valvular disease necessarily stand in any fixed causal relation; the change may be concurrent, not sequential; the resulting damage from inflammation of the endocardium lining the valve, and the dilatation of the heart from paralysis of its walls, from contiguous or continuous irritation, may proceed *pari passu*, and the hypertrophy may be altogether an ulterior condition. The morbid anatomist is constantly meeting with cases of marked dilated hypertrophy, with a very insignificant amount of valvular change, and with others, again, in which much valvular disease exists, without any greater amount of thickening of the walls than might be essential in the young to the proper maintenance of the circulation—in fact, a true conservative hypertrophy.

From this selection of cases, there are at least two, and those well marked, of musical diastolic murmur. Now, musical diastolic murmur is of itself, clinically speaking, exceedingly rare; but even excluding this fact from consideration, there are residual phenomena in these cases well worthy of consideration, and apparently difficult of explanation. In the first case, although the murmur be so loud and extensively diffused, not the slightest *frêmissement* is to be detected; and even conceding diastolic *frêmissement* to be uncommon, the same argument may be urged with respect to a diastolic musical murmur. But this latter phenomenon existing with unusually distinctive character, it is difficult to comprehend why no *frêmissement* should have been perceptible. Does it constitute a sufficient reply, to argue that in this case the great agent for its production—the contractile power of the heart—was weakened, and the elasticity of the arterial wall probably much impaired? One could scarcely rest satisfied with this reasoning, or comprehend why an impulse sufficient to engender sonorous vibrations of so marked and extensive a nature, and in such immediate proximity with the chest wall, should not have developed tactile vibration simultaneously. It must be remembered, however, that in the second case, No. 10, very marked diastolic *frêmissement* was perceptible; but here existed a powerfully acting heart, and no evidence of impaired elasticity of the arterial coat.

Having thus far discussed some of the more salient points of the cases reported, an inquiry may now be instituted into the semeiotical importance of diastolic murmur. Practical physicians have for some long time recognised the division of murmurs into those of inorganic and organic origin. But I believe that the most experienced observers are unanimous in the opinion that a diastolic murmur is never of inorganic origin; consequently, a murmur accompanying or replacing the second normal sound of the heart at once enters the domain of murmurs of organic origin. Now, theoretically speaking, a diastolic murmur may conceivably occur at both the arterial as well as at the venous *ostia*. Clinically speaking, however, a diastolic murmur at the mitral orifice is exceedingly rare, and, even should it be detected, is combined with certain peculiar characters. For example, such murmur is generally slight, profound, circumscribed, pre-diastolic as well as diastolic; while the rhythm of the heart and pulse is strikingly irregular. But if a diastolic murmur be rare at the mitral orifice, the same remark will, *à fortiori*, apply to both the arterial and venous *ostium* of the right chambers. Furthermore, if exception be made for the occurrence of diastolic murmur in some rare cases of aneurism, as pointed out by Gendrin, we may, *par voie d'exclusion*, in the immense majority of instances, generally regard a diastolic murmur, superficial, diffused, simply blowing or musical, as bearing strong testimony to the existence of regurgitation through the aortic valves; and this testimony becomes converted into direct clinical evidence, if, upon more careful examination, the murmur be found to conform to the subjoined rules.

1. Its principal *focus* is at or near the mid-sternum.
2. It ascends the aorta to the carotids, completely masking the second sounds of the aorta and pulmonary artery.
3. It is frequently audible over the whole anterior surface of the chest, masking the normal *tic-tac;* so that the rule laid down by Littré finds no constant application.
4. It is audible *in epigastrio*, masking the second normal sound; so that the rule laid down by Rayer finds no application.
5. The murmur passes with diminishing intensity to the apex, and is gradually lost towards the left axilla.

These lines of direction apply principally to the simple blowing murmur. The musical murmur, which would appear simply a higher degree of blowing, is much more widely diffused, being audible over all the posterior surface of the chest, and the entire length of the spinal column. Musical murmur is also occasionally associated with well-marked diastolic *frêmissement* and arterial thrill.

The pulse was not by any means constantly of a collapsing character in these cases; nor was such character associated with those alone in which the chambers of the heart were enlarged and thickened. Indeed, the peculiarity of the pulse in many cases appears liable to considerable variation, being some days well marked, at other times but faintly so. It is also a question whether such character of the pulse, together with marked visible pulsation of the superficial arteries, may not occur in other conditions of the circulatory system, besides patency of the aortic valves. The retardation described by Dr. Henderson was not observed.

It is also worthy of remark, that neither hypertrophy of the heart nor general symptoms appear necessarily to be coexistent with moderate insufficiency of the aortic valves.

ORIGINAL NOTES OF LONDON HOSPITALS.

DISEASES OF BONES.

A BOY, aged 12 years, recently under the care of Mr. Skey, afforded that surgeon an opportunity of displaying to his class a somewhat singular form of diseased bone. The left leg was very much larger than the right, fully an inch and a half in circumference more in extent; yet there was not a vestige of ordinary inflammation present. Mr. Skey ordered iodide of potassium in ten-grain doses, with bark, etc. Two and a half years ago, the patient said, he complained of pain in the limb; but at present it did not annoy him, except for its size. After the case had been a few days in hospital, Mr. Skey said, it presented an instance of inflammation of the medullary canal, or *inside of the bone*, without external lesion. He believed that bone may in such cases die from within; and probably in this instance such a state of things existed.

A second case in the wards exhibited the evil effects of depletion. H. B., aged 15 years, was admitted into St. Bartholomew's, December 8th, with pain in the left leg, from the knee to the ankle. The wretched young man was emaciated to an almost skeleton thinness; he was weak, worn out, and pale. Mr. Skey, in reading the notes of the case, said he had no hesitation in ascribing the boy's illness to the treatment by unskilful hands out of hospital. The young man should have had iodide of potassium and bark, with wine and generous diet, like the previous patient. As it seemed, he was quite well up to a week previous to the 8th, or the day of his admission. It appeared, however, on the 5th he had a chemist or surgeon to see the limb, who placed thirty leeches on it! The pain then suddenly increased; and on the second day after (the 7th), the same "skilful leech" applied ten more, or forty leeches in all: while during this time there were fully two pints of pus under the integuments, which Mr. Skey let out on the 8th. On the 10th, the report states, the young man, though yet emaciated to a shadow, pale, and gaunt, from his previous sufferings, was quite relieved; but the probe went up and down for some inches along bare bone. The tibia was quite exposed. He was then ordered bark, wine, and soups, to get up his strength. The tibia was bare; but, by better diet and more generous treatment, Mr. Skey hoped to have a more easy separation of the dead bone. Granulations would be thrown out: these were rather an index, he thought, of improved health, than the source of new bone; they were an "anachronism"

of Nature's; they had no business there; but they would be absorbed, and then the dead bone would come away.

INFILTRATED CANCER.

Mr. Erichsen, in removing a cancerous breast some days since, spoke of the difference between "infiltrated" scirrhus and simple adherent scirrhus. He very much feared, where infiltrated scirrhus was present—that is, infiltration of the skin of the breast, and of the mammary gland itself—that this was a bar to any operative interference. The other, or second form, so familiar to surgeons—adherent scirrhus, or simple dimpling in of the nipple—was not so formidable a disease. The surgeon should take care, however, and remove all the diseased gland, and even allow himself a good margin, so as to take away all the affected structures. The patients were usually women beyond the age of child-bearing, so that the gland could never be of any further use; and its entire removal was imperatively called for, as even the surrounding tissues too often become impregnated with the cancer elements.

OPERATIONS ON TUBERCULOUS SUBJECTS.

The question as to the propriety of surgical operations being performed where patients show a tendency to tuberculous deposit has been recently decided in the affirmative. In a case of painful chronic knee-joint disease, requiring amputation, sent up to Mr. Erichsen last month, to University College Hospital, he was unwilling to undertake the operation till a minute examination of the young man's chest had been made by Dr. Jenner. If such a patient were labouring under the advanced stages of tubercle, with emaciation, cough, and night sweats; in other words, if such a patient could not, in all human probability, live very long, from suffering under advanced consumption, it would be a question whether there would be vigour enough for the healing of surgical stumps, in addition to the strength necessary to battle against the depressing influences of the lung disease; and the surgeon should not operate. But in the present case Dr. Jenner thought the removal of the limb would remove one exciting source of irritation, as tubercle was only threatening; and as a lesser evil of the two, he advised excision of the knee rather than amputation; which was performed on the 6th ult.

OPERATION OF PHARYNGOTOMY.

This very rare operation was performed on the 21st of January, at Guy's Hospital, by Mr. Cock. As we have seen the patient several times, a short abstract of the case will be interesting. A somewhat similar operation is familiarly known as having been performed by Mr. Arnott, and given in the seventeenth volume of the *Medico-Chirurgical Transactions*.

T. G., aged 21 years, a resident of Dartford, was admitted into Guy's Hospital on the 17th January. It seemed, from the singular history of the case, that though a young man, and apparently very healthy, he had for some time worn a false tooth, fixed in a gold plate, and attached in the usual manner to the adjoining teeth. While asleep the previous night, the tooth and its plate got loose, and the patient unconsciously swallowed them both. He woke up a little after, in consequence of the pain he suffered; and a surgeon was sent for, who in vain tried to extract the offending body. The man was then brought up from Dartford to Guy's Hospital, and was at once seen by Mr. Cock, who found the tooth and plate low down in the pharynx; but he was unable to effect its extraction. The patient felt pain when he made an effort to swallow food, while liquids also met considerable resistance in deglutition.

Next day, Mr. Cock and Mr. Hilton both made attempts with a long piece of wire, doubled back, to disengage the foreign body from the pharynx, but without success. The patient was desired to keep ice constantly in his mouth; and the external parts of the neck were fomented; the patient also being kept very quiet.

Jan. 19th. Mr. Cock to-day passed a gum-elastic catheter down behind or through the ends of the doubled up plate: through this the patient was fed with beef-tea and wine; but it was still impossible to extract the plate.

Jan. 20th. It was thought better to-day to feed the patient only, and not irritate the parts.

Jan. 21st. As it was decided that pharyngotomy should be resorted to, in order to prevent any further evil effects of irritation of the parts, arrangements were made this day for the operation. Very considerable interest was excited in the hospital, and a large number came to see the operation. The patient, having been brought into the operating theatre, was placed carefully under the effects of chloroform. The operation itself, as expected by those present, was one of very considerable delicacy, and no little danger; yet, except for some unavoidable arterial hæmorrhage, it passed off most favourably.

Mr. Cock began by making a free incision from about the level of the upper border of the thyroid cartilage down to the sterno-clavicular articulation, dividing, necessarily, the skin, platysma, and cervical fascia, and wounding a small artery, which was ligatured. Mr. Cock next divided the omo-hyoid, with some fibres of the sterno-thyroid and sterno-hyoid; and drawing aside the thyroid gland, he was obliged to divide one of the branches of the superior thyroid artery. The carotid sheath was now exposed on the outside, and the thyroid gland on the inside. The former, with the sterno-mastoid, was drawn carefully aside by retractors, and the dissection continued along the outer surface of the thyroid gland; the cellular tissue being divided partly by the blade and handle of the knife, partly by the finger; the surface of the vertebræ now coming into view with the pharynx. The foreign body was next indistinctly felt through the posterior walls of the pharynx, directly behind the cricoid cartilage. The pharynx was opened here, and the knife grated against what proved to be the false tooth. The opening in the pharynx was enlarged upwards and downwards by a blunt-pointed bistoury, and the foreign body was at once seized by a pair of forceps, and drawn carefully out of the wound; a few fibres of the thyroid gland having been also divided, to allow of its exit. The patient was ultimately removed to bed, the wound left unclosed, and cold water dressings applied.

Jan. 22nd. The patient is reported to have had a good night. He is still fed with wine and beef-tea.

Jan. 26th. Improving rapidly.

Feb. 3rd. Patient seems to have got fat and improved in hospital, and speaks very gratefully of the attention and care shown him while under treatment.

SCOTT'S PLASTER.

In some affections of joints (of the knee particularly), it is very useful sometimes to get the part into as quiet a state as possible. The best plan yet known is that called Scott's plan, much used in London hospitals, viz.: Sponge the skin of the part (the knee, for instance) with spirits of camphor till the skin smarts, and looks red. Then spread an ointment, composed of equal parts of the ung. hydrargyri fort. cum camphorâ and plain ceratum saponis, on lint; cut the lint into narrow strips, and apply them freely round the knee to the part, fully four inches above and below the condyles of the femur: over this next apply soap plaster, spread on calico, cut also in strips; this may be applied for a fortnight or longer, if no pain ensues in the knee: while over the whole is rolled a bandage or roller, steeped in gum and chalk. The effect of this plan in removing pain and swelling is sometimes very remarkable. It is in particular favour at St. Bartholomew's hospital and the London Hospital, this year, in cases where it is advisable, especially in females, to give the patient every chance of recovery previous to having recourse to the knife.

OPENING THE SAC IN HERNIA.

The question of the opening or not opening the sac in hernia is beginning to be discussed more calmly and dispassionately in hospitals, now that the fashion and novelty of not opening the sac has partly worn away. A man, recently in the London Hospital, owes his life perhaps to the fact of the sac having been freely opened; and though the intestine is exposed, the patient does not seem to suffer very much.

G. D., aged 55 years, with an old hernia of some years standing, stated that, while engaged before Christmas last, he fell against a table, and injured his rupture. He went to work again, as if nothing had happened; but then began to complain of symptoms of incarceration. He was admitted October 17th into the London Hospital. The tumour was then quite irreducible. The intestine during operation gave way, and he was ill for weeks; a singular protrusion of the gut, with the remarkable and beautiful peristaltic action quite visible, continually going on. Had this accident occurred without opening the sac, and had the intestine burst into the peritoneal cavity, Mr. Adams thought that death would have been inevitable.

It is very remarkable how widely surgeons of the very first eminence differ on the question of operation with or without opening the sac. Two of the chief surgeons of the two Borough hospitals lately met together in Guy's, at the bedside of a hernia patient. One surgeon said he would not think of operating without opening the sac; to which the Guy's surgeon replied, that he could not see how his friend could even use the taxis, or return the intestine at all, without opening the sac, and seeing it; for the operation was only intended to assist the taxis. To this the St. Thomas's surgeon answered, that he thought all or a great deal of the fatality of hernia cases arose from abuse of the taxis, and a very great deal from not opening the sac, but returning mortified intestine; and that, as far as his experience went, backed by that of St. George's Hospital, Charing Cross, and others, he would in all cases open the sac early. That was the chief, if not the only point: *it would do no harm if the intestine were sound;* it would save many lives, if it were not sound, which are now sacrificed to a theory, and some imperfect statistics. The age of patients is perhaps the only other element of essential moment.

NEW NEEDLES IN CLEFT PALATE.

In one of his recent operations for cleft palate, Mr. Fergusson explained the steps of the operation, and showed three forms of needle in common use in holding the ligature. The earlier steps of the operation consisted in a free division of what Mr. Fergusson conceives to be the levator palati and palato-pharyngeus muscles by a peculiarly shaped knife, which can sink into the pterygoid fossa. Two ligatures were used, and a peculiarly formed curved needle, with a single eye, simple, like an ordinary sewing needle. A second form of needle, known as "Gibson's needle", is also occasionally used; but it "hitches" sometimes in the parts. A third needle, the most recent improvement, is a needle made by Weiss, in which a notch in the needle is converted into a closed eye by pushing up another piece. Mr. Fergusson seemed to prefer the simple needle with the simple eye.

Original Communications.

OBSTETRIC CASES IN PRIVATE PRACTICE.

By George Bellasis Masfen, Esq., Surgeon to St. Mary's Hospital, Manchester.

ON THE CONNEXION BETWEEN HYSTERIA AND OVARIAN LESION.

A short time since, I brought before the members of the Association (Journal, December 14th, 1855, page 1105) a few cases illustrative of ovarian disorder as one of the causes of hysteria. I have observed these two diseases, or rather forms of disease, so frequently associated, that I cannot but think that they have a more intimate connexion than has generally been supposed.

Though the influence of the sexual system in the production of hysteria has always occupied an important position among the various theories which have been framed on this subject, the uterus, not the ovary, has been the organ specially alluded to; and at the present day, the greater prominence which has been given to the psychological symptoms has caused this influence to be, in great measure, overlooked; at any rate, the relation between them is still somewhat obscure. Dr. Tilt speaks of hysteria as being caused by functional disorders of the ovario-uterine organs, and, again, as being a symptom of the inflammatory affections of the ovario-uterine apparatus; and my friend Dr. Whitehead relates cases of fatal hysterical apoplexy, in which the ovarian bodies were found greatly enlarged. Nevertheless, cases are recorded by eminent practitioners, in which pain referred to the ovarian region was described as merely hysterical, and in which the idea of ovarian mischief was distinctly repudiated. I purpose, therefore, from time to time, to bring forward the details of such cases as seem more particularly to bear upon the points in question. At the same time, I must not be understood as asserting that ovarian disorder is present in every subject of hysteria, for I have myself seen cases in which, though my attention has been especially directed to the subject, I could not detect any symptoms of the kind. Neither do I wish to assert that the simple treatment of a local affection is, in all cases, sufficient to produce a satisfactory result. In this, as in most other ailments, attention to the general health is the first consideration; and, in the majority of cases, occurring as they do in anæmic constitutions, the continued use of ferruginous tonics is frequently requisite.

Case. On May 1st, 1855, I was called to attend Mrs. M. E. W., a dark complexioned, healthy-looking young lady, aged 25 years, in her second confinement. At her first labour, she had been delivered of twins by a respectable neighbouring practitioner, after which she had had fever, and, as she said, her life had been despaired of; she had kept her bed for upwards of six weeks. About a month previous to my being sent for, she had fallen down stairs, and hurt herself severely, but had not called in medical aid. She remembered once or twice in the course of her life to have had a fit of hysterics, but was not generally predisposed to such symptoms, and did not consider herself hysterical.

The labour was terminated without any remarkable circumstances, except that the after discharge was rather more copious than usual; and she was delivered of a healthy male child. She continued for three or four days without any bad symptom, but after this she did not appear to gain ground. The pulse was 104, thready, and easily compressible. She complained of no pain, but did not appear to gain strength, and had no appetite. I ordered an occasional dose of colocynth and hyoscyamus, and a vegetable bitter three times a-day. She was excessively irritable and peevish, and on the 12th her state of health appeared to act so prejudicially upon the child, that I recommended her to wean it; and this proceeding was followed by a marked improvement both in it and the mother. She now began to complain of considerable pain in the back and loins, and also at the lower part of the abdomen: and on the 15th she told me that the white of an egg, which she had eaten in the morning, had come away undigested, and had caused a great deal of pain. I requested to see the next discharge of the kind, and on the 17th I was shown a watery offensive motion, containing two portions of thick glairy mucus, about equivalent in appearance and quantity to the raw white of an egg, also a few streaks of blood. I prescribed a mixture of nitro-hydrochloric acid, and ordered to be injected, every night, creasote, acetic acid, and tincture of opium, of each fifteen minims, suspended in a pint of gruel. Under this treatment she continued to improve, the bowels being relieved every other day by colocynth and hyoscyamus, as the injections were retained. The mucous discharge was repeated every three or four days in diminishing quantity, its last appearance being on June 2nd. The pain in the back and loins was quite gone, but there remained a good deal of tenderness at the lower part of the abdomen, on either side. This was increased on pressure over the region of the ovaries, the part corresponding to the uterus being quite free from pain. The former remedies were discon-