thinking that then their child's eye had got rid of its enemy. This is a melancholy picture, but it has often happened to me, and I have been obliged to explain, as kindly as I could, the real state of the case to the anxious mothers. If the humours have not escaped, but there has been protrusion of the iris through one or more ulcers of the cornea, these portions remain fixed there, and staphylomatous tumours are formed of different shapes, the iris presenting often a resemblance to so many heads of flies, and hence the name, *myokephalon*. The eye remains irritable for a long period after the inflammation and excessive purulent discharge has ceased, and capable of communicating the disease to others; and frequently the most obstinate remnant of the disease is that which I referred to before as the granular lids, in which the papillæ are enlarged and hardened, and are very rough, and they become loaded with blood directly you evert the eyelids, if they were not so before. This occurs after all these forms of muco-purulent ophthalmia, but it is more aggravated after a long-continued attack of purulent or gonorrhœal ophthalmia, and when it has been greatly reduced; it may be speedily reproduced by excess or exposure.

In inquiring after the predisposing causes of this disease, we must refer to published records and monographs on this subject, and we there are reminded that a soldier's hard life, his constant exposure to every vicissitude of temperature, his close barracks, and his occasional excesses, have marked him especially as one likely to be attacked, and seriously too, by this disease. Such has been the case. On the Continent it was asserted that the insufficient clothing and very tight collars gave rise to a predisposition to these attacks, and the medical authorities in Belgium are said to have observed a sensible diminution in this disease amongst the soldiers since those evils were remedied. I can easily understand that bad clothing might give rise to cold, and thus to ophthalmia, but I cannot conceive what the collars have to do with it, except that they might, by being too tight, produce congestion in the head, and I apprehend our soldiers wear them as tight as others. It has been now long allowed by all who hav e studied the subject, that the too well-known Egyptian expedition seemed to be the cause of the introduction of a very severe and contagious form of ophthalmia to this country, and this disease long afterwards followed our troops wherever they went. Dr. Vetch, in the accounts to which I before alluded, mentioned 636 cases of ophthalmia as having occurred in one regiment, between August 1805 and 1806. In one battalion of the 52nd Regt., consisting of little more than 700 men, fifty lost both eyes, forty lost one. He also states, that in the summer of 1808 he had more than 900 soldiers under his care thus affected. The military reports on this subject state also that in 1810, at the Chelsea and Kilmainham hospitals, as many as 2317 soldiers were entirely blind from purulent ophthalmia. I refer to these reports for the purpose of drawing your attention to the severity with which this fearful disease raged amongst us for some few years after our soldiers had returned to this country from Egypt. But although this is the case, and although we find that it prevailed for so long a period in Egypt, it is equally true that it prevailed in other countries troubled with the heat of China and sandy deserts; and it has at different times suddenly arisen in ships far away from land; and our comparative immunity has, with much justice, been ascribed to the coldness of our climate, and to our cleanliness and care. Experiments and unfortunate accidents without end had proved the strictly contagious nature of this disease, —and here Mr. Mackmurdo mentioned several instances which had occurred under his own care, confirmatory of this statement,—but I do not believe that it is communicable through the atmosphere, otherwise than as catarrhal ophthalmia is often epidemics, and has passed on gradually to a purulent form of disease. Dr. Guillie, of Paris, applied purulent matter to the eyes of some children in the blind asylum, and produced purulent ophthalmia in each case. Others have performed similar experiments on animals, with different results; and I might detain you much too long a time were I to recount the arguments and statements that have been brought forward for and against the doctrine of this disease being contagious. I have told you that our nurses and our pupils have been thus affected after assisting patients; I have told you of whole schools where all the boys washed together and used their towels promiscuously, being thus affected; and I have directed your attention to the military reports on this subject. Can you doubt, after that, that it may be thus produced, as well as that it may arise from an aggravated catarrhal ophthalmia, passing into this worse stage of inflammation, and presenting similar characters. I shall proceed further on this subject when we next meet.

Clinical Observations
ON
MEDICAL CASES IN ST. THOMAS'S HOSPITAL.

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Gentlemen,—There have been several cases of laryngeal disease under my care during the past winter, some of which are deserving of especial attention, as affording some points of practical interest. In all, the laryngeal affection was but secondary to other diseases; and, indeed, secondary affections of this portion of the respiratory apparatus are, in the adult at least, much more frequent than primary affections. The pathology of chronic laryngeal diseases has been hitherto but very imperfectly investigated, and affords you an ample field for study. There are a certain number of symptoms that may be said to be common to these diseases, and they are so marked and characteristic that you cannot easily overlook them; such, for example, as loss or alteration of voice, impeded breathing, attended by more or less of stridor, and the peculiar hoarse laryngeal cough. But such symptoms may depend on very different pathological conditions, and will have a very different import in different cases. Nor is the diagnosis so easy as some imagine. You may have all the more characteristic symptoms in the most marked degree, and they may be more or less persistent, for a considerable length of time, and be associated with such general symptoms as apparently to warrant a very confident diagnosis of serious organic mischief, and yet, after death, the larynx itself may present no appreciable anatomical lesion. And, on the other hand, you will sometimes be surprised to discover after death very extensive organic disease of the larynx or trachea, in cases which during life presented only the mildest or even no symptoms of laryngeal affection. Now, these are very important practical facts, and the former is well illustrated by the case of the woman, Stevens, who was, for several months, in Ann's ward, during the whole of which time she was the subject of what are usually termed laryngeal symptoms of the most marked, and, occasionally, of the most formidable character. She was an unmarried woman, aged thirty-one, a servant, and was admitted under my care on the 6th Nov. 1849. She stated, that six or seven years previous to her admission, she had fractured one or more ribs by a fall on the right side, and that from that time she had never enjoyed good health, but had been weakly, and the subject of cough. For the last two years, subsequent to an attack of erysipelas, her health had been still further impaired. For several months past, her cough had been very bad, and attended by pains about the chest, and considerable expectoration, which occasionally has been tinged with blood. Latterly, she has had considerable dyspnœa, her appetite and digestive powers have become impaired, the bowels irritable, and she has lost flesh.

On her entrance into the hospital she had the appearance of a person in the advanced stage of phthisis. There was a considerable amount of dyspnœa, and the breathing was accompanied by a harsh, laryngeal sound. Her voice was altered, and the cough was very troublesome, and of a hoarse, croupy character. She expectorated much opaque, greenish, tough, muco-purulent matter. There were frequent hectic flushings and night perspirations. The tongue was cracked and glazed, and the appetite much impaired. There was dulness on percussion beneath both clavicles, with mucous and sonorous rhonchi and gurgling; but owing to the degree of aphonia constantly present, we could not obtain any satisfactory information from the vocal phenomena. The breathing was 22 per minute; pulse 108, small, and feeble; the action of the heart natural. She complained of sore throat and difficulty of deglutition, but no disease of the throat could be detected, to the examination of which she at first objected, in consequence of (as was afterwards discovered) her wearing a false palate for congenital deficiency. I need not trouble you with further details of the general progress of the case, but will confine myself to the more immediate object of attention, the laryngeal affection. Soon after her admission, she had a somewhat formidable paroxysm of increased dyspnœa, attended by great

distress, and an aggravation of all the laryngeal symptoms. This attack was, to a certain extent, clearly of a spasmodic character, and was relieved by antispasmodics and sedatives. But though she obtained from these and some other remedies considerable relief, the laryngeal symptoms continued to such an extent, as to lead me to order a blister to the throat, and small doses of blue pill, with conium, notwithstanding that she denied the existence of either pain or tenderness over the larynx. She was still further relieved by these means. But the voice and breathing maintained their hoarse and whistling character throughout her illness, and she was at intervals the subject of similar, though less severe spasmodic exacerbations of the more prominent laryngeal symptoms. The nitrate of silver, in solution, was applied two or three times to the larynx, but she made so much objection to the examination of the throat, that this remedy was not persevered with. A certain amount of pain and difficulty of deglutition continued to the end, and the paroxysms of cough were frequent and distressing. Repeated attacks of diarrhœa still further exhausted her, and she died on the 18th of March, emaciated to an extreme extent.

The *post-mortem examination* revealed a few old adhesions of the pleura on both sides, and numerous cavities in the upper portions of both lungs. These cavities, however, were not the results of tubercular disease, but were, in fact, dilated bronchial tubes. These pouches, and the bronchi generally, were loaded with muco-purulent matter, and were surrounded by condensed pulmonary tissue. Here and there, especially in the lower lobes, and in the midst of condensed and congested pulmonary tissue, were small purulent deposits. Many of these appeared to be recent, and were surrounded by patches of pneumonia. The larynx was healthy, but the upper portion of the trachea was studded with ulcerations, some superficial and more recent, others deeper and of longer standing. Towards the bifurcation of the trachea these ulcerations became more numerous and were generally deep. The intervening mucous membrane was thickened, soft, and injected. A similar condition pervaded the lining membrane of the bronchial tubes throughout, but there were no distinct ulcerations below the bifurcation of the trachea. The liver was considerably enlarged, waxy in texture and appearance, but neither granular nor fatty.

I shall not attempt to analyze the various symptoms that were present in this very interesting case, but confine myself to one or two remarks having reference to the thoracic disease and the error of diagnosis. Practically this was not, perhaps, of much consequence. The association of chronic laryngeal disease with phthisis is, you know, sufficiently common; and in the absence of any evidence of syphilitic disease, there was strong reason for concluding that, in such a case as this, the laryngeal affection was but a consecutive complication of tubercular disease of the lungs. There had been constitutional and local symptoms of pulmonary disease, long before the occurrence of laryngeal symptoms, and the constitutional symptoms were those of phthisis; that is, there had been a gradual loss of flesh and strength, irritable bowels, dyspnœa, cough, hæmoptysis, muco-purulent expectoration, and hectic flushings.

Now such previous symptoms, coupled with the actual condition of the woman on her entrance, warranted, at all events, a strong suspicion of phthisis, and the physical examination of the chest, so far as it could be carried, confirmed this suspicion. But we had to contend with special difficulties in the physical examination of the lungs, in consequence of the amount of aphonia, and the tracheal and laryngeal symptoms, always present, to a greater or less extent, by which we were deprived of all aid from the vocal phenomena, and in consequence of which, the ordinary respiratory phenomena were greatly modified. In such circumstances, I believe, that so far as the diagnosis is to be derived from physical signs, we must trust mainly to percussion. Now there was distinct, although not any great amount of, dulness on percussion beneath both clavicles, *i. e.*, over those portions of the lungs where we generally expect to find it in phthisis. Were there, then, no means by which our erroneous diagnosis in this case might have been avoided? I think not. I do not believe that in the present state of our knowledge we have any means of deciding positively, in many instances, between phthisis and dilated bronchial tubes, even in the absence of any such laryngeal complication as existed here. If, indeed, we had had an opportunity of examining the case at successive stages of its development, and thus had been able to trace its progress, a correct diagnosis might have been established. We might, for example, have ascertained the existence or absence of dulness on percussion previous to the signs of cavities. And perhaps the chronic character of the leading symptoms ought to have excited more attention and suspicion than they did. The fact of her cough having existed, more or less, for six or seven years, might have led to the suspicion of its being bronchial rather than the result of tubercular disease, but this would by no means warrant our concluding that such a case was not one of phthisis. With respect to the condition of the larynx, the report of the post-mortem examination states that this was healthy, but as the lining mucous membrane only was examined, there may have been wasting, or other disease of the muscles of intonation sufficient to account at least for the aphonia and hoarseness. It is not, however, necessary to suppose any such change, for alterations of tension of the soft parts, and of the innervation, are sufficient to induce symptoms, but in that case we should not have expected them to have been so uniform or persistent. She had, however, such an amount of disease of the trachea, as must have proved a constant source of irritation of the larynx, and which of itself might be sufficient to produce a certain measure of laryngeal breathing, and alteration of voice. You know that hoarseness and considerable aphonia may be induced by over-exercise, or what is called straining of the voice; and so, in many cases of phthisis, I believe it will be found that alteration of voice, and other laryngeal symptoms, occur before there is any appreciable organic change in the larynx, and which I think may be explained by reference to the lax œdematous condition of the adjoining structures, and the frequent straining of the vocal apparatus by the paroxysms of cough. But in the present case, as I have before hinted, the circumstances in which the laryngeal affection occurred seemed to justify the inference, that, independent of the manifest nervous character of the spasmodic exacerbations, there was some organic disease of the larynx. This case, then, must be considered as very instructive both with regard to the laryngeal and the pulmonary affection, and, did our time admit, would warrant a much more minute examination of its several features than I have been able to give.

The next case to which I have briefly to call your attention is that of the man Fellows, who was for some time in Jacob's ward. The history that he gave of himself was, that he had been ill four months with cough and expectoration, and that he had several times spat blood; once, about a year ago, to a considerable extent. He had for some months been losing flesh and strength; his bowels were irritable, and his appetite impaired; his pulse quick, his skin sweating, and his aspect anæmic and cachectic. His tongue, which was pale and flabby, was the seat of several large, deep, irregular ulcers. He spoke with effort, and always in a hoarse whisper, and his cough had a marked laryngeal character. He complained of sore throat and of some dysphagia. The painful and ulcerated condition of the tongue rendered it difficult to examine satisfactorily the state of the fauces and pharynx, but there appeared to be several ulcers towards the base of the tongue on each side. The physical examination of the chest indicated the existence of extensive tubercular disease, there being signs of consolidation and breaking down of the pulmonary structure over both apices. There was no evidence of his having had any syphilitic disease. Of the general remedies that were employed, he appeared to derive most benefit from the cod-liver oil; and of the local applications that were used to the ulcers of the tongue, the nitrate of silver, both in solution and in the solid form, afforded him most relief. Very little change took place either in the appearance of the ulcers or in the laryngeal symptoms. His dysphagia, however, increased, he had latterly great difficulty in swallowing, and he died exhausted, without there being any great amount of emaciation.

On examination of the body after death, there were found old and general pleuritic adhesions. In the apex of each lung there were large tubercular cavities, and the pulmonary tissue throughout both lungs was very generally studded with tubercular masses. The bronchial mucous membrane was throughout congested and thickened. In the vicinity of the glottis there were two apparently recent ulcerations: one very irregular, extending through the mucous membrane. The upper part of the larynx, the epiglottis, and adjacent parts of the pharynx, were studded with enlarged and distended follicles; some of these had the appearance of having burst, and presented a central ulcerated depression. These follicles were numerous and distinct on both surfaces of the epiglottis, and on the side of the tongue at its base, where there were several small ulcerations. There was also extensive disease of the intestinal glands, and towards the termination of the ileum

and in the ascending and descending colon there were considerable patches of ulceration.

The principal feature, in the case of this man, to which I would direct your attention, is the condition of the follicles at the upper part of the larynx and in the pharynx. We had here a well-marked example of a disease comparatively little known in this country till lately, and which has been termed follicular disease of the throat. We are indebted to Dr. Green, of New York, for an excellent practical account of this affection, and also for directing attention to the importance and efficacy of local treatment. Indeed, the whole subject of the treatment of laryngeal affections by local applications, and especially nitrate of silver, has been brought under the notice of the profession, by Dr. Green, in such a way as to claim our earnest attention, and I take this opportunity of bringing the subject under your notice. Although to Dr. Green is undoubtedly due the merit of carrying out systematically the principle of treatment which he recommends, and of proving its extensive applicability, and although he really deserves, to a great extent at least, the merit of originality, with a degree of honesty and frankness highly honourable to him he admits, that previously to his investigations, both the practicability and utility of applying local agents directly to the larynx had been demonstrated. More than thirty years ago Sir Charles Bell had recourse to this method of treatment, and recorded several cases of its successful employment.

Messrs. Trousseau and Belloc, in their work on Laryngeal Phthisis, &c., published in 1837, claimed for themselves the merit of being the first to employ topical remedies in the treatment of chronic diseases of the larynx. But whatever other merits may be accorded to their excellent practical work, the merit of priority, in reference to the *principle* of the treatment they adopted, is certainly not due to them, as the details of the following case sufficiently prove. You will find this case, together with other cases, and many very excellent practical observations, in a work entitled "Surgical Observations, being a Quarterly Report of Surgical Cases," published by Sir Charles Bell, in 1816.

"I was requested," he says, "by Dr. Southey, on the 18th of April, to visit a patient of his, in the hospital, who had been ill since Christmas. She was at that time attacked with cold and sore-throat, and from the beginning she could speak only in a whisper. Her voice has never returned, and at present her whispers are scarcely audible. She coughs in a very singular manner; she says it is an inward cough; it is the exertion of coughing, without the sound. . . . For three nights she has not been able to lie down. She expectorates a great deal; it is mucus and pus; pulse 63; breathing 42; her breathing has a harsh sawing sound. On the evening of the 18th, the hospital attendants becoming alarmed at the condition of this woman, I was sent for at eleven o'clock. She was sitting up in bed, breathing with much difficulty, but her countenance was of a red colour, the violence of the fit had subsided, and the blueness had been succeeded by redness and fulness. Dr. Southey came in. We wished to see her swallow: she tried a little broth; much of it went into the windpipe, and she had a great struggle in recovering. We concluded that the epiglottis was eaten away by ulceration. . . . Having ascertained, by putting my finger over the root of the tongue into the glottis, that it was rough and irregular with ulceration, I proposed to touch the surface with the argentum nitratum. It was considered hazardous; but something was necessary, and I was confident that the application would allay irritation.

"I made a small pad of lint, and attached it to the ring of a catheter wire, and bent the wire so as to pass over the root of the tongue and epiglottis; I dipped the lint in a solution of twenty grains of the caustic to half an ounce of water, and touched the glottis with it in this manner. With the fingers of my left hand I pressed down the tongue, and stretched the forefinger over the epiglottis; then directing the wire along my finger, I removed the point of the finger from the glottis, and introduced the pad of lint into the opening, and pressed it with my finger.

"On withdrawing the lint, instead of coughing, she began to speak more audibly than usual, and had neither cough nor spasm from this rough operation. I repeated the application four times, and her breathing was sensibly better when I left her."

Now, I have given you the details of this case, not merely for the sake of maintaining the principle "suum cuique tribuere," and claiming for our distinguished countryman the credit due to him in reference to an important point in practice, but also for the sake of adducing an authority in physiology which none can dispute, as to the *practicability* of introducing remedial agents directly into the glottis. In this country, as well as in America, it has been very confidently stated to be both "anatomically and physiologically impossible" to introduce a foreign body through the glottis without producing such irritation and inflicting such violence as would almost necessarily prove fatal. It is maintained by such persons, that independently of the obstacle presented by the epiglottis, the attempt to pass a probang into the glottis would inevitably induce spasmodic closure of the glottis, and such a degree of resistance and irritation as would effectually prevent the accomplishment of the object. But I need not attempt to answer any such theoretical objections, nor to adduce, as might readily be done, evidence of foreign bodies having frequently been passed into the larynx, both accidentally and intentionally, without any serious bad consequence having resulted. For many of you *have seen* how readily, in some of the cases that have been lately under my care, a sponge dipped in a strong solution of nitrate of silver has been introduced into the larynx; and you must have been struck with the very insignificant degree of irritation that has attended the operation.

In various forms of laryngeal and pharyngeal affections, in males and females, in adults and children, I have applied, by means of a sponge, strong solutions of nitrate of silver to the larynx, and in no one single instance have I met with anything beyond the most trifling and momentary degree of spasmodic action, or, indeed, of irritation of any kind, as the direct result of such application. But it may be asked what evidence I have that the larynx has really been entered? I reply, that by a little tact and practice, in a large proportion of cases, it is very easy so to expose the epiglottis as to enable you to *see* that the sponge passes along the pharyngeal surface of the epiglottis into the larynx. For this purpose, it is requisite that you should be provided with such an instrument as this:—It consists of a blade of plated metal bent at a right angle, and fixed into a handle. The horizontal portion of the blade is tongue-shaped, slightly hollowed on the under surface, and is about three inches and a half long and one and a quarter broad at its widest part. The vertical portion is two inches and a half long, and the handle into which it is fixed is four inches long. I am indebted to Dr. Wagstaff, of New York, for the pattern of this very convenient instrument, as well as for much valuable information on a subject to which he has paid considerable attention. By means of a spatula of this kind you may examine the fauces in any ordinary case of cynanche with far greater facility than you can by the common methods. For, in the first place, the hand of the operator does not interfere with his obtaining a full view of the fauces, and the whole aperture of the mouth is left free for manipulation with the other hand. In the next place, you obtain a perfect command over the tongue, and may thus press down the dorsum, and, at the same time, drag forward the base, so as readily to expose the tip of the epiglottis. If you do not at first succeed in fully exposing the pharynx and the tip of the epiglottis, wait a little, and allow the tendency to spasmodic action about the fauces to subside, when you will be able, without difficulty, to expose (and keep exposed almost as long as you please) the fauces so completely as to admit of your making a minute and careful examination. I must, however, reserve for another opportunity any further remarks, either on the mode of manipulation, if you are about to apply medicaments to the larynx, or on the advantages derivable from such practice.

COMMENTS ON THE

INUTILITY OF RESORTING TO THE ITALIAN CLIMATE FOR THE CURE OF PULMONARY CONSUMPTION.

(FROM PERSONAL OBSERVATION IN ITALY.)

By THOMAS BURGESS, M.D.,

TRANSLATOR OF "CAZENAVE'S MANUAL OF CUTANEOUS DISEASES," AND AUTHOR OF "THE REGIONAL PATHOLOGY OF THE SKIN."

No. I.

No greater popular delusion prevails than the belief in the existence of some undefinable specific virtue in the climate of Italy for pulmonary consumption.

Although this fallacy has been pointed out by several modern writers on climate, and although it is difficult to conceive how so unfounded and so erroneous a notion ever got possession of the public mind, yet it still prevails very exten-