been nourished by nutrient enemata. The only cerebral symptom observed was extreme drowsiness.

29th.—The throat continues to clean. Can swallow milk and beef-tea to-day.

March 18th.—Has not had any unfavourable symptom since the operation, gains strength, and takes his food well. Surgical wound healed except at one small point, through which, this day, a foreign body (evidently the knot of the ligature) was discharged.

April 27th.—General health excellent; throat nearly well; still some oozing from a speck in the centre of surgical wound. The arteries, above the ligatured vessel, show no return of pulsation.

REPORT OF

A CASE OF PHTHISIS PULMONALIS,

ACCOMPANIED BY ULCERATION OF THE LARYNX AND PLASTIC EXUDATION INTO THE TRACHEA AND BRONCHI.

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JOHN S—, aged thirty, a Norwegian, was admitted into the Newcastle Infirmary, under my care, on the 18th of January, 1872. For nine months he had been employed as a fitter at one of the engineering works on the Tyne. For six months he had suffered from cough, shortness of breath, occasional pain in the chest, slight hæmoptysis, loss of flesh, and gradual diminution of strength.

At the time of his admission he was much emaciated, his voice was husky, his cough was almost incessant, and he was expectorating large quantities of nearly pure pus. His pulse was feeble (120), and his respirations were short and hurried (33). The chest anteriorly was flat, and was almost stationary, even in forced respiration. There was marked dulness upon percussion in both infra-clavicular regions, and in the left upper scapular region. The irritability of the muscles under percussion was well marked. The respiration was harsh, bronchial, and was accompanied with bubbling rhonchus, especially in the left infra-clavicular region. Upon examination with the laryngoscope, the mucous membrane of the larynx and chordæ vocales was seen to be ulcerated. A strong solution of nitrate of silver was applied to the larynx with the curved brush, and sedatives, nourishing food, and wine were administered.

Jan. 27th.—The respiration in the left infra-clavicular region was hollow, cavernous, and was accompanied with gurgling rhonchus. The voice was muffled, and at times was changed into a hoarse croaking whisper.

Feb. 10th.—After some hours of urgent dyspnoea, and during a violent paroxysm of coughing, the patient expectorated a piece of false membrane, about four inches in length, tubular at one extremity, and distinctly transversely marked and indented. From its size it was surmised that it had been dislodged from the lower portion of the trachea, or from one of the main bronchi.

On the evening of the 12th he died from exhaustion, but without having ejected any further mass.

Autopsy, fifty-seven hours after death.—The lungs were both adherent to the chest wall, the left more firmly than the right, especially near the apex. The upper lobe of the left lung was excavated with caverns, anfractuons, about the size of large nuts, communicating one with another, and with indurated lung between them. The upper half of the lower lobe was studded with yellow and grey tubercle, the yellow being in excess. The lower half of the lower lobe was darkly congested. The main bronchus and bronchial tubes were lined with false membrane, which at places was loose and easily raised. The pleural covering of the upper lobe was greatly thickened; that of the lower lobe was spotted with dark pigment. The upper lobe of the right lung was similar in appearance to that of the left, with the exception of the cavities being smaller, many not being larger than peas. The lower lobe was dotted with yellow and grey tubercle, the grey preponderating over the yellow. The main bronchus and bronchial tubes were lined with false membrane. The trachea was lined throughout with false membrane, which was separable in layers and easily

raised from the mucous surface, which was tumid and of a dull-red colour. The false membrane very closely resembled moistened parchment, and when examined under the microscope appeared to be made up of altered epithelial cells. The cavity of the larynx was covered with pus. The mucous surface presented an irregular-shaped loss of substance, with serrated ragged edges. The chordæ vocales could not be recognised. The heart, liver, and kidneys were healthy. The bronchial and mesenteric glands were not enlarged nor tuberculated.

The particular interest of this case is, the association of tubercle in the lungs and of tubercular laryngeal ulceration with the formation of false membrane in the air-passages, the ulcerative action being limited to the larynx, and the membranous croupous or aphthous inflammation to the trachea and bronchial ramifications, large and small; the two processes—that of the morbid condition of the blood giving rise to the deposition of tubercle and to the membranous inflammation affecting the same continuous membrane—being in close juxtaposition, and being apparently dissimilar, yet resembling each other in the lowness of organisation of the products. Possibly, the exudation upon the mucous membrane of the respiratory tract was only an extreme condition of that form of aphthous or diphtheritic stomatitis which is not uncommon towards the close in cases of chronic phthisis pulmonalis. The condition of the lungs very typically exemplified the anatomical characters of tubercle, and the changes which the tubercles undergo—namely, that tubercle in its early stage is grey and afterwards becomes yellow, and that yellow tubercle softens and finally gives rise to excavation.

Newcastle-on-Tyne, May, 1872.

OPHTHALMIC NOTELETS.

By J. F. STREATFEILD, F.R.C.S.

I. ON THE PRESERVATION OR DESTRUCTION OF THE CONJUNCTIVA IN CASES OF EXTIRPATION OF THE GLOBE.

THERE is one other, a fourth, class of cases in which the total destruction of the conjunctiva should probably be accomplished for the benefit of the patients who are minus an eye—those, namely, whose conjunctivæ are so peculiarly irritable naturally, or the shape of whose conjunctival sac after the excision operation is so peculiar, that though the artificial eye looks well and can be well retained in place, it, for some unknown reason, is a cause of so much irritation that it cannot be worn very well or continuously, and if an artificial eye can only be worn at intervals it no longer answers the purpose of the counterfeit organ. In the cases I now recall to mind the conjunctival sac is always discharging more or less; if the offensive discharge does not exude from between the lower lid and the glass eye, the deep cup of its concave back is at all events filled with matter of the discharge when the eye is removed at bedtime. (This shape of the back of the artificial eye is an absurd tradition of the times when artificial eyes were put upon old shrunken stumps of accidentally wounded and lost or surgically abscised and dangerous eyes, and I have tried ineffectually to get the makers to make the concavity much shallower, and so get probably more movement from the deep hard mass of scar-tissue on which the artificial eyes now have to rest, and a broader, blunter edge.) The glass eye being removed the formerly ocular conjunctiva is found to be raised into four cedematous swellings by the cruciform depression of which I have spoken, and perhaps in the centre of it is one of those common little button-like fleshy excrescences (which should be snipped off). The conjunctiva is secreting more or less offensive discharge. Alum lotion and the artificial eye no longer being worn soon cure all this, and yet it will return again and again when the artificial eye is in use. (Of course I am not referring to the cases in which the glass eye is rough at the edges, and a new one is required.) The conjunctiva in such cases as these had better probably be altogether destroyed.

I have heard tell of cases in which, after removal of a lost eye and the wearing of an artificial eye in its place, the