and gas jet, during the progress of a virulent case of diphtheria in private. I am not aware that this idea has been systematically carried out in any hospital but that which I attend. It has been partially tried in the Town's Hospital, and in the fever-house, Royal Infirmary.

We have before us a second, and considerably enlarged edition of Dr M'Call Anderson's well known work on Parasitic Diseases of the Skin. Having reviewed the first edition in a former series of this Journal,* it only remains for us to notice some points about which there is still a difference of opinion among dermatologists as regards the true nature of these so-called parasitic affections. In order to understand the position Dr Anderson occupies, it will be necessary to indicate briefly the views of dermatologists at the present time. They may be conveniently classed under the following heads—(1), Those who, with Wilson, deny the parasitic nature of the so-called fungus; (2), Those who admit the presence of a parasite, but regard it as an accident in the course of a constitutional affection; (3), Those who, with Tilbury Fox, hold that the cause of the diseases is the presence of a parasite, and only one; and that the apparent differences in the character of the fungi and their diseases are due to different states of soil and constitution, which develop only a certain stage of the parasite; (4), Those who, with Dr Anderson, believe that soil and constitution have little influence upon the growth and development of the parasite; and that there are at least four distinct species whose presence on the human subject produces as many distinct diseases. For all practical purposes Dr Anderson's view and classification are sufficient, for we do not believe that it matters much, as far as diagnosis and treatment are concerned, whether there is one or more species.

* Glasgow Medical Journal, Vol. IX, Jan. 1862.
Dr Anderson recognises four distinct species—

The parasite of Favus . . . (Achorion Schoenleinii.)
" Ringworm . . . (Tricophyton.)
" Chloasma . . . (Microsporon furred.)
" Alopecia areata . . . (Microsporon Audouini ?)

The second and third chapters are devoted to a general and minute description of favus and the favus growth. The only varieties recognised depend upon the structures affected.

"Favus attacks three different structures of the skin—namely, the orifices of the hair follicles, the epidermis, and the nails; hence three varieties of the disease are recognised, viz.: favus pilaris, favus epidermidis, and favus ungualis." (p. 10).

"The disease generally begins with itching, followed by the appearance of the cup-shaped crusts, but in many cases the pruritus is accompanied by an erythematous state of the skin. This redness, accompanied by slight swelling and desquamation, may be diffused or circumscribed, in which latter case it forms, according to Bazin, minute circles of a very uniform diameter, which are distinguished by these two characters, their small and uniform size, from the circles of tinea circinata (ringworm of the body), which have a variable diameter, and are sometimes very large. This erythematous condition is more frequently seen when the disease extends to the body, but it is probably just as frequent on the scalp, where it is overlooked from being hid by the hairs, or the disease has passed this stage before the patients find it necessary to seek advice. The yellow crusts soon appear in the place of the erythema, or we may see the red patches at one spot and the cups at another." (p. 15).

"There is hardly any part of the body where the favus cups cannot develop themselves, because there are few parts altogether devoid of hairs. This is taking for granted that a favus cup always develops itself in the orifice of a hair follicle, which I believe to be the case." (p. 17).

If the favus cup "always develops itself in the orifice of a hair follicle," how can it form beneath the nail unless a hair has been improvised for the occasion, as in the case on the glans penis mentioned by Lebert? Now, we hold that it is not at all necessary, neither does it happen in the early stages of the disease, that one or more hairs are found in the centre of each cup, nor are the hairs associated with the cups infiltrated with spores. It was hinted in the review of the first edition that "the questionable statement about the parasite falling into the hair-follicle pointed to a somewhat different interpretation of the preliminary erythema from the true one,"—"and that favus epidermidis presents the most simple and beautiful example, not obscured by any covering, of the manner in which the parasite is sown and grows."

If Dr Anderson is correct in stating that there is a preliminary redness and itching followed by the appearance of the cup, either the redness is due to the presence of the parasite or there is a preparatory stage, as some assert, of granular or other matter
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forming a fit soil for its development. If this latter view is the true one, the disease is not essentially parasitic; if the former is held, the erythema, and consequently the parasite, affects the whole epidermis independently of hairs and hair follicles. If one of the red patches of favus epidermidis—of which Dr Anderson has given a beautiful chromolithograph—be carefully removed and examined, the outer surface will be found to consist of a very thin layer of epidermis, beneath which are irregular spaces bounded by compressed epithelium, and filled with granular cells and sometimes fragments of epithelium. In the centre of this granular mass the cup appears to develop, still covered by the superficial layer of epithelium, which gives way in the centre as the cup matures. The mature favus cup presents the following appearance in section—The basis consists of the above granular cells having the surface next the skin covered by a few layers of epidermic cells. From this granular layer fine fibres run vertically towards the surface or centre of the cup, mixed with a considerable quantity of fine granular matter, and terminating in mycelial tubes, branching and yielding spores in great abundance. At the margin of the cup these tubes have a horizontal position, and point to the centre. The surrounding epithelium rises with the cup overlapping, and apparently holding it in position. The red areola which surrounds the cup presents the same appearance as the preliminary red patches, and is continuous with the granular layer of the cup. Hairs are found in all positions, withered and transparent, but containing no spores. A quantity of the granular matter is frequently found in the sheaths, which are considerably dilated, but otherwise seem to have no definite relation to the formation of the cup. If, then, the spores are first deposited in the orifice of the hair follicle, they very soon spread, by their development in a horizontal direction, between the layers of the epidermis, producing, as we believe, the preliminary redness.

The favus cup might thus, with considerable propriety, be viewed as a single individual plant, whose habitat is between the superficial and deep layers of the epidermis, in which it lives, grows, and decays. It might be asked, as Wilson does, how can it get beneath the layers of the epidermis? The answer is, that the parasite, having once effected a lodgment, either in the hair follicle or beneath the accumulated scales, so abundant in dirty subjects, moisture and warmth will do the rest.

If the view enunciated above is the correct one, how does it bear upon the various plans of treatment which have from time to time been recommended, constitutional and local, by means of epilation, immolation, and suffocation, &c.? If the disease is, as we
believe, due to the presence of a parasite, removal or destruction is clearly the proper course. In favus of the epidermis, the removal of the red patches and cups, with their areolae, followed by a liberal use of soap and water, effects a permanent cure. In favus of the head, Dr Anderson recommends epilation, followed by the application of a parasiticide. Epilation, by clearing out the dilated sheaths filled with the granular cells of the parasite, and at the same time acting as a pretty powerful stimulant, may be of considerable value, but will not certainly reach the cells imbedded in the surrounding epidermis, and for these parasiticides are requisite.

Dr Anderson has tried carbolic acid, a well-known parasiticide, but has been disappointed in the results, for this simple reason, that parasites in the air and parasites beneath the epidermis are totally different things. We believe that the so-called parasiticides are, at the same time, powerful stimulants, and facilitate the desquamation of the epidermis containing germs, the removal of which is, in our opinion, a *sine qua non*.

The Jew’s night cap, by removing a considerable quantity of epidermis as well as hairs, when followed up by suitable applications, has produced good results in the hands of some practitioners.

Although Dr Anderson believes the local treatment capable of effecting a cure in the worst cases, he finds it sometimes necessary to correct any deviation from the natural state of the general health, recommending, at the same time, good food, pure air, and tonics. Under such treatment the results have been very satisfactory.

Under the name of *Tinea Tricophytina*, or ringworm, Dr Anderson includes ringworm of the head (*tinea tonsurans*), ringworm of the body (*tinea circinata*), ringworm of the beard (*tinea sycosis*), and a variety of tinea circinata, the so-called *eczema marginatum*. His proofs, clinical and microscopical, of the identity of the parasites are, in our opinion, incontrovertible.

This parasite attacks by preference the hair follicle and shaft, where it infests the hairy portions of the body. Dr Anderson states, that it differs from favus in having a relatively greater number of spores than tubes. The spores are also considerably larger in size than in favus. In the very elaborate engraving of the hair in sycosis, the general accuracy of which we can confirm, we miss the mycelial tubes, often empty and branching, which are frequently found imbedded in the body of the hair. The hairs of this disease are, for obvious reasons, much more friable and difficult to extract than those of favus.

Dr Anderson joins issue with Hebra on the true nature of
sycosis. The latter denies the parasitic origin of the disease, but says, if he discovered a parasite, he would simply call it ringworm of the beard. He regards sycosis as an eczema. Dr Anderson asserts that sycosis is caused by the presence of the parasite of ringworm (which he has frequently demonstrated), but admits that there is a non-parasitic disease, *eczema impetiginosum*; so that, after all, the dispute is one of mere words, and of the relative frequency of the one disease over the other. A certain Herr Kobner, who either seems to be possessed of the happy knack of detecting the parasite, or whose lines seem to have fallen in pleasant places, finds the parasite in from 63 to 69 per cent. of the cases of sycosis; and Dr Anderson, whose skill we cannot doubt, finds a large proportion parasitic. He believes the most frequent cause of the disease is a foul shave. Barbers indignantly deny this. It is not easy to see, how a razor, stropped and dipped in hot water, and applied in the most scientific manner, should be the means of transmitting the disease from one person to another. It cannot be the cause in the other forms of this disease, nor is it at all likely in so rare an affection. We should rather think dirt, and the less frequent shaving amongst the working classes—who, as a rule, enjoy the luxury of a shave and a clean face once a week—a more likely source, thus giving the five clear days required for the development of the parasite.

Cases having all the symptoms of the early stage of sycosis, itching, redness, circular patches resembling erythema circinata, with general erythema of the chin, attributed to a foul shave, are frequently met with where there is no *sycosis*, and no parasite, although the disease has existed for weeks. The truth is, that the skin of the parts usually shaved is affected with a variety of inflammatory, as well as parasitic diseases, all of which patients are in the habit of ascribing to a foul shave; consequently their testimony is worthless. Dr Anderson has succeeded in demonstrating the presence of a parasite in the so-called *eczema marginatum* of Hebra, and considers it a variety of ringworm. It is certainly a much more obstinate affection, sometimes resisting every kind of treatment for years.

It is natural to suppose that in a disease such as tinea, affecting the hair and hair follicle, epilation should form an important element in the treatment, but not, as Wilson supposes, by being "a stimulant remedy of a very effectual kind." A parasitic or suppurating follicle is a very powerful source of irritation, which epilation at once removes.

*Alopecia areata* is, as Dr Anderson thinks, of doubtful parasitic origin, although it presents all the symptoms of a parasitic disease, with this important exception, that he has not been able
to discover the parasite. We presume he has retained it out of deference to Bazin, from whose work he has reproduced a very characteristic engraving of the condition of the hair in this disease. We agree with Tilbury Fox, that the disease is essentially parasitic, but that the parasite has a very feeble hold on the epidermis and sheath of the hair, thereby frequently escaping observation. The fungus is to be detected in those hairs only which break off close to the surface of the epidermis, leaving the diseased root indicated by a black dot. If this part be extracted and carefully examined, it presents the following appearances: the epidermis surrounding the orifice of the follicle, and which is supposed to hold the hair in its position, adheres closely to the shaft, and is charged with spores and fine filaments bearing spores. Scales of epithelium, and spores adhering to the shaft, may be traced a considerable way down the follicle. The hair itself is opaque and ragged at its extremity. The bulbous appearances, sometimes seen at various points of the shaft, are not, as Bazin supposed, caused by the presence of the parasite in the body of the hair, but are simply root-cells which retain their form and size. This diseased portion of the hair does not appear to remain long in the derma, but is thrown out by a process of natural epilation, facilitated by the loosening and separation of the collar of epithelium at the orifice in which the parasite flourishes. In this way it can be easily explained why the parasite so often escapes detection. The downy hairs which replace the diseased stumps contain no trace of the parasite, partly because the disease has run its course, and a natural cure has been effected, and partly because the diseased hairs breaking off quickly, leave only healthy ones. Dr Anderson recommends epilation of the downy hairs, parasiticides and stimulants. The latter, he has found to be the most efficacious, because in most cases there is no parasite present, and the weak hairs recover, in the course of time, their natural size and vigour with, and frequently without treatment.

In the concluding chapter on vegetable parasites, the author discusses the question of identity of species. The arguments and proofs founded on clinical and other experiments are, in his opinion, conclusive as to the existence of specific differences among the parasites present in the skin diseases which affect the human subject.

The following is a summary of the proofs adduced in favour of the non-identity of the achorion schoenleinii, the tricophyton, and the microsporon furfur, the parasites met with in tinea favosa, tinea tricophytina, and tinea versicolor respectively:

(1). In all cases of successful inoculation with the achorion, tricophyton,
and microsporon furfur, the same parasitic disease has been produced as that from which the parasite was taken.

(2), Of the innumerable cases occurring in the human subject illustrative of the contagious nature of tinea favosa, tonsurans, and versicolor, which have been recorded, there is no authentic case (if we except Hutchinson's above referred to) in which one of these diseases gave rise to one of the others.

(3), The difference in the appearance of the eruptions, when fully developed, is so very striking as to lead to the belief that they are produced by separate parasites.

(4), There is no authentic instance on record of the transition of one of these diseases into one of the others.

(5), The difference in the appearance of the achorion, tricophytina, and microsporon furfur is sufficiently striking to enable the observer in many cases to form a correct diagnosis from the microscopic examination alone.

(6), Of the numerous instances on record of the transmission of tinea favosa and tinea tricophytina from the lower animals by contagion or inoculation, favus has always given rise to favus, and tinea tricophytina to tinea tricophytina." (p. 170.)

The second part of the work is devoted to the consideration of those animal parasites which attack the cutaneous envelope. The diseases produced by these insects are so thoroughly understood that they do not call for special criticism.

We have bestowed some pains on the examination of this volume, because we consider it by far the ablest work on the subject in the English language. It is written in a clear and vigorous style, the description of the diseases is lucid and lifelike, added to which the eminently practical character of the work must gain for it a very general acceptance among the profession. The book is printed in beautifully clear type, on toned paper, and its value is greatly enhanced by very excellent and truthful illustrations. Altogether it reflects great credit on the author, artists, and publisher.

II.—The Liverpool Medical and Surgical Reports. October, 1868. Edited by F. T. Roberts, M.B., B.Sc., Lond., Physician to the Northern Hospital; and Reginald Harrison, F.R.C.S., Assistant-Surgeon to the Royal Infirmary. pp. 139. London: Churchill, 1868.

A really practical and unpretentious volume like the one before us is quite a treat. There is perhaps little or nothing very new in it, but there are many papers on subjects specially interesting to the profession at the present time.

Among them, we may instance a paper by Mr Hamilton, on two amputations treated by M. Maisonneuve's method of pneumatic aspiration. This method has been described by its inventor in the Practitioner (No. 1.), and consists of drawing a
closely-fitting india-rubber hood over the end of the stump, the interior of this hood being connected with the receiver of an air-pump, so that the pressure of the air-tight hood, combined with the suction of the air-pump, may tend to draw away any fluids in the interior of the stump. This method has found little favour in this country, these two cases being respectively the second and third in which it has been tried in Britain: the first having been Mr Gamgee’s (of Birmingham) case of amputation of thigh, described in Lancet, 1867, vol. 2, pages 484 and 670. M. Maisonneuve, with an inventor's partiality for his own offspring, believes that this method will do away with pyæmia and purulent absorption, and will “prevent the dead liquids from putrifying on the surface of wounds.” But Mr Gamgee’s case died of pyæmia, and after death the femoral vein was found occluded by purulent clots—and in Mr Hamilton’s first case, an amputation of the leg, “there occurred an absorption of pus corpuscles on the third day, by the superficial layer of lymphatics, which produced a flush of redness and inflammation at the spot where further progress was arrested. . . . Again, the suppuration in the inguinal glands, commencing on the sixth day . . . was due to pus carried up by the absorbents;” and on the fifth day, when the hood was removed, the lint which enveloped the end of the stump was found “saturated with pus, which smelt abominably.” In Mr H.’s second case, an amputation of the arm, there was vomiting and other constitutional disturbance of such an alarming character, that the hood was removed on the evening of the fourth day, with immediate improvement in all the symptoms. Both these cases recovered, but the healing process does not seem to have been remarkable either for rapidity or the contrary.

Although we do not admit the correctness of M. Maisonneuve’s statement, that ninety-five per cent. of the deaths occurring after operations are due to septicæmia, still there can be no doubt of the immense mortality caused by it, which would be done away with, if one could “prevent the dead liquids from putrifying on the surface of wounds.” But that the method of pneumatic aspiration does not do this, is abundantly evident from these cases; and it seems open to many other objections, as Mr Hamilton points out in his remarks on his cases—such as causing excessive discharge, &c. Hence, we do not think that the method of pneumatic aspiration will find adherents among our hospital surgeons, in its present form at all events. Although, perhaps, we ought to judge more cautiously, and not condemn at once a method which, like this, evidently requires considerable nicety of manipulation. Much of the blame attributed to the method may be in
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reality due to defects in its application, and our judgment ought to be the more lenient when we consider that Professor Lister's antiseptic system has been a complete failure at almost all the London hospitals, and this for reasons connected with mechanical details, as is demonstrated by the present success of cases treated antiseptically at University College Hospital compared with their previous failures.

There is an admirable paper on "Local Applications to the Throat and Nostrils," by Dr Banks, formerly Demonstrator of Anatomy in our University. He insists greatly on the use of Thudicum's instrument, or some modification thereof, in all cases of ozena, and shows how, when taken in time, this troublesome complaint may be cured by directing a stream of water, medicated according to circumstances, through the nostrils, by means of this easily-used apparatus. Dr Banks suggests two surgical accidents, in which this instrument of Dr Thudicum will be often found of service, viz., in the case of impacted foreign body in the nostril, and in cases of severe epistaxis. He notices Dr Adams's modification of Seigle's steam spray-inhaler as being the best as well as the simplest and cheapest of its kind, and the portable spray-producer of Dr Brackenridge. The paper is well worth the perusal of all who wish to treat diseases of the throat and nostrils accurately and successfully.

Dr Higgins, in a brief article of a few pages on "The use of Compression in certain Surgical Cases," directs attention to a method of treating sprains, which is probably new to the profession in its present form, though Dr H. makes no strong claim to originality, and, in fact, confesses to having borrowed the original idea from the "bonesetter." He foments the sprained joint for a couple of hours—on its removal from the hot water, he dries it carefully—and proceeds at once to strap it as tightly and equally as he can, with a double layer of adhesive plaster cut in strips an inch wide. Next day (having removed the already loosened plaster of the day before) he repeats this strapping, and twice again, at an interval of two days between each time of application. The last is allowed to loosen and come off of its own accord, which it generally does in three or four days. "By which time," says Dr Higgins, "I find the patient able to use his limb, and free from pain; in short, cured." And his success, as narrated in a number of cases, is such as to induce one to try this method of treating these very troublesome and vexatious accidents, with better hope of a speedy cure than is generally attained under the ordinary treatment.

We have given a few samples of the contents of this volume of "Reports," and can assure our readers that the other papers
will be found equally readable, interesting, and instructive. Obstetrical surgery is well represented by Dr Skinner's article on "Incision of the Cervix uteri;" while Dr Inman and Dr Turnbull contribute respectively papers on Ulcer of the Stomach and on the use of Bromide of Potassium.

III.—Diseases of Children, A Clinical Treatise based on Lectures Delivered at the Hospital for Sick Children, London. By Thos. Hillier, M.D., Lond., Fellow of the Royal College of Physicians; Physician to the Hospital for Sick Children, and to University College Hospital, London. pp. 402. London: James Walton, 1868.

On the Wasting Diseases of Infants and Children. By Eustace Smith, M.D., Lond., M.R.C.P., Physician Extraordinary to His Majesty the King of the Belgians, Physician to the North West London Free Dispensary for Sick Children, and to the Metropolitan Dispensary. pp. 261, London: James Walton, 1868.

There are many indications that the diseases of children are about to receive, and indeed to some extent, are already receiving, in this country, a greater degree of attention. The establishment of children's hospitals in many, if not all, of the large centres of population, and the appropriation of special wards in the London Hospitals for the treatment of children, indicate a growing interest in this department of medicine. It is seldom that careful and frequent observations on the course of disease, and on the results of treatment strictly adhered to, are recorded on anything like an extensive scale, outside the walls of a hospital. So long, therefore, as children (at least with diseases peculiarly their own), were seldom admitted to the wards of our hospitals, it was quite natural that our conceptions of the course of their diseases, and of the importance of our treatment, should be either on the one hand, vague and loose, or on the other, definite, with that definiteness which springs from ignorance and limited experience.

We have already noticed in these pages (November, 1868) the work of Mr Holmes on the surgical diseases of children, published on his retiring from the Hospital for Sick Children, in Great Ormond Street, London, and we now propose to notice two works, which take up part at least, of the great medical branch of children's diseases. Both works are fragments: that of Dr Hillier seems to be rendered even more fragmentary, by the premature death of the author, preventing as it does, the expansion and development which the work might have undergone with his increasing experience and more reaching insight. Dr Hillier's book is essentially clinical, and he has not hesitated to sacrifice all appearances of completeness to the clinical principle. Dr Eustace
Smith aims at completeness in a limited department,—that of chronic wasting diseases, having "found that even the best systematic treatises dealt but imperfectly with the clinical condition of chronic wasting."

He accordingly devotes his first chapters to "Simple atrophy from insufficient nourishment," and to the atrophy so frequently associated with chronic diarrhoea and persistent vomiting: he then proceeds to those general diseases, rickets, syphilis, worms, and tuberculosis, whose course is strongly marked by the "wasting" of which he treats. Now, while we admit that there may be, as the author alleges, a deficiency in existing works on the first three topics, where the wasting is pre-eminently the condition to be contended with, it surely resembles an attempt at making up his book, to bring in, under this plea, diseases such as rickets and syphilis, which as affecting the child, have engaged the attention of medical, surgical, and obstetrical writers, as well as of specialists in children's diseases. No doubt, in treating of the more simple forms of wasting, it was competent to refer to the more complicated, but in the absence of more definite and personal investigations than the author has given evidence of in this volume, systematic chapters on these diseases had better, we think, been omitted. His first four chapters, however, are valuable, as treating in detail of a most important class of infantile disorders, and as giving minutely his ideas on the proper treatment. To the student or practitioner who may have seen but little of children, and who is apt to be puzzled as to what advice to give regarding suckling, weaning and feeding, in cases where the progressive wasting declares plainly that the nutrition is impaired, we can recommend this book for the fulness of its directions and the soundness of its advice.

We fully appreciate the great importance which Dr Smith attributes to the eye of the physician in the diagnosis of infantile complaints:—

"As the infant is unable to communicate his ideas by speech, the eye should be practised to gather from the expression and gestures of the child, the information he can communicate in no other way. A careful perusal of the face is, therefore, of the utmost importance."

But we must hesitate before accepting such definite rules as follow:—

"Thus, pain in the head is indicated by contraction of the brows; in the chest, by a sharpness of nostrils; and in the belly, by a drawing of the upper lip" (page 5).

As an indication of Dr Smith's accuracy of description, we give the following account of the fatal termination of chronic diarrhoea. After speaking of possible complications, the author continues:—
"When the disease terminates fatally, the child often dies from one of the above causes. Sometimes, however, he sinks and dies without our being able to say that any of these complications are present. In these cases the emaciation becomes extreme. The eyes, deeply sunken in their sockets, have a dull, ghastly look, the cheek bones project, the cheeks sink in, the nose sharpens, a furrow passes on each side from the upper part of the ala of the nose, and forms a rough semicircle round the corners of the mouth; the lips are red, cracked, and covered with sordes, and the inside of the cheek and lips, and the surface of the tongue, become aphthous, or are covered with thrush. The tongue becomes dry, and, when free from thrush, is apt to have a granular appearance from projecting papillae. The complexion is dull and earthy-looking, and the skin seems tightened over the projecting bones of the face. The fontanelle is deeply depressed. The body generally appears to consist of little more than the bones covered by the dry, rough, flaccid skin; each rib stands out sharp and distinct on the wasted chest. The belly may be flaccid, but more usually is full and prominent, as the emaciated and relaxed walls yield before the pressure of the flatus in the bowels. The skin of the abdomen becomes of a dirty-brown colour, or is speckled with brownish spots. The feet and hands are cold, and often look purple, even when not actually cold to the touch. The child lies quiet, with eyes half closed and dim. Occasionally he draws up the corners of his lips, and wrinkles his brow, as if to cry, but makes no sound; but for this plaintive sign, and for his slow, quiet breathing, he might be thought to be dead. In these cases death takes place almost without a struggle, and it is often difficult to say at what precise moment the child ceases to exist." (pp. 53, 54.)

As to treatment, Dr Smith rightly gives the first place to dietetics. No one need hope to contend with such a disease as chronic diarrhoea with wasting, without giving the most careful attention to the feeding of the child, and he must spare no pains to impress on the nurse or mother the importance of adhering to the instructions as to quantity and kind of food, and also to the frequency, time, and manner of feeding.

Cleanliness, ventilation, and warmth come next in importance. Dr Smith attaches much value to the use of the flannel bandage—"an article of clothing no infant or young child should be without."

Under the head of remedies, the only point we think worth calling attention to is the smallness of the dose recommended in ordering cod liver oil.

"For a child under two years of age, ten drops will be a sufficient dose at first. The quantity, after the first few days, can be gradually increased, but a careful watch must be kept upon the stools, and the appearance of any oil unchanged in the evacuations is a sign that the quantity must be reduced. For a child of this age we can seldom go beyond thirty drops, three times in the day." (p. 13).  

Although we think that cod liver oil is often given in too large doses, we cannot regard such small doses as being so universally demanded.

Dr Hillier's work, based on cases observed within the wards.
of Great Ormond Street Hospital, is one of much greater originality, and possesses more interest for those actively engaged in the treatment and study of children's diseases. Those who know the author by his writings on skin disease are prepared to find him the representative of the newer notions on the nature and treatment of disease. Notwithstanding the great excellence of the classical work of Dr West, and although his later editions give much more cautious advice as to depressant remedies than the earlier editions contained, there is something in his directions a little out of harmony with the newer notions of the treatment of acute disease, which are now so generally acknowledged in the case of the adult. Thus, in cases of pneumonia, which may be taken as a typical disease, Dr West recommends bleeding in the early stage, antimony "given in a dose of $\frac{1}{2}$ of a grain every ten minutes till vomiting is produced in the case of a child of two years old, and continued afterwards every two hours for a period of twenty-four or thirty-six hours," or, in other cases, "from two-thirds of a grain to a grain of calomel, combined with two grains of James's powder, may be given every six hours to a child two years old."

Dr Hillier, without denying the possibility of bleeding being sometimes useful, says:

"Usually, however, the best treatment is to keep the patient in bed, in a room about 60°, well ventilated, without a draught, to give a simple saline mixture containing citrate of potash or nitre, a milk diet during the height of the fever, and, when the temperature falls, some good beef tea. Pneumonia must be regarded as the local manifestation of a general disease in the great majority of cases. The tendency of the disease in children is towards recovery. The great point is to do nothing to interfere with a rapid convalescence. Antimony is seldom necessary or desirable. . . . I believe calomel is a drug which is not to be recommended except as an occasional aperient. . . . Wine is not often required, unless the patient be in a very cachectic state, and does not take nourishment well. It may be often given on the subsidence of fever with advantage. During convalescence, the use of iron in a mild form is of service, steel wine (Ph. L.) or ferrum redactum: quinine is also useful at this stage." (pp. 31-33.)

Such, with proper treatment for special symptoms, which Dr Hillier does not neglect to indicate, we regard as much nearer the true treatment for pneumonia in children than the so-called antiphlogistic method still practised by some.

On the causes of disease Dr Hillier is equally advanced.

"Until recently, nearly all the convulsions of infants were ascribed either to teething or to worms: it is very doubtful whether in a healthy child these causes can produce convulsions at all: in a predisposed subject they no doubt often excite them." (p. 374.)

*Lectures on the Diseases of Infancy and Childhood, by Charles West, M.D. Fifth edition, 1865; pp. 342-343.
Not only were convulsions so readily assigned as a cause, but diarrhoea, pneumonia, typhoid fever, and tuberculosis have often, there can be no doubt, been allowed to slip past under the comprehensive title of "febrile disturbance due to teething," and when convulsions ended the fever in death we had only a further confirmation of the excessive sensitivity of the fifth pair of nerves as distributed to the poor child's gums! Such ready diagnosis was a fitting basis for an almost universal treatment by the gum lancet, "grey powder" and other mercurials. This ascription of everything possible and impossible to teething is destructive of all scientific inquiry, and is unworthy of medical men, who are often too apt to give way to the ignorant prejudices of mothers on this point, and so contribute much to the mischievous popular delusion—mischievous, we say, because while many of the causes of diarrhoea, convulsions, &c., are preventible, the fatalistic assumption that "it is all the teeth" covers a multitude of sins committed against suffering infancy. We cannot forbear quoting from the report of a children's hospital with an extensive dispensary practice, in which, with considerable naïveté, the authors admit "having so far advanced in our knowledge of the true nature of such cases, that after the most careful examination, we, without hesitation, affirm that only eighteen instances of diseases due solely to the effects of dentition have come under our notice during the past twelve months," so that, while in 1860 49 cases per 1000 were referred to dentition, in 1863 the proportion was reduced to 14, and in 1866 to two cases per thousand. Truly, an instructive statement.

Diarrhoea is the most favourite case of disease alleged to be so frequently due to dentition. We have always considered that the potency of this cause could not be great, seeing that the number of teething children must be pretty equal throughout the course of the twelve months of the year, while the number of cases of infantile diarrhoea met with in the winter months is most trifling as compared with the summer and autumn seasons. (See Dr West's Lectures, p. 624.) The causes of simple diarrhoea in the adult are generally acknowledged to be mainly connected with food, climate, and locality, and we can see no reason for putting aside such influences of well known potency, to indulge in fanciful conjectures as to the influence of a tooth just piercing the gum, or of one not yet arrived at that state, but which we, in our wisdom, think ought to be arriving. Such fancies seem to us to resemble the reference of haemoplasys to a "haemorrhoidal basis," and the weakness of a phthisical woman to her suppressed menstruation. We earnestly advise the practitioner never to let himself believe
that disease is due to dentition unless the indications are irresistible, and to ply well all means of diagnosis before attributing grave morbid disturbance to a physiological process.

We recur to Dr Smith's book to quote his remarks on the relation of diarrhoea to dentition:—

"Many children are said always to cut their teeth with diarrhoea. Perhaps, however, dentition in these cases is not so entirely to blame as is commonly supposed. No doubt during the cutting of teeth the bowels generally are in a state of irritability, for we know that at these periods the follicular apparatus of the intestines is undergoing considerable development. The bowels then are ripe for diarrhoea, there is increased sensitivity to the ordinary exciting causes of purging, but without the presence of these exciting causes diarrhoea is by no means a necessary result of such a condition of the alimentary canal. We find that looseness of the bowels is a more common accompaniment of dentition in summer and autumn than in winter—that is, at a season when the changes of temperature are so rapid and unexpected, and when, therefore, the child is particularly exposed to sudden chills, rather than at a time of the year when the temperature, though lower, is more uniformly low, and when precautions are more naturally taken against the cold. Dentition too commences at a period when the child is beginning to require additional food besides that furnished by his mother's milk, and consequently at a time when he is so liable to be supplied with articles of diet unsuited to his age. Even if the diet be a suitable one for the infant when in health, it by no means follows that the same regimen will be found equally appropriate at a time when the febrile irritation set up by the advancing tooth has temporarily reduced his digestive power. His ordinary diet may then become indigestible, and therefore irritating to his bowels." (pp. 64-65.)

Dr Hillier gives in a succession of chapters his views on pneumonia and pleurisy; croup and diphtheria; rachitis and tuberculosis; chorea, paralysis, convulsions and brain affections; scarlet and typhoid fevers, with a few other diseases less fully treated. He also gives numerous cases selected, either as being typical, or as being of special interest. The cases are, as a rule, carefully recorded and condensed, and in many instances are enriched by thermometrical notes. In lobar pneumonia, the author calls attention to the sudden fall of the temperature which occurs in favourable cases about the 5th or 10th day, a fall so sudden, that we believe it is in many cases erroneously attributed to the action of some remedy used immediately before it occurs. In lobular pneumonia, he says, the normal standard is reached after three or four days' gradual sinking. We extract the temperatures from

Case 3.—Pneumonia, right upper lobe. Boy; age 8 years.

Nov. 27th—(7th day). On admission, Pulse 132; Resp. 56. Evening
Temp. 103°; Pulse, 136; Resp. 56.
" 28th—(8th day). 10 A.M. Temp. 104°.2; Pulse 132; Resp. 60.
3 P.M. " 105°.2; " 132; " 64.
9½ " 98°.6; " 108; " 52.
" 29th—(9th day). " 97°.8; " 108; " 36.
" 30th—(10th day). " 98° " 102; " 36.
This is a well marked instance of a great fall of temperature occurring within a few hours. We have ourselves seen one or two instances of equally rapid defervescence in this disease in the child. As to the diagnosis of pneumonia, the author reminds us that children suffering from this disease, as well as other diseases of the chest, frequently complain of "pain in the belly;" he remarks on the frequency of herpes of the nose and lips, although he does not regard it as necessarily of favourable import, and he alludes to the frequent insignificance of the cough. The percussion note of the upper part of the affected lung is frequently tympanitic, and is even more frequently so in the course of pleurisy. The fine crepitation so usual in the adult, is not unfrequently missing in the child, and is heard more frequently during resolution than at an earlier period. He records a case of pneumonia of the right upper lobe mistaken at first for scarlatina (on account of the presence of the red rash sometimes seen in this disease) and afterwards for hydrocephalus. "The case is an instructive one as showing the importance of carefully examining the chest in a child seized with sudden cerebral symptoms and fever." This advice is one which can scarcely be too often given.

Pleurisy, he says, is often mistaken for pneumonia, by mis-interpreting the bronchial breathing and increased vocal resonance, which, as he truly says, are not uncommon signs of this disease in the child; the usual absence of friction sound, except during absorption, increases the danger of error, while the entire absence of cough, or other indications of chest disease, frequently causes this disease to be overlooked in children. He recommends Professor Lister's antiseptic method "in the treatment of empyema requiring to be tapped. I have tried it," he adds, "in one case of left empyema in a girl aged four years, with very good effect: there was a fistulous opening for seven weeks after the operation, but the matter was never in the slightest degree fetid, the discharge ceased, and the child made a complete recovery" (p. 77.)

On the disputed question of the propriety of tracheotomy in laryngeal obstruction in croup and diphtheria, Dr Hillier is rather in favour of the operation, as giving a chance of recovery, and in fatal cases rendering death somewhat less distressing. The value of his opinion is, however, somewhat lessened by the comparative fewness of his cases.

"Dr Buchanan, of Glasgow, has saved seven out of 21 cases. In the hospital for sick children, in my own practice, I have had five recoveries out of 22 cases operated on. I believe that in well-selected cases at least 25 per cent. may be saved" (p. 148.)
As to the frequency of albuminuria in scarlet fever, Dr Hillier found it present in 47 cases out of 72. Some of these, however, had come under treatment for renal symptoms.

"There is no doubt that in different epidemics the relative number of cases of albuminuria varies. Some observers (Begbie, Holder, &c.), have found albuminuria in nearly every case—others in about one-third or half of the cases. I have found it once on the second day, twice on the fifth day, three times on the ninth day; in two other cases during the second week; twice in the third week; three times in the fourth week. Once it was present from the 11th to the 13th day, and then disappeared until the 20th day." (p. 297.)

In the chapter on Typhoid fever we have several interesting and instructive cases of this disease, which is so often mistaken for something else, or confused under the vague title of "infantile remittent," a name which, with the author, we would like to see abolished. Dr Hillier considers that in the majority of cases stimulants are required at the end of 12 or 14 days. We are inclined to endorse this opinion, as about this time, even in cases not alarmingly severe, the pulse usually becomes weak, and is inclined to be irregular and intermittent, a sign which even the most extreme of the "non-stimulating" school allow as an indication for the administration of alcohol. Intermittent pulse in children does not, however, seem to have such grave import as in the adult. Remarking on typhus, of which, however, the experience is usually small in children's hospitals, Dr Hillier usefully points out that diarrhoea seems in this disease more frequent in the child than in the adult, and that the course of the fever is usually run in a shorter period.

We have no space to notice much interesting matter to which we have not even alluded, but we can confidently recommend our readers to the book itself as being full of instruction, for the author does not select his cases to vaunt his practice, but frequently to point out errors and difficulties. Such cases are usually more instructive than multitudes of "cures." The combination of post mortem notes with clinical history must be duly appreciated by the private practitioner, who seldom has the advantage of this all-important means of extending his knowledge and correcting his ideas regarding the diseases of children.

In taking leave of the book we have again to express our regret at the death of a young physician who had shown such ability and independence in the investigation of a difficult subject.
IV.—A Practical Treatise on Bright’s Diseases of the Kidneys. By T. Grainger Stewart, M.D., F.R.S.E., &c. Edinr. 1868. 8vo, pp. 188.

This work, by the well-known author of several valuable papers on the subject to which it refers, is the fruit of researches extending over a series of years, in the pathological department of the Edinburgh Royal Infirmary. The present work is a very able and consistent attempt to set in a clear light the rather involved and difficult questions connected with the ultimate pathology of Bright’s disease; and Dr Stewart, in accordance with his opinions, rightly prefers a designation indicative of a plurality of forms, while he is moved by a sound conservative instinct, and by a regard for the great name of Dr Bright, “to preserve the memory of the illustrious discoverer in connection with his work.” The spirit which has dictated this remark will be approved by none more heartily than by those who have most carefully followed the course of modern research; and, although desiring to do every justice to the investigations on this subject which have appeared during the last quarter of a century, we agree with Dr Stewart in thinking that it is not yet possible, even were it expedient, to do away with the nomenclature so generally adopted by the profession in the first instance. The name “Bright’s disease,” not only was, and is, a convenient one in itself, but it constitutes a just tribute of admiration from the whole world, to a physician who must still be regarded as having done more to illustrate the general field of internal pathology than any other in the present century, unless it be the illustrious Laennec.

Dr Stewart recognises three forms of pathological process, essentially distinct, but occasionally found in combination, as entering into the general description of “Bright’s diseases,” i.e. of the structural diseases of the kidney attended by albuminous urine, and the other symptoms referred to by Dr Bright. These three forms he denotes as—1st, The inflammatory form; 2d, The waxy or amyloid form; 3d, The cirrhotic or contracting form. It is, perhaps, more particularly in regard to the second of these that Dr Stewart has something original to tell us; but in regard to all of them, his views are well worthy of consideration.

It will be observed that the “fatty degeneration of the kidneys,” once so much in the eyes of the profession as the chief, or (as it was once asserted) exclusive representative of Bright’s disease, disappears entirely from Dr Stewart’s nomenclature, or rather is dwarfed into a “stage of fatty transformation” pertaining to the “inflammatory form.” In this respect, Dr Stewart
follows the lead of Frerichs,* although in other particulars he would probably disown the conclusions of that eminent and able observer. It is rather disappointing to us to find that no more formal discussion of this subject appears in Dr Stewart’s work, more especially as we agree with him in thinking that “fatty degeneration” of the renal epithelium is not, per se, a form of Bright’s disease. In a supplementary chapter, there is, indeed, a brief dissertation “on the simple fatty degeneration of the kidney;” but the facts adduced are neither novel nor convincing. The relation which fatty degeneration bears to the other pathological processes, its connection, in particular, with the well-known “granulations” of Bright, and of these with the atrophic process, might, we think, have been better made out. The descriptions of individual cases are also defective as regards pathological details; and, altogether, we must frankly declare that in this portion of his work Dr Stewart has shewn an insufficient appreciation of the questions with which he had to deal. The whole course of observation on this subject, since the startling, but fallacious announcement made twenty-two years ago in the Medico-Chirurgical Transactions that fatty degeneration and Bright’s disease were identical,† has been a practical illustration of the wise caution and reserve which guided the inquiries of the great physician who first wrote of the “diseases of the kidney connected with albuminous urine and with dropsy.” The connection of the “inflammatory” with the chronic form of the disease (or diseases), the presence or absence of a congestive stage as an essential part of the process, were discussed, indeed, by Dr Bright, but were left by him as unsolved questions to his successors. Have we done anything farther to solve these questions now? Dr Stewart’s book gives us a rather imperfect and unsatisfactory answer to this question. We do not venture to say that a perfectly satisfactory answer was attainable; but the use of the word “inflammatory” as including a long series of changes ending in atrophy, required, we think, a far more complete discussion of the various opinions entertained, and also a far more complete record of facts observed, than any that appears in this volume.

Let us, however, add, that in many points we agree with Dr Stewart. It is only in a modified sense, indeed, that we can accept the term “inflammatory” as having this very wide interpretation; as covering at once the acute desquamative process following scarlet fever, and the fatty kidney with opaque granu-

* Die Bright’sche Nieren-Krankheit und deren Behandlung. Braunschweig, 1851.
† Med. Chir. Transactions, vol. 29, p. 2.
lations and dropsy, but without any decidedly acute stage. We believe, however, that in certain cases the first of these forms may gravitate into the second; and that both of them may be succeeded by an atrophic stage, as described by Frerichs and others.

The symptoms attributed to this form of Bright's disease are—diminished quantity of urine, with a large amount of albumen, often with blood, and tube casts, which in the advanced stages become granular, the urine also losing its bloody quality, and becoming greater in quantity. Dropsy takes place early, in the majority of cases. Recovery may occur after the earlier attacks; but very commonly the disease becomes chronic, and the well-known complications ending in uraemia, or in some form of pulmonary affection, bring about a fatal result. The treatment recommended by Dr Stewart is in no respect different from that commonly in use, at least in Scotland. He maintains the usefulness of diuretics up to a certain point in all stages of the disease, following in this respect the practice of Dr Christison, in opposition (and, as we think, rightly) to many of the earlier authorities.

Let us now pass to the "waxy or (so-called) amyloid form" of Bright's disease, on which, as we have already said, Dr Stewart has many valuable observations to offer. He does not, indeed, give us anything strictly new, in fact or experiment, as to the pathological or chemical nature of the "waxy" change, which he regards as being a true degeneration or transformation of tissue, rather than an infiltration. Admitting (what Dr Dickinson and others deny), the occasional production of a blue or violet colour in the waxy tissues on the addition of iodine and sulphuric acid, he nevertheless dissents from Virchow's inference that there is any truly "amyloid" character about the substance; but still retains this term "as being in general use." He adopts, in the main, the view of Kekulé and Friedreich, that the "waxy" material "is a nitrogenous substance closely allied to albumen." In general, these conclusions, derived from the most recent scientific investigations, do not differ, by so much as a single shade, from those adopted and published many years ago by the author of this review, and, therefore, we have no hesitation in agreeing with Dr Stewart at this point. He is rather inclined to adopt the still more recent, and certainly very interesting, conclusion of Dr Dickinson, that the "waxy" substance may be "de-alkalised fibrine;" but he does not on this account concede that it is to be viewed as an exudation from the blood, nor does he regard the connection of the "waxy" with the suppurrative process as invariable, though, as all admit, it is most

*Transactions of the Edinburgh Physiological Society, Monthly Journal of Medical Science, February, 1854, p. 186; and May, 1854, p. 398.
frequently associated with exhausting forms of constitutional or local disease, such as syphilis, tubercle, caries, and chronic suppuration.

The waxy degeneration commences in the vessels (often in the malpighian bodies), and in its earliest stages can only be recognised by the iodine test. By and by the small straight arteries also undergo thickening, and afterwards the whole organ becomes increased in weight, smooth on the surface, very pale, and having the peculiar colour and translucency characteristic of this degeneration. Dr Stewart affirms (what is in accordance with the majority of observations) that the tubuli uriniferi and their contents, however "waxy" looking, do not participate in the peculiar change of colour produced by iodine; and he regards the increase in bulk and weight of the kidney as due mainly to the distension of the tubules with hyaline material, probably arising from transudation, having the same causes as in the "inflammatory" form of Bright's disease. At this stage, therefore (though not necessarily in the earlier stage), the urine becomes albuminous, and the phenomena of the preceding form, including fatty degeneration of the epithelium, may be developed. To all intents and purposes, the inflammatory has supervened on the waxy degeneration, and may accompany it into the final stage of atrophy, which is common to both forms.

The clinical history of this state is so important, and seems to have been so carefully studied by Dr Stewart, that we shall give it here in his own words:—

"An individual who has long suffered from wasting disease, such as scrofula, caries, necrosis, or syphilis, or who, though without palpable disease, is of feeble constitution, feels an increasing weakness, and begins to pass large quantities of urine, and to drink largely. He is, contrary to his usual custom, obliged to rise repeatedly during the night to make water, and on each occasion passes a considerable quantity. The amount of urine varies from 50 to upwards of 200 oz. daily, always bearing a relation to the amount of fluid drunk, generally nearly equalling it in amount, sometimes even exceeding it. The feet and ankles may become oedematous after a hard day's work, but return to their natural condition during the night's repose. In many cases there is observed a hardness and swelling in the hepatic and splenic regions, dependent on an increase of bulk of the liver and spleen. The patient feels a constant lassitude and unfitness for exertion. His urine gradually becomes albuminous, and a few hyaline tube-casts are to be found in the very scanty sediment which it throws down. It is of low specific gravity, 1005 to 1015. The blood in many cases presents some peculiarities when examined microscopically, the white corpuscles being somewhat increased in number, and the red presenting a flabby appearance, with a marked tendency to tail—that is to say, instead of forming into rouleaux, like healthy corpuscles, become stretched out into a series of long oval bodies. These changes I have observed only when the degeneration affected the lymphatic or blood glands. The patient may continue in this state for months, or even years—may undergo a temporary
or perhaps even a permanent improvement—the liver and spleen becoming diminished in bulk, and the blood resuming a more healthy character. But, in a great majority of cases, no such favourable result occurs, the patient, sooner or later, becomes steadily worse, and sinks, either from the renal disease, or from one of the many maladies which accompany it.

"If from the renal disease ascites or general dropsy gradually supervenes, the urine may diminish in quantity, so as at times to be almost or altogether suppressed. It is very albuminous, but not of high specific gravity, and contains fatty and hyaline casts. Occasionally drowsiness comes on, and the disease terminates amid coma and convulsions. In such cases it is, however, as a rule, found that an inflammatory affection of the tubules has become superadded to the original degeneration of the vessels, and so the death cannot properly be referred to the waxy degeneration. But, in other instances, a fatal termination results from the accompanying maladies, perhaps most frequently from diarrhoea, a result of waxy degeneration of the intestine, from phthisis, one of the most common causes of the lesion, from exhausting discharges of chronic abscesses, or of caries, or necrosis, or from constitutional syphilis." (pp. 71-3).

"In many cases a peculiar cachexia exists, the characteristics of which are apparent at all stages of the disease. There is a pale anaemic appearance, with occasionally a little dark pigamentary matter in the skin, particularly about the eyelids, an air of general debility, and a pasty or waxy complexion. This would seem to be most commonly associated with the syphilitic form. In other cases there is a characteristic appearance of the face, with which I have become familiar, when the surface generally is pale and clear, but a very distinct congestion exists over the cheeks. This is not a congestion like a blush, but is seen by the naked eye to depend upon the distention of small vessels quite above the size of capillaries.

"The character, then, upon which we mainly depend for diagnosis are the increased flow of urine, the albuminuria, the absence of dropsy, the previous history, the complications, and the appearance of the patient." (pp. 88-9).

The observation of the urine, according to Dr Stewart, thus marks the distinguishing characters between the waxy and other forms of renal degeneration. The constantly large quantity and low specific gravity in the early stage; the insidious and gradual development of albuminuria; the frequent absence of dropsy, and the presence, on the other hand, of one or more of those exhausting forms of disease that are known to be related, pathologically, to waxy degeneration, will often serve to assure the diagnosis. Of course, care must be taken not to confound mere diabetes insipidus (much more diabetes mellitus) with waxy degeneration. The presence of scanty tube-casts, therefore, and of a small amount of albumen may be required to complete the evidence. The prognosis is not altogether bad, having regard to the renal condition alone; for the secretion of urea seems to be well maintained, and nervous complications are rather rare; but the patient usually dies exhausted from the concomitant diseases, and occasionally the urine falls very much in amount towards the close, especially if there is diarrhoea, which often proves fatal.
The treatment is mainly tonic and supporting, and includes chalybeates, with cod-liver oil, iodine, and all other special remedies required for the associated diseases. The dyspepsia is best treated by the liquor strychniae, in doses of five to ten minims several times a-day. Opium must be given when there is diarrhoea, but with due care to avoid checking the renal secretion. "Diuretics are of little service in this disease,—the urine being already excessive, their action would be injurious rather than beneficial." p. 105.

These interesting, and, in many respects, original observations, seem to be borne out by the cases annexed, in which, however, as in those before alluded to, we miss some important pathological details which we are sure Dr Stewart must have observed, though he has apparently not thought it worth while to record. It is rather provoking to meet with such deficiencies as those to which we refer, in the work of a professed pathologist. We are told, for example, in very numerous instances, that "the spleen was waxy," or "the intestines were waxy," or the liver-cells, or the malpighian bodies had "the usual appearances" in waxy disease. We have no doubt of the essential truth of most of these descriptions; but confidence is not to be won by such statements where facts are doubtful; and, moreover, the teacher of a great school ought, above all men, to set an example of accuracy in detail, and of generalising from particulars, rather than of particularising general impressions.

The cirrhotic or contracting form of Bright's disease is the last of the three main divisions of Dr Stewart's book. It is, in the main, well described, especially from the clinical side. But many persons will refuse assent to the general doctrine here promulgated, that this form consists "essentially of an hypertrophy of the connective tissue of the organ, and a consequent atrophy of all the other structures." We do not assail this statement, which is supported to a certain extent by the apparent analogy of the liver, as well as by the high authority of Virchow, but we acknowledge that we have had some difficulty in verifying it, and our difficulties are not removed by Dr Stewart. How are we to distinguish, in any particular case, atrophy determined by hypertrophy of the connective tissue, from atrophy arising as the last stage of a morbid process in the tubuli and epithelium? We confess that we should like to have had this point more fully discussed, on the basis of the facts here presented. Thus, in one of these cases (xxvii.), labelled as the cirrhotic form, there was pale, slightly albuminous urine, persistently averaging 120 oz., and never at any time less than 80 oz. in the twenty-four hours. Either, therefore, polyuria is not so characteristic of the waxy
kidney as Dr. Stewart affirms, or this was a case of originally waxy kidney, which had lost its specific characters, in a great measure, by passing into the atrophic stage. Again, another case (xxx.), given as a typical case of cirrhotic kidney in the first instance (p. 124), re-appears afterwards (p. 147) in a new phase, as a case of combined cirrhotic and inflammatory kidney, and ends shortly afterwards; when the “connective tissue was found much increased, and the substance atrophied towards the surface; the epithelium was cloudy and granular, and many of the remaining tubules were blocked up by exudation, in some parts recent, in others of older standing, and fatty.” This man had suffered from ague thirteen years before, and was gouty. Can any one assure us that he had never suffered from “inflammatory” disease of the kidneys previous to this last attack? As the “waxy” kidney is usually complicated in its later stages with “inflammatory” changes; and both waxy and inflammatory, on Dr. Stewart’s own showing, tend to atrophy, how can he be certain that there may not be forms of atrophy arising out of one or both of these conditions, in which the characters of the original disease are lost, or nearly so? We raise these doubts without professing to solve them, only for the purpose of showing at what points the inquiry seems to us still open. The clinical history of this form, except as regards its alleged connection with gout, seems to us rather ill-defined. Its great tendency to end in uraemia is well known. In respect of obscurity of origin, however, it finds a ready parallel in the cirrhosis of the liver, and we are not prepared to say that the alleged pathology of the renal affection may not be correct, although great difficulties exist in adjusting the relations between this and the other forms of Bright’s disease.

The space we have assigned to this review will, we trust, be accepted as our assurance that Dr. Stewart has written a very useful book; and although we have ventured on a few criticisms, we have done so only in the full knowledge and appreciation of the excellent work done by the author, not only in connection with the present subject, but in his admirable papers on Bronchiectasis, Acute Atrophy of the Liver, &c. &c.

V.—THE PRINCIPLES AND PRACTICE OF OBSTETRICS. By GUNNING S. BEDFORD, A.M., M.D., Professor of Obstetrics, the Diseases of Women and Children, and Clinical Obstetrics, in the University of New York, &c., (Illustrated by Four Coloured Lithographic Plates, and Ninety-nine Wood Engravings.) Fourth edition, carefully revised throughout, and enlarged. Pp. 764. New York: William Wood & Co. 1868.

This is a portly volume of nearly eight hundred octavo pages, embracing almost every subject of interest in the theory and
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practise of midwifery. It is dedicated to the Alumni and Students who have attended the author's lectures in the University of New York. As evidencing its acceptability in America, by the end of thirteen months from the first publication it had reached a third edition, and now in this the fourth edition it presents additional interesting and valuable material. Being in the form of lectures, and the style throughout clear and graphic, not unfrequently sensational, it is a very readable book, so much so that opening it at random one is tempted to read on regardless of the more systematic study of its contents. Much of these are necessarily common to all midwifery text books; such as the description of the female pelvis with its viscera, the changes produced by impregnation, the contents of the gravid uterus, the adaptation of the foetus to the maternal passages in parturition, and similar subjects.

With respect to cranial presentations he adopts generally the views of Naegele and his school. Among these, that while the relative frequency of the various cranial presentations at the outlet of the pelvis may be represented in the usual order, as First, Second, Third, and Fourth,—on the other hand, at the brim of the pelvis, the Third is next in point of frequency to the First. He makes no reference to the views more recently advocated by some authors (e. g. Velpeau, Cazeaux, West, Matthews Duncan, Paterson, Leishman) against the alleged lateral flexion or biparietal obliquity of the head as it enters the pelvic brim. These gentlemen maintain, as the result of careful observation, contrary to the view of Naegele and his followers, that the head enters the antero-posteriorly oblique plane of the pelvic brim directly, that is without any such lateral flexion, and that only as it descends it acquires a lateral obliquity relatively to the adjoining portions of the pelvic walls.

At page 63 he describes a case of protracted labour, in which he first removed by means of a probe-pointed bistoury a firm polypoid tumour attached to the posterior lip of the cervix uteri, and then completed delivery by forceps. The écraseur is now generally employed as the most available instrument in the removal of such growths. That which has a single steel wire instead of the chain or wire rope is specially efficient for fibrous uterine tumours.

His opinion as to the effects of city life on the function of menstruation is given in the following highly characteristic passage:

"How different is it with those born and educated amid the tinsel and excitement of city life! Look at our metropolis, New York, with its enterprise, its commercial prosperity, its immense wealth, its princely
edifices, more like the palaces of the old world, than the unpretending structures of an infant, but mighty republic—look, I say, at all these things—the products of successful enterprise, and indomitable energy—and then turn to the pallid cheek and wasted features of those interesting creatures who are to do the honours, and constitute the gems, of these magnificent domiciles. In this contemplation, the philanthropist will find cause enough for lamentation; he will see that city life, with its rounds of excitement, its prurient books, and no less prurient dance, has forced into premature action the nervous system of the young girl, and thus entailed upon her the melan-choly results of this contravention of the laws, which nature has declared essential to health."

With regard to the period of greatest aptitude for impregna-
tion he expresses himself thus plainly, though his opinion is not that generally held:—

"Woman, then, is most apt to become fecundated at this particular time, when the ovule, in all its development, lies on the surface of the ovary; therefore, the simple suggestion, on your part, to the husband to have intercourse with his wife just before the catamenial crisis, will very likely result in impregnation. I am quite confident I can refer to more than one instance in which I have succeeded, in this way, in adding to the happiness of parties, who, for years, had been honestly, but vainly, toiling for the accomplishment of their hopes. It is a matter of historical record, that Henry II. of France, after protracted disappointment, and almost desperate under baffled hope, consulted the celebrated Fernel as to the modus in quo of impregnating his Queen, Catherine de' Medici; the king was advised to cohabit with her royal highness only at the menstrual evolution; this counsel was scrupulously observed, and the result was the birth of an heir to the crown."

The lecture on the physiology of conception is otherwise, perhaps, one of the best in the volume. It is a very fair and interesting summary of what is known on the subject at the present day.

He considers nausea and vomiting so indispensable to healthy gestation, that when they are not experienced spontaneously, artificial means should be employed to produce them! A startling rule of practice this, regarding the benefits of which further testimony is needed. We fear that many a healthy process of gestation must, in this way, be quite unnecessarily interfered with.

"I am so well satisfied of the importance, so far as healthy gestation is concerned, of the two phenomena—nausea and vomiting—and so truly do I regard them as necessary links in the chain of processes instituted by nature for the successful accomplishment of the work of reproduction, that, when these phenomena are absent, I invariably have recourse to minute doses of ipecacuanha for the purpose of inducing an irritable condition of the stomach. In more than one instance, I have succeeded in this way, in carrying ladies to their full term, who had previously miscarried—and in whom, on inquiry, there could be detected no cause for miscarriage, except that they had experienced neither nausea nor vomiting."
The following is a remarkable instance of mistaken diagnosis in pregnancy:—

"A case occurred some years since in this city, which is well calculated not only to arrest attention, but to fix on the mind the necessity of positive knowledge in obstetric medicine, and the value of accurate diagnosis in disease. A female applied for professional advice; she had for some time previously laboured under general derangement of health, and was most solicitous for relief. The practitioner whom she consulted, being much embarrassed by the history of the case, requested the opinion of several medical friends. The consultation resulted in the unanimous decision that the patient was affected with dropsy, and it was proposed that the operation of paracentesis, or tapping, should be performed. The medical gentlemen assembled, according to appointment, and the trocar was thrust into the abdomen of the confiding woman; no fluid, however, escaping; it was, indeed, literally what has been denominated a 'dry tap,' and you may well imagine the astonishment of the spectators. A few days subsequently, the patient died from the effects of inflammation, and the autopsy revealed the interesting, but astounding fact, that the instrument, instead of passing into what was supposed to be an accumulation of fluid, was thrust into the very heart of a living foetus! What greater misfortune could befal any one of you than an error like this—to survive it, would require almost a lifetime, so far as your professional reputation is concerned, to say nothing of the stinging rebukes of conscience."

Then he instances a case of his own in which he successfully vindicated the character of a young lady, the daughter of a Church of England clergyman, from the suspicion of pregnancy, which suspicion had had the sanction of two physicians. Dr Bedford declared that the symptoms were due not to pregnancy but to the presence in the uterus of a large fibrous tumour. The young lady died of consumption, accelerated by her intense grief, and an examination of the body proved his opinion to be correct. The whole narrative is a good example of the sensational style already referred to. It is far too lengthy for transcription here, and we would refer the reader to the volume itself, but the last three sentences will illustrate what we mean:—

"It may surprise you, gentlemen, yet it is an interesting fact to communicate, for it exhibits the true and unwavering character of the man that, during the post-mortem examination, the father stood by and witnessed every stage of the operation; his form was erect, his face pale and thoughtful, and so crushed was his heart that one tear, it seemed to me, would have broken the agony of his grief. As he stood before me he was not unlike the stricken oak in the forest, which, though stripped of its branches, was yet upright and majestic. The moment I had removed the tumour from the womb he seized it convulsively, and exclaimed, 'This is my trophy; I will return with it to England, and it shall confound the traducers of my child!'"

The depraved appetite often accompanying pregnancy, as for chalk, slate pencils, &c., he considers a strong presumptive evidence of that condition. But the arguments used by him in
defence of this opinion seem disproportionately ponderous. The club of Hercules ought surely to be reserved for greater occasions than this.

"I attach more than ordinary importance, as a sign of pregnancy, to this depraved appetite, and am disposed to regard it, under certain conditions, as quite a significant circumstance. For example, if a married woman, whose general health has been uniformly good, should suddenly exhibit this morbid taste, I should be much inclined to look upon it, all things being equal, as a strong presumptive evidence of impregnation. If you ask me to explain why—my answer is, I cannot, except as a matter of observation. But there are many things, which I firmly believe, and yet cannot comprehend, except on the principle of faith. Man's belief would be sadly curtailed if he rejected everything for which he could not give a satisfactory explanation. You believe in God, and yet who among you can comprehend His infinite existence? You believe in eternity, and where is the human intellect adequate to the comprehension of the vast theme?"

As illustrative of the sympathy existing between the ovaries and mammae the following case is interesting—it also reveals one of the modes successfully adopted in the treatment of amenorrhoea, namely, the application of leeches to the groins:

"On the 11th of May, 1857, Mrs R. came to the clinic for professional advice under the following circumstances: She had been married twenty-three years; was forty-two years of age, and her only child was nineteen years old. With the exception of the period of pregnancy and lactation, her courses had always been regular, until about six months before she applied for advice; but she had within these six months become much alarmed from the occasional swelling of one of her breasts; and, on inquiry, it was ascertained that at the time the courses should have appeared, the tumefaction of the breast invariably occurred, and subsided as soon as the catamenial flow took place. There was not the slightest indication of tumour or other disease of the mamma; it was simply an example of what, perhaps, might be properly termed mammary metastasis. The patient was directed to have four leeches applied to each groin a few days before the usual time for the return of the menses, with a view of relieving the ovarian irritation. This simple suggestion had the effect of restoring the function, entirely removing the engorgement of the mamma. I have seen several cases of hypertrophy of the breasts following amenorrhoea, and the hypertrophy has always yielded on the restoration of the menstrual function."

He regards the true areola around the nipple as one of the most positive signs of pregnancy, and illustrates this part of the subject by several of Montgomery's coloured lithographic plates. Occasionally pregnancy may exist without the true areola, and a case in point is adduced. The lady had all the signs of a six months' pregnancy except those of the breast. Dr Bedford used ballottement, and on its evidence alone expressed his conviction that the lady was pregnant. She gave birth to a daughter three months afterwards. He makes no mention of having used auscultation in this case, which surely would have revealed
more than ballottement alone could regarding the presence of a six months living foetus.

He takes due notice of the fact, that for the first two months of pregnancy the abdomen instead of being prominent actually recedes, and in the hypogastric region is flatter than usual; that about the third month there is a noticeable prominence in the hypogastric region which declines at the fourth month; that from this period onwards the fulness increases, the fundus of the uterus rising higher and higher in the abdomen, until, towards the end of the ninth month, the whole organ descends and the abdomen becomes less prominent.

The lectures devoted to the evidences of pregnancy are specially worthy of note. He places great reliance, as we have seen, on the evidence afforded by ballottement, and the process itself is thus clearly described by him:

"Mode of Detecting Ballottement.—The rules for detecting this movement are simple. In the first place, the examination may be made either in the erect or recumbent position. The index finger of one hand is to be introduced into the vagina, and carried upward and backward to the portion of the uterus at which the neck and body of the organ unite—the other hand is to be applied expanded over the abdomen, for the purpose of grasping the fundus of the womb. You are then gently and suddenly to press with the index finger from below upward and from behind forward, against the body of the uterus; this pressure will usually cause a momentary ascent of the foetus, which immediately again descends, and rebounds, as it were, against the finger. This sensation, once experienced, is quite confirmatory of the condition of the female; for you must remember that the relation of the embryo to the uterus is peculiar; though lodged within the womb, yet it enjoys great capacity for motion, either active or passive, for the reason that it is surrounded by more or less amniotic fluid, which enables it to rebound to any impulses which it may receive. I know of no other condition of the uterus, either healthy or morbid, other than pregnancy, capable of producing this sensation of rebound, and therefore, when the latter is really recognised, it is an indication of pregnancy of very great import."

With respect to the pulsations of the foetal heart he of course holds, that while their being heard proves indisputably the existence of a living foetus, their not being heard does not disprove its existence. He concurs with those who hold that there is no distinction between the uterine murmur and the placental souffle, or rather that what is called the placental souffle is nothing more than the murmur of the very vascular uterine walls.

On the subject of the various causes of abdominal enlargement he has accumulated much valuable and interesting matter. As to operating in extra-uterine pregnancy he remarks—

"Should you discover, at any time, an incipient abscess in the abdomen, vagina, or rectum, etc., occasioned by the death and decomposition of the
foetus, I need not tell you that it should be promoted by warm fomentations, and, if necessary, opened, so that a passage may be afforded to the foetus; and its extraction assisted by the various instruments necessary for the purpose. Dr Campbell, in an excellent memoir on the subject, presents some interesting details. He says it is well proved by experience that, when the suppurative process is established, or a breach is actually formed in the parietes of the abdomen, the integuments may, with safety, be largely incised, or the pre-existing aperture freely dilated with success. He records thirty cases in which gastrotomy was performed, or the breech dilated, and of these, twenty-eight recovered. In twelve cases of gastrotomy, resorted to after the suppurative process was well advanced, ten were successful. In nine cases operated on, when the foetus was still alive, or soon after its death, all were fatal."

In the last volume of the Transactions of the Obstetrical Society of London, Dr Braxton Hicks, after describing a case of extra-uterine fcetation successfully treated by abdominal section, refers to certain circumstances that should regulate operative procedure in such cases. That abdominal section should not be performed unless the symptoms are urgent, nor until inflammatory adhesion seems to exist between the cyst and the peritoneum. The incision should be made within the area of adhesion, the centre of which is probably the point of greatest tenderness. The opening ought to be small, that it may not extend beyond area of adhesion, nor induce hernia. The contents of the cyst should be removed in portions, rather than that the opening be unduly enlarged, or the cyst ruptured, in which case there would be a discharge into the cavity of the abdomen almost certain to prove fatal. These views entirely corroborate those of our author on this subject.

A considerable section of the volume is taken up with practical instructions in regard to the conduct of simple and complicated labour. The posture he prefers the patient to assume during delivery is that of lying on her back, and this especially when operative measures are required, either manual or instrumental. At page 579 there is a set of woodcut illustrations of the instruments used by Dr Bedford, and among these the old scissor-shaped perforator, which we cannot but consider both awkward and dangerous, compared with the more modern instrument whose blades, opening by approximation of the handles, are quite under command.

Viewing the work as a whole, so rich in material, and so attractively written, we do not wonder that it should be a popular text-book in the medical schools of America.
Few diseases are fitter subjects for treatment than those of the urinary organs; at the same time there are none in which surgical procedures are more fruitful of evil consequences if conducted with want of care or knowledge. The general practitioner, no less than the experienced surgeon, is liable to be called upon to deal with them—especially with such as tend to obstruct the flow of urine—and he must have frequent resort to the use of instruments which demand considerable dexterity in their manipulation. The lectures, therefore, comprised in the volume before us, containing, as they do, most valuable practical instruction in regard to the diagnosis and treatment of such cases by instrumental and other means, are well worthy of being carefully read by all who take any interest whatever in the subject.

After an introductory lecture on the points to be mainly attended to in forming a diagnosis in cases of urinary disorder, Sir Henry Thompson passes on to consider “the diseases which are essentially obstructive,” viz., stricture of the urethra and enlargement of the prostate. In considering the treatment of stricture by simple dilatation and the relief of retention of urine from whatever cause, the question which comes first in order is that of the kind of instrument to be used, and Sir Henry expresses, at the outset, a very strong opinion in favour of the flexible bougie and catheter, alleging that they occasion much less irritation than others by their passage through the urethra. “The passage of an instrument,” he says, “into the urethra must per se be a source of irritation;” and again—

“Do not pass an instrument unless there is some good reason, unless there is some evil for the sake of curing which it is worth while to incur a little irritation. Acting upon this principle, you will choose such an instrument as you know by experience or otherwise to produce the least possible irritation. And this leads me to the question of the difference between solid and flexible instruments.”

A little further on he tells us that a large personal experience has taught him that “beyond all question the flexible instrument is the best—if only you know how to use it—for

* The word “solid” used throughout the work in contra-distinction to “flexible” is confusing. Of course a flexible bougie is solid, while a silver catheter, evidently meant to be included amongst “solid instruments,” is not. By “solid” we are required to understand rigid, metallic instruments.
the treatment of stricture and for all maladies of the canal, whenever it is available. I am so certain of this," he continues, "that I have no hesitation in saying that a great part of the success of any man who has much to do with this subject will depend upon his use of flexible instruments as against solid."

The objection to metallic bougies and catheters on the score of their causing too great irritation is certainly groundless, provided they be judiciously used. We find that Sir Henry Thompson, like other surgeons, passes a metallic sound into the bladder whenever symptoms of stone exist, and he gives us no warning in regard to any irritation likely to follow. Nor has he any great dread of irritating the urethra by the passage of so large and rigid an instrument as the lithotrite, even when the prostate is more or less diseased. "I make no difference whatever in respect of that matter," he says; "I would as soon crush in the case of hypertrophied prostate as in any other. It is only a question of delicate manipulation." But if the danger of irritation be a real one, surely it will be present in all its force in a case where the walls of the urethra are intensely inflamed, so much inflamed and swollen as mechanically to obstruct the flow of urine. Now, what does Sir Henry recommend in such a case? He expresses disapproval of the old system of warm-baths, opium and blood-letting, and advises the passing, without delay, of a moderate-sized gum catheter;" adding—"But in the event of the gum instrument not passing you should try a silver instrument of the same size." This surely is an admission that no great harm need be anticipated from the use of a silver instrument even when the urethra is greatly inflamed, while, at the same time, it recognises its greater efficiency, seeing it is to be resorted to under circumstances of failure with the flexible instrument. In the case of very tight stricture or of one complicated with false passage, and therefore unusually embarrassing, Sir Henry frankly admits the necessity of using rigid instruments. He says, "In cases of difficulty a small gum instrument is often not of great service. I have been advocating gum-elastic instruments as the rule, but if you have to deal with a very tight stricture and fail to pass the flexible catheter after one or two trials, you must use a small silver instrument;" and again, "when you have to deal with a very narrow stricture, take a silver instrument which you intend to guide. Do not rely upon mere groping to find the orifice." This last sentence expresses very happily the difference between the manipulation of a rigid instrument and that
of any other. In the one case we search for the orifice by \textit{guiding} an instrument, over which to its extreme point complete control is obtained by virtue of its rigidity; in the other case we "rely upon mere groping," the hand of the operator having little or no influence in directing the point of the soft and yielding instrument. On account of this superiority in the metallic instruments Sir Henry Thompson recommends their use in certain cases of difficulty, but for ordinary practice, insists on the use of the gum-elastic. We doubt the wisdom of this advice. If there be a serious risk in the employment of a rigid instrument, it is that of poking its point through the wall of the urethra, and this risk will be just in proportion to the difficulty of the case. It will most readily happen where the stricture is very tight and the instrument, therefore, very small. But it is just for such cases that Sir Henry reserves the metallic catheter or bougie, while he removes the only guarantee we have that the risk involved in its use will be understood and avoided, namely, that the operator is well practised in its manipulation. This cannot be so long as he uses gum-elastic instruments in his daily practice.

It may be taken for granted that a metallic catheter introduced into the bladder for the relief of retention, provided it be passed with ordinary skill, and without the employment of force, will cause no more irritation than a gum-elastic instrument, and will be found much more efficient. But how is it in regard to the repeated passing at intervals of a graduated series of metallic bougies through a stricture with a view to dilatation? Even this will not cause great irritation, provided the instruments are not passed oftener than every fourth day, and in some cases it may be at even longer intervals. No mistake—and we believe it is a common one—is more fatal to success in dilating strictures than the too frequent employment of bougies. It is in this way that irritation, causing aggravation instead of relief of the symptoms, is frequently produced. Sir Henry Thompson recommends that the gum-elastic instruments be used every two or three days. With metallic instruments such a course, we feel sure, would result in disappointment.

Sir Henry Thompson's method of relieving retention in cases of hypertrophied prostate is novel. Keeping in view that the obstruction is generally in the floor of the urethra, or, in other words, that the continuation of the urethra must be sought for upwards, he uses a gum-elastic instrument which has been kept "on an over-curved stylet for a month
or so." The stylet having been withdrawn, and the shaft turned back, it is introduced. In its passage down the canal, "in spite of the heat of the urethra, the catheter has a tendency to curve more instead of less," from having been kept so long in an over-curved condition. In this way its point tends to pass above the prostatic obstruction when it encounters it. "And this," we are told, "is precisely the difference between success and non-success." But even in this case Sir Henry cannot afford entirely to discard the rigid instruments. "If you fail to pass a gum-elastic instrument," he says, "by all means use a silver one. The silver prostatic catheter is sometimes essential." We believe that a silver catheter of ordinary curve and large size is the best instrument in almost all cases of prostatic obstruction. It will succeed as well as the prostatic catheter, and is free from the danger of laceration which a very long curve entails. When the obstruction is reached, the hand of the operator should depress the instrument so as to tilt its point upwards, and, if necessary, the forefinger of the left hand in the rectum will aid in still more thoroughly doing this. With the combined effect of these two movements, the catheter will generally slip onwards into the bladder. The position of the patient is important. Sir Henry tells us that in these cases, if the bladder is very much distended, we should pass the instrument with the patient in the lying position, as alarming or even fatal syncope may ensue when the urine is suddenly withdrawn from the bladder of a patient who is standing. But we believe that it is just in the case of enlarged prostate that the erect posture is of great value; for the bladder, weighty with contained urine, as well as the other viscera, by their gravity carry the prostate downwards, and thus obviate more or less the necessity of tilting the instrument very much upwards, which generally constitutes the difficulty of such cases. All danger of syncope may, of course, be avoided by passing the instrument with the patient in the erect posture, and then directing him to lie down before the urine is allowed to flow.

The treatment of stricture by rupture, and by cutting, is fully discussed, but it is evident that Sir Henry Thompson prefers dilatation to any other method. Should extravasation of urine occur, he advocates numerous and very free incisions, by which the urine is allowed to drain away, apparently making no attempt to get a catheter into the bladder. "And what happens? Why, just what happens after puncturing the bladder. When the water flows off by another passage, the urethra begins to improve, and in three or four days you
will probably have no difficulty in passing No. 3 or 4 catheter."

In the treatment of "simple urinary fistula," dilatation of the stricture which is the cause of it, is relied on for its cure. "Dilate the stricture, and in nine cases out of ten the fistula will heal."

Want of space prevents our noticing the lectures on Stone in the Bladder and its treatment, but we would recommend their perusal to all who have not read the larger work on "Practical Lithotony and Lithotrity" of the same author. The remarks they contain on the symptoms of stone, the use of the sound, and the points which must determine our selection of either operation in any given case, appear to us very judicious, while the instructions for the performance of the operations are clearly and concisely given.

The last three lectures are devoted to a consideration of Diseases of the Bladder, Haematuria, and Renal Calculus. Altogether, we esteem very highly this little work, and feel sure that, although addressed originally to students, it will be found no less to merit the attentive consideration of all practical surgeons.

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Clinical Record.

I.—CASES OF INTRAOCULAR HEMORRHAGE.

Under the care of, and Reported by, Dr George Rainy, Surgeon to the Eye Infirmary.

The following cases illustrate the rapidity with which blood effused into the interior of the eye may be absorbed. They also show that, in these cases, sudden changes in the state of vision may occur which are not proportioned in degree, or in rapidity, to the rate at which the re-absorption takes place, and which, accordingly, we must partly attribute to some other cause—probably to variations in the state of the local circulation.

Case 1. Repeated hemorrhage into the vitreous body, with repeated recoveries. —Jane G., a stout florid young woman, of about 24 years of age, consulted the late Dr Mackenzie on the 13th September, 1865, and was repeatedly seen afterwards, sometimes by Dr Mackenzie himself, and sometimes by me. When she first applied, the left eye was totally blind. The affection was of two months' duration, and had been much aggravated by the patient's stooping to lift corn. On examination with the ophthalmoscope, the fundus