the idea that an abscess had burst and its contents been discharged into the bronchi. For some days after this she appeared to lie at the point of death. She rallied under the use of stimulants in four days, and went on living a wretched life of pain, with restlessness, cough, and spitting, until the 18th of August, when at night she appeared to be dying from suffocation; but she again rallied, and, beyond getting weaker, appeared for some time much as before. On Aug. 30th vomiting after food ensued, and lasted for some days. On Sept. 8th the mouth and tongue were quite raw, and she had great difficulty in swallowing solids; vomiting also frequently occurred. She became weaker and weaker, and died on Sept. 29th.

Autopsy, twenty-six hours after death.—The body extremely emaciated. The right pleural cavity was full of pus; both lungs were bound down to the spine by firm adhesions. The whole of the right lung was riddled with tubercle and small vomicae about the size of acorns; the left lung also contained a considerable quantity of crude tubercle, some of which was in a state of suppuration. There were firm adhesions between the liver and diaphragm; the liver and spleen were healthy; the left kidney was pale and anæmic. The right kidney was converted into a bag of pus; the whole of its secreting structure being entirely destroyed. The supra-renal glands were healthy.

WEST LONDON HOSPITAL.

BRONCHOCELE BULGING THE TRACHEA INWARDS, NEAR THE BIFURCATION, AS SEEN WITH THE LARYNGOSCOPE; NEURALGIC PAINS OF THE NECK AND ELSEWHERE.

(Under the care of Dr. GIBB.)

MANY patients apply for medical relief under the impression that the larynx is chiefly involved in disease, when their maladies exist in other parts of the body, although perhaps secondarily influencing the larynx. A careful examination with the laryngoscope generally clears up any doubt, as in the two instances which we now publish, wherein a view was obtained of the entrance of one or both bronchial tubes. The details will be found interesting. We may mention, also, that there is at the present time in the hospital, under Dr. Gibb's care, a young woman, aged twenty-three, with severe laryngismus stridulus, due most probably to pressure of some enlarged glands upon the pneumogastric nerves within the chest. The spasms, at night especially, are sometimes most distressing, and suffocation has been imminent several times. The most careful examination with the laryngoscope shows everything to be normal in the larynx and trachea, the vocal cords moving with the most surprising rapidity, yet possessing their usual greyish-white colour.

Elizabeth T—, aged forty three, married, no children, was admitted Sept. 15th, 1862. She has had a tumour or swelling in the neck ever since she was a girl; but it has remained stationary in size to the present time. She has had bronchitis for the last three months, and is subject to pains about the knees, arms, and shoulders. Two years ago she had an attack of sciatica. During the last winter she suffered much from pains in each side of the neck and upper part of both sides of the chest, which she attributed to the tumour. At times she has pains between the shoulders, also over the heart, and she feels this latter more if she uses the arms much, when her fingers become numb. She is a very tall, stout, plethoric person, with the atheromatous expression well marked. A tumour of the size of a turkey's egg is present on the right side of the base of the neck, resting upon the upper part of the chest, but not entering it; it is divided into two parts, movable above but not below, where it is apparently in connexion with the trachea. She has no dysphagia; but when she swallows the tumour is wholly drawn up, and she feels as if something were sticking in her neck. She has slight dyspnoea when she takes cold, and pain on either side of, but not in, the tumour. She has follicular disease of the fauces, with injection of the membrane, but no ulceration. The laryngoscope showed the epiglottis a little red, the larynx capacious, vocal cords healthy, the passage downwards unobstructed until near the bifurcation of the trachea on the right side, where there was a bulging inwards produced by the adhesion and pressure of the bronchocele since youth. In other respects the bifurcation was well seen, as shown in the woodcut, for the trachea was large and wide—indeed it seemed larger than usual. The bulging inwards partially obstructed the view of the right bronchus. The heart was moderately large and flabby, with feeble but regular

sounds, and no distinct bruit. Its action was, however, heard all over the chest. She was nervous and low-spirited, and very uneasy about the "weakness in the throat" and pains in the neck and chest, which made her very miserable from their steady persistence.

a, The epiglottis. c c, The vocal cords, between which are seen the rings of the trachea and the bronchial tubes, b being on the left. The parts are reversed as seen by the mirror.

Under the use of general tonics, such as quinine and other remedies, and the use of an embrocation, she improved in health, and the pains diminished. The tumour appeared to become a little smaller, and she thought she breathed better. In November the cough was rather troublesome; this subsequently got better. When lately seen she was thinner, and could use her arms and hands in needlework, which she could not do when first admitted. The old pains in the limbs had wholly disappeared.

DYSPNOEA AND APHONIA, PROBABLY DUE TO AN ANEURISM; THE RIGHT BRONCHUS SEEN WITH THE LARYNGOSCOPE.

(Under the care of Dr. GODDARD ROGERS.)

Elizabeth S—, aged forty-five, was admitted in November, 1862. The mother of eleven children, six of whom are living. Always healthy up to four weeks ago, when she experienced sudden dyspnoea and pain at the root of the neck in front. The voice then began to fail, dyspnoea came on, and subsequently aphonia. She was examined, at Dr. Rogers's request, by Dr. Gibb with the laryngoscope on the 3rd December, who found that the voice was sometimes natural, and at other times a whisper, with an occasional croupy sound and a cough. Has had prolapsus uteri for three months. Has now pain in the right side of the base of the neck and across upper part of sternum, with occasional severe dyspnoea at night. Thirsty; mouth very dry; pulse same in both wrists. Is stout, with ruddy complexion, and atheromatous expression. There is deep pulsation felt on the right side of the neck, and sometimes there is pain between the shoulders. There were no special symptoms of cardiac or lung disease. The larynx was normal; trachea seen as far as the tenth ring. Dr. Gibb suspected the disease might be aortic aneurism, from the suddenness of the attack and active symptoms.

On January 1st, 1863, she was again examined with the laryngoscope. There was now pain and soreness continually on the right side of the neck, extending to the right side of the head, face, and eye. The veins were prominent on the right forehead; she felt giddy and disposed to fall on stooping. Cough spasmodic, and distressingly persistent; pain not so uneasy about sternum; voice has returned; is thinner and weaker; orthopnoea at night. Has had a lump in the left side of the left breast five years.

Laryngoscopy showed the mucous membrane of the vocal cords relaxed, and a good view was obtained of the right bronchus. This was well seen three times; but all Dr. Gibb's

a, The epiglottis. b, The opening of the right bronchus. c c, Vocal cords, between which are seen the rings of the right half of the trachea.

efforts, by change of position, reversing the mirror, and other artifices, failed to obtain a view of the left. He thought the aneurismal symptoms were somewhat clearer.

June 10th.—Although this patient has remained under observation, with improvement in the more distressing of her symptoms, no fresh feature has appeared to call for special note beyond the fact that the evidence afforded by the laryngoscope proved that the symptoms did not depend upon any laryngeal disease. Dr. Gibb was inclined to believe that the inability to see the *left* bronchus was due to spasm, in some way influencing the trachea, which was more contracted on the left than the right side.

WESTMINSTER HOSPITAL.

PHAGEDENIC ULCERATION OF THE TOES, INVOLVING THE PARTIAL DESTRUCTION OF THE OUTER AND INNER, AND TOTAL DESTRUCTION OF THE INTERMEDIATE ONES.

(Under the care of Mr. HOLTHOUSE.)

CAROLINE B—, aged forty-seven, married, and the mother of three children, the youngest five years of age. She has not menstruated during the last eight months, and is very pale and cachectic looking. Admitted into Queen Anne ward on the 13th of January, with an unhealthy-looking, spreading ulceration on the front part of the right foot, which had destroyed all the toes except the inner thirds of the great toe and the outer third of the little toe. The surface of the ulcer was of a dirty-ash colour, without granulations, and secreting a thin, watery, and highly fetid discharge; and the whole foot was somewhat swollen, but not red.

History.—Between one and two years ago she suffered much from boils, a succession of these making their appearance in various parts of the body. The last was on the right leg, and was one day accidentally struck with a chair, which set up a good deal of additional inflammation; it, however, at length healed, but was succeeded by an eruption which, from her description, would seem to have been eczema. This “settled in” the foot and toes, and the leg got well; but she became so lame that she was obliged to apply at a dispensary, where she was a patient for six months. She subsequently came under the care of Dr. Smyth of Lambeth, who, finding the ulceration continued to spread, sent her to Mr. Holthouse, by whom she was admitted, in the condition above described.

The treatment consisted in the exhibition of the mineral acids with bark and opium, and the application of yeast poultices, and afterwards black-wash, to the ulceration. Under this treatment the progress of the disease was at once arrested; the ulceration soon afterwards put on a healthy character, and on the 14th of February it had nearly healed. On the 25th of the same month the patient was discharged cured, and very much improved in her general appearance.

In some remarks made by Mr. Holthouse at the bedside of the patient, he said he had never before met with a case similar to this. In the situation and in the character of the ulceration, it more nearly resembled some of the forms of tertiary syphilitic disease than anything else he could liken it to; he had never, however, seen such destructive results from that cause, neither were there any other appearances or any history of syphilitic disease to warrant this supposition. Excepting the character of the ulceration, the effects closely resembled those of frost-bite.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

TUESDAY, JUNE 23RD, 1863.

MR. PARTRIDGE, PRESIDENT.

OBSERVATIONS ON STERILITY IN MAN; WITH CASES.

BY T. B. CURLING, ESQ., F.R.S.,
SURGEON TO THE LONDON HOSPITAL, AND EXAMINER IN SURGERY TO THE UNIVERSITY OF LONDON.

THE object of this communication is to show that a want of aptitude to impregnate may coexist with the capacity for sexual intercourse, or, in other words, that man is subject to *sterility* independently of *virility*.

The author states that sterility in man may arise from the following causes:—

1. Malposition of the testicles.
2. Obstructions in the excretory ducts of the testicles.
3. Impediments to the escape of the seminal fluid.

1. *Sterility from malposition of the testicles.*—The author remarks that the opinion of John Hunter “that when one or both testicles remain through life in the belly they are exceedingly imperfect, and probably incapable of performing their natural functions,” is corroborated in a remarkable manner by the facts adduced in this paper. After describing the condition of detained testicles, the author states that the question to be considered is, whether a testicle that has not passed into the scrotum can secrete a fertilizing fluid. He assumes, as quite established, that to possess this property the semen must contain zoosperms.

Having referred to the observations of Professor Goubaux on horses, and to those of Follin and Godard on man, the author remarks that the proofs adduced by these observers were not sufficiently cogent and numerous to establish the law that cryptorchics are infertile; and it could not be expected that assent should be given to results so remarkable and unexpected without evidence of the most convincing character. Opposite opinions continue to be entertained, and have recently been avowed by Dr. Alfred Taylor.

The author gives the particulars of two cases of double detained testicle in married men (cryptorchics) without children; and also two cases of single detained testicle, the second testicle, in one case, being completely atrophied, and in the other having been removed by operation. In all four cases the copulative powers were satisfactory; but the ejaculated semen was destitute of spermatozoa. The author gives a table, which includes these four cases and five others, three described by Godard, one by Puech, and one by the President of the Society, making nine in all, in which the fluid ejaculated by men with retained testicles was submitted to examination and found to be destitute of spermatozoa. In confirmation of the results obtained in these cases, he deduces some observations made upon the lower animals by Messrs. Goubaux, Follin, and Godard; and he furnishes a table of eight cases in which the fluid found after death in the substance of a retained testicle—in the epididymis or vas deferens, or in the vesicula seminalis on the side corresponding to the misplaced gland—had been examined and found destitute of spermatozoa. They have not been discovered after death in the spermatic ways of a detained testicle in any one instance that he knows of.

The facts which have been brought forward as opposed to the conclusion that cryptorchics are sterile, are chiefly instances in which they are reputed to have procreated children. Three cases are cited: one recorded by Mr. Poland, another communicated by Mr. Cock, and a third by Mr. Durham. The author feels no little hesitation in calling in question the claims to paternity in these cases; but remarks that as yet no case has been found in which a retained testicle has been fully proved to be capable of secreting a fertilizing fluid. The observations collected in the paper seem sufficient to show that, as a rule, they do not; and though he sees no valid reason why there should not be exceptions, still the evidence is wanting to establish the exception in either of the instances of reputed paternity which have been mentioned.

2. *Sterility from obstructions in the excretory ducts of the testicle.*—After giving a brief account of Gosselin’s researches, in which he showed that after attacks of gonorrhoeal epididymitis the channel for the semen is temporarily and sometimes even permanently obstructed, causing, when the epididymitis is double, sterility, the author relates three cases occurring in his own practice of permanent obstruction in the epididymis of both testicles in married men whose wives were barren. In all three the patients had vigorous powers; but there was a total absence of spermatozoa in the ejaculated fluid. The author insists on the importance of careful and prolonged treatment in cases of epididymitis to obtain the removal of inflammatory effusions.

The author remarks, that the passage of the semen from the testicle may be prevented by congenital absence of the vas deferens, which, if double, would occasion sterility. A case of the kind, in which the testicles were sound, had been observed by John Hunter.

The excretory duct of the testicle is liable also to be interrupted by tubercular deposits in the epididymis. It is well ascertained that this part is much more frequently the seat of tubercle than the body of the gland, and is often extensively diseased, whilst the substance of the testicle remains sound. The author gives a case in point, in which the semen was destitute of spermatozoa.

3. *Sterility from impediments to the escape of the seminal fluid.*—It is well known that a close stricture in the urethra so completely interrupts the passage of the seminal fluid, that in ejaculation it regurgitates into the bladder, where it mixes