

lip, and was transferred as an in-patient to Mr. Adams. The sore was seated on a specifically indurated base, the induration being at this time somewhat concealed by accidental inflammatory exudation; surface slightly fretted, discharging pus; sub-maxillary glands much enlarged and very painful. While under observation, sore-throat, lepra, and alopecia set in, while the glands gradually became less and less painful and smaller. The sore for some time had no tendency to heal.

INDURATED CHANCRE OF THE LIP.

(Under the care of Mr. C. F. MAUNDER.)

CASE 3.—A man, about fifty years of age, presented himself amongst the out-patients, with a sore on the centre of the lower lip. It was seated on an indurated base; its surface was somewhat concealed by a scab, formed apparently partly of blood, and partly of pus; it was painless, and attended by enlarged, indolent, indurated, and painless glands. Mercury was prescribed, and under its influence (although the patient was unfortunately only a fortnight under observation) the sore took on healthy action, and the enlarged glands had almost disappeared.

These three cases, which have been lately under observation at the London Hospital, are worthy of record, because each and all were considered by some surgeons to be examples of epithelioma. In Cases 1 and 2, neither the age of the patients nor the short existence of the sores, attended as they were by an adenopathy, was in favour of epithelioma; whilst the appearance of secondary symptoms clearly indicated the nature of each case. In Case 3, age was in favour of epithelioma; but the beneficial effect of mercury dissipated any doubt previously existing in the minds of some. Enlarged glands attendant on the indurated chancre usually appear before the expiration of twelve days from the origin of the sore, while the enlarged glands follow epithelioma generally not earlier than after the lapse of twelve months.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

TUESDAY, NOVEMBER 5TH, 1861.

DR. COPLAND, PRESIDENT.

RUPTURE OF THE LIVER, TWO CASES, ETC.

DR. MURCHISON showed one specimen of considerable rupture from a person killed in a recent railway accident; the other specimen was less extensive. An example of rupture of the diaphragm was also shown, through which a large portion of the liver and the stomach escaped into the chest. A case of rupture of the stomach was likewise exhibited. It was remarkable that the blood was in a fluid state in one of these cases.

DR. COPLAND believed it was common, in death from injuries to any of the internal organs supplied from the great ganglionic system, for no coagulation of the blood to take place.

In answer to a question from Dr. O'CONNOR, DR. MURCHISON stated that death was immediate after the rupture of the liver.

DR. PEACOCK exhibited a

HEART WITH AN OPEN DUCTUS ARTERIOSUS.

The specimen was removed from a man thirty years of age, whose previous history was not known, and who died suddenly at St. Thomas's Hospital before he could be placed in bed. The heart was of large size, and presented marked hypertrophy and dilatation of both ventricles, but more especially of the right. It weighed 20½ oz. avoirdupois. The pulmonary artery was of full size, and gave origin to the ductus arteriosus in the usual situation; the latter was freely open, and of sufficient capacity to give passage to a writing quill. The whole aorta was of small size, but the ascending aorta was relatively large. Beyond the origin of the left subclavian artery the vessel diminished considerably in capacity, and expanded after the entrance of the ductus arteriosus. Dr. Peacock regarded the case as an example of a permanently pervious condition of the ductus arteriosus resulting from congenital contraction of the portion of the aorta distal to the left subclavian artery.

The same gentleman also exhibited a specimen of an

ANEURISM OF THE DESCENDING THORACIC AORTA,

which had produced laryngeal symptoms from pressure on the left recurrent nerve, had given rise to hæmoptysis from involv-

ing the lung, and finally produced death by rupturing into the left pleural cavity. The man from whom the specimen was removed was thirty-five years of age and a scaffold builder. He was received into St. Thomas's Hospital on the 12th of June last, and had then suffered from dyspnoea for twelve months, but was able to follow his work till a week before his admission into the hospital. When first seen, he had considerable dyspnoea, increased on exertion; spoke with a peculiar, hollow, interrupted, and feeble voice; and had a loud, ringing cough. There was a prominence of considerable size below the middle and outer end of the left clavicle, and the sound on percussion was there entirely dull; respiration was abolished, and replaced by abnormal pulsation and feeble double murmur. The left external jugular vein was also much distended. At the base of the heart there was a feeble diastolic sound, propagated down the left side of the lower part of the sternum; and the pulse was somewhat of a regurgitant character, but equal in the two wrists. Some time after his admission he began to spit blood, and continued to do so for a considerable period, but never in large quantities. The left radial pulse also became fuller and firmer than the right. While in the hospital the external prominence almost entirely disappeared. He died suddenly by syncope on the 29th of October, having been first taken with faintness and insensibility at about one o'clock in the morning. From this state he rallied in about an hour, and then suddenly expired while getting out of bed at about seven o'clock. The aneurismal sac was found to arise from the descending portion of the arch of the aorta, immediately beyond the origin of the left subclavian artery. It involved the posterior and right side of the vessel, and was of an oblong form, its largest diameter being about three inches, and from above downwards it was fully the size of a large orange. On the right and posterior part it had pressed upon the bodies of several of the vertebrae, causing their denudation and absorption. On the left the sac involved the upper lobe of the left lung; it had also compressed the main branches of the lower lobe, and so caused collapse of that portion of the lung. The aneurism had opened by a small aperture, not larger than would admit an ordinary probe, into the cavity of the left pleura, and about four pounds of coagulated blood were found in that cavity. The left recurrent laryngeal nerve, when making its turn round the aorta, must have been compressed between the vessel and the sac. The upper part of the sac rose above its point of origin, and formed the prominence observed beneath the clavicle during life. The heart, and especially the left ventricle, was somewhat hypertrophied and dilated. The aortic valves were thickened, and the right segment was introverted and contracted at its free edge, and was considerably beneath the level of the other segments, so as to allow of regurgitation from the aorta into the ventricle. The results of the examination after death very fully illustrated the various symptoms which had been observed during life.

DR. COPLAND pointed out, as a remarkable circumstance in this case, that the bloody sputum was not direct from the aneurism; that it was from interference with the circulation through the lung, which was pressed upon by the sac of the aneurism.

DR. CRISP asked if Dr. Peacock thought that Valsalva's treatment would not contribute to maintain life longer than any other mode in these cases?

DR. PEACOCK thought it very unlikely. He agreed with Dr. Stokes, that if fibrin was to be formed, it would be by nourishing the system, and not by lowering it. He had adopted in this case rest, perfect quiet of mind and body, and fair nutritious diet. Incompetency of the aortic valves, he thought, especially contraindicated Valsalva's treatment.

DR. COPLAND agreed with Dr. Peacock.

DISEASE OF THE AORTIC VALVES.

DR. R. BENNET presented this preparation, the peculiarity of which was, that the disease of these valves, although very slight anatomically considered, had been productive of very marked symptoms and of the gravest changes, leading in no long period to death. He described the physical signs met with during life.

DISEASE OF SUPRA-RENAL CAPSULES.

DR. MONTGOMERY showed these and a portion of the skin from a very typical case of Addison's disease in a boy. The deeply bronzed skin and the disease of the supra-renal capsules were the only abnormal conditions found throughout the body. He died apparently of debility, slowly increasing in spite of all treatment.

CASTS OF TEETH IN SYPHILIS.

MR. NUNN showed two casts from the teeth of two un-