

dition of the disease; all owe their origin to primary disease of the lung; all lead to general wasting of the body. Tuberculosis may supervene upon the first and second varieties. Passing rapidly in review the clinical symptoms of the disease, Dr. Shepherd passed on to consider the descriptions afforded by older writers of the post-mortem appearances, illustrating his remarks by drawings from Carswell, Colberg, Thaon, &c. All these representations of so-called "tubercle" were, he alleged, due to catarrhal products, and he would compare an inflamed pulmonary lobule to an inflamed sebaceous follicle. Skoda held that every pneumonia of the apex of the lung was tubercular, and he himself had had cases of general capillary bronchitis with localised dulness at one apex. Rindfleisch, in his recent article, places the original seat of tubercle-granulation at the point of transition of the bronchi into the alveoli. So called "phthisis ab hæmoptoe," of which he had seen examples, were undoubtedly instances in which the phthisical process originated in intra-alveolar changes. Dr. Shepherd referred also to two cases, in one of which the father was suffering from chronic phthisis, while the son was dying rapidly of a more acute form of the disease. The granulation was frequently nothing more than a vesicular lobular pneumonia, which might or might not be associated with perivascular growth. Turning then to that form of phthisis which is essentially extra-alveolar—viz., fibroid phthisis, Dr. Shepherd stated his belief that in most cases there was a history of spirit-drinking; in others of syphilis. He thought the syphilitic form could be clinically recognised, being marked by cough and dyspnoea, with the physical signs of chronic phthisis without diarrhoea. There was generally good nutrition. The lung, in addition to the fibroid induration, or interstitial pneumonia of some authors, was usually emphysematous. In no part does it present anything like miliary tubercle. He mentioned cases referred to by Moxon, Sturges, and others, in some of which hæmoptysis was a prominent symptom. The lecturer concluded by referring to miner's phthisis, in which an interstitial fibroid overgrowth, probably dependent on changes in the lymphatics, was produced by the inhalation of foreign particles.

In the third lecture Dr. Shepherd pointed out that heridity in phthisis was but little more than a tendency to catarrh (the *dispositio catarrhalis* of Morton). He pointed out also how the age at which the disease showed itself was frequently inherited, and then passed on to analyse a few of the earlier symptoms of the affection. Of these, hæmoptysis, cough, dyspnoea, and pain in the chest were the most frequent. He believed that hæmoptysis, so often absent, was really beneficial between the ages of twenty and twenty-five, being due to hyperæmia of the bronchial mucous membrane and alveolar capillaries. But generally, before hæmoptysis occurs, there has been some mischief already set up. Analysing a large number of cases which had occurred at the Victoria Park Hospital, with regard to the period at which hæmoptysis first appeared, he had found by far the largest number of cases fall between the ages of eighteen and twenty-five years. With regard to the lung to be first affected, he mentioned that whereas Laennec held this to be the right, Louis was of the opposite opinion. His own observations led him to much the same conclusion as that arrived at by Dr. Hughes in 1842—viz., that the difference between the two sides was too trifling to be of any importance. He gave a few statistics culled from the Victoria Park Hospital records, tending to show the greater prevalence of the disease among males and the influence of in-door and out-door work. He had compiled other tables, which he would not then produce. The result of all was to show that Broussais, the upholder of the inflammatory origin of phthisis, was right in holding out a possibility of a cure, while the advocate of the pure tubercular hypothesis, Laennec, was wrong in regarding it as absolutely incurable. Devoting a few words to the question of treatment, in which he urged the frequent examination of the excreta in order to check the too indiscriminate and wasteful use of cod-liver oil, he condemned the practice of prescribing this drug without regard to the individual case. Much more did his remarks apply to the pancreatic emulsion so largely composed of fat. The lecturer concluded by a summary embracing the points travelled over, and insisting upon the great advantages to be derived from hygienic measures in the treatment of the disease.

Correspondence.

"Audi alteram partem."

ON PUNCTURE OF THE TESTIS IN ACUTE ORCHITIS.

To the Editor of THE LANCET.

SIR,—In my remarks on "Acute Orchitis" I was careful to allude to Mr. Henry Smith's operative measure as one of "puncture," "paracentesis," "perforation," "the introduction of the narrow-bladed knife into the parenchyma of the testis;" but I find that in one passage the phrase "undivided testicle" accidentally insinuated itself. After Mr. Smith's distinct and repeated repudiation of the propriety of the application of such descriptive terms as "incision of the testis," "division of the testicle," "splitting up the testicle," &c., it would be neither candid nor courteous to employ them any more; but in justice to Mr. Holmes and others, including myself, who were at first impressed with the apparent severity of the procedure, and the boldness and freedom with which the bistoury seemed to be handled, I would call Mr. Henry Smith's attention to the following passages from his writings on the subject. In his paper in THE LANCET in August, 1864, Mr. Smith, relating his first case, says:—"With a view of evacuating the pus, I took a bistoury and made a *free and deep* incision into the supposed abscess," the result being that "the tubes of the testicle shot out from the wound, forming a protrusion the size of a nut." The favourable termination of this case led Mr. Smith to adopt the treatment by puncture, and he tells us that "in the next case of acute orchitis which presented I made a *deep and free* incision with a sharp narrow bistoury, emitting about half a teaspoonful of serum and several drachms of blood." I have italicised the epithets *deep and free*, because, in his letter in THE LANCET last week, Mr. Henry Smith explains that he merely intended to convey the idea that he "carried the narrow knife freely into the substance of the testis as regards depth, not as to length or breadth of the incision," and I think he will at once admit that they really convey more than he desired. Moreover, in his paper in THE LANCET of the 8th of January, Mr. Smith observes that the sudden relief from acute pain is due to the circumstance that the unyielding tunica albuginea is *freely incised*. Who would gather from this that the procedure simply consisted in the introduction of a blade a sixth of an inch in breadth into the testis and its withdrawal without enlarging the opening, either upwards or downwards? The idea derivable from Mr. Smith's language, that a free incision was made through the tunica albuginea, doubtless tended to prejudice the treatment by *puncture*, and if Mr. Holmes had not inveighed *more suo* against "splitting up" the testicle, the innocent character of the method would not have been established. But just in proportion as Mr. Smith limits the solution of continuity in the tunica albuginea and narrows his knife, in the same proportion does he render it less likely that the relief is due to cutting that tunic, and more probable that there is no necessity for interfering with the tunic at all. Admitting, as I do most cheerfully, that Mr. Smith often removes pain and shortens the duration of orchitis, admitting that the treatment deserves more consideration than it has received from surgical authorities, I maintain that he has failed to show that any advantage has accrued in his cases from puncturing the *testis*. Let him narrow his blade still further and use a cataract needle, and let him in the next hundred cases avoid wounding the testicle, and puncture in one or two places the tunica vaginalis only, and then let him tell us whether the results are equal or not to his present mode of procedure. If sufficient relief does not result from evacuation of the fluid in the tunica vaginalis I will become one of his disciples, but until he has overthrown our existing pathology and given a more complete demonstration of the value of interfering with the gland itself, I must follow him afar off, with Mr. Spencer Watson and Mr. Ferguson McGill.

I am, Sir, yours &c.,

Finsbury-square, April 3rd, 1876.

WALTER RIVINGTON.