifice admitted with difficulty the tips of two fingers; the valve was much thickened, but not ossific. The aortic orifice admitted only the tip of one finger; the edges of the valves were fringed with minute vegetations, some of which were with ease scraped away. Each segment of the valve was attached by its border to its neighbour, thus, as it were, forming a single valve; this valve was throughout thickened and rigid. The valves on the right side were healthy. The muscular structure was not undergoing fatty degeneration. The coronary arteries were slightly atheromatous. The aorta, in its whole extent, was in a state of atheromatous degeneration; in the abdominal portion, the patches had become ossific, and at one or two places bony spiculæ projected into the interior of the vessel. In the external iliacs the same condition was present, as also, to a small extent, in the radials. The kidneys were much enlarged, congested, and granular, easily giving way under pressure.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

TUESDAY, JUNE 26TH, 1860.

MR. F. C. SKEY, F.R.S., PRESIDENT.

ON CONGESTION OF THE HEART AND ITS LOCAL CONSEQUENCES.

BY WILLIAM JENNER, M.D.,
PHYSICIAN TO UNIVERSITY COLLEGE HOSPITAL, ETC.

THE author stated that the objects of this paper were to call attention to the occurrence of congestion of the muscular tissue of the heart, to the most common and direct consequences of that congestion—viz., induration and toughening of the walls of the heart,—and to the influence which those changes of texture exercise on the development of dilatation of that organ, by rendering permanent every increase in capacity from over-distension, which would be temporary in a heart whose walls were normal. Impediment to the passage of the blood, Dr. Jenner said, through the right side of the heart, whatever its cause, must be attended by over-distension of the veins of the heart; and as very gradually developed, long-continued, intermittent congestion of any organ, the functions of which are over-actively performed, notwithstanding its congestion, is followed by induration, toughening, and hypertrophy, so the walls of the heart will, under the conditions specified, become harder, tougher, and thicker than natural; and as these changes in the texture of the walls of any hollow viscus are the conditions which determine the occurrence of *permanent* dilatation of that viscus, when pressure on the inner surface of its walls is sufficient to over-distend them, so when these changes affect the walls of the heart, and there is great impediment of the escape of blood from its cavities, they lead to

its permanent dilatation. After describing the general and microscopical characters of hearts, the walls of which are indurated, toughened, and thickened from long-continued congestion, the author detailed several cases, for the purpose of illustrating the general positions maintained in the paper.

Dr. C. J. B. WILLIAMS, while admitting the value of the paper, observed that the doctrines contained in it were those he had been in the habit of teaching in his lectures, and expressed surprise that the author of the paper had not spoken of the modifications in the effect of congestion which result from the different states of the blood that exist in special conditions—for example, in cyanosis.

Dr. JENNER had consulted the literature on the subject of his paper, and had failed to discover that his views had hitherto been adopted by the profession.

A CASE OF ACUTE CARIES OF THE WALLS OF THE TYMPANIC CAVITY, PRODUCING ULCERATION OF THE INTERNAL CAROTID ARTERY.

BY JOSEPH TOYNBEE, F.R.S., F.R.C.S. ENG.,
AURAL SURGEON TO ST. MARY'S HOSPITAL, AND LECTURER ON AURAL SURGERY AT ST. MARY'S HOSPITAL MEDICAL SCHOOL.

Cases of ulceration of the internal carotid artery, arising from caries of the walls of the tympanum, being so extremely rare that the author had found but one on record, he had been induced to lay the following case before the Royal Medical and Chirurgical Society:—

W. C—, aged forty-six, a jobbing builder, was admitted, under Mr. Toynbee's care, at St. Mary's Hospital as an out-patient on the 18th of August, 1859. He was sallow and thin, and evidently out of health. Two years previously he had received a violent blow on the head above the left ear. Three months before his admission at the hospital, during a violent fit of coughing, he was seized with intense pain in the left ear, which became constant; this pain was followed by discharge, which was also constant. In spite of all treatment, the pain and discharge continued, and on the 16th of January blood of a bright-red colour came from the ear, and continued to do so at intervals until the 27th of January, when the patient died.

Upon a post-mortem inspection, the upper and anterior osseous walls of the tympanum were found to be carious, and there was a large aperture communicating with the cavity of the canalis caroticus. A small ulcerated opening was found in the internal carotid artery, through which the hæmorrhage had taken place.

ON BRIGHT'S DISEASE, CONSIDERED IN RELATION TO ITS ORIGIN IN THE TUBES THEMSELVES, OR IN THE INTERTUBULAR STRUCTURES.

BY W. H. DICKINSON, M.B. CANTAB.,
MEDICAL REGISTRAR AND DEMONSTRATOR OF ANATOMY AT ST. GEORGE'S HOSPITAL.

The object of this paper was to show that all the forms of diseased kidney, large and small, rough and smooth, were capable of arrangement into two great classes; that in one there was disease proper to the secreting surface of the tubes, while in the other there was disease essentially of the structures between them; and that the great characteristic difference between these two conditions was the presence or absence of superficial granulation.

The author first sketched the pathology of tubular disease, which gave rise to the large smooth kidney, regarding as unimportant those distinctions which depended on the nature of the material which filled the tubes. He commenced by explaining the method made use of in the investigation. Portions of the gland were boiled in water slightly acidulated with acetic acid, and then dried until hard enough to allow sections to be cut from them. These, moistened with water, and magnified 80 or 100 diameters, showed the structure of the kidney in a very beautiful manner, and had the advantage of exhibiting the various elements of the gland in their natural relation to each other, which cannot be satisfactorily attained by any other method.

The various successive changes which produced the large, smooth kidney were adverted to: the increase of size; the anæmia, more in appearance than reality; the smooth surface, and loose capsule. It was then maintained that the essence of the disease was merely excessive secretion, as the only portions of the gland affected were the tubes. A drawing was exhibited showing that the gland was perfect in all its parts, and the tubes in contact with each other. The accumulation within the ducts of their own secretion was shown to be the sole cause of the enlargement of the organ, and the microscopic characters of this epithelial product were examined at some length. The frequent development of oil in the cells was regarded as the consequence of the disease, not as the cause; and the occa-