chanter was placed above and behind its natural position, as in luxation. Thus the only diagnostic signs on which we can rely are the ease with which we can rotate outwards, the greater mobility of the limb, and the power of lengthening it by a moderate force, in fractures, when compared with luxations. I need not insist on the importance of the diagnosis when we recollect that one able surgeon says that his patient died of the effects of repeated attempts made to reduce a supposed luxation; and Professor Smith's twenty-ninth case was mistaken for a luxation(*a*).

In conclusion I may remark, that, in the subject of the injury I have now described, there was a fracture of the humerus on the same side, partly within, partly without the capsular ligament, with absorption of the bone to the extent of one inch and a half; all the other bones were perfectly healthy. Both preparations are in the Museum of the Dublin School of Medicine.

ART. XII.—*On Chronic Pneumonia.* By JOHN POPHAM, A.B., M.B., Physician to the Cork North Infirmary.

THE pathology of chronic inflammation of the pulmonary tissue is still in such an unsettled state, and it is so difficult to draw the boundary line between induration of the lung arising from slow structural inflammation, and the consolidation which is met with in phthisical lungs from grey tubercular infiltration, that it is important to place on record any case which may throw even a doubtful light upon this difficult question. I venture, therefore, to submit the following, which appears to me to present some points of unfrequent occurrence bearing upon this subject; not with the view of generalizing from a single example, but in the hope that it may stimulate others to give instances of a more decided character drawn from more ample observation.

(*a*) *Loc. cit.* p. 29.

A woman, named Bridget Callanan, aged 44, was admitted into the Cork Union Hospital, April 14, 1848, with cough and dyspnœa. She was a worn-looking person, with a remarkably sallow countenance, and according to her own account she had been ill for six or seven weeks, daily becoming worse, her occupation as a fruit-seller obliging her to sit during all kinds of weather in the open air. Besides the severe cough and oppression, she complained greatly of palpitation, which caused her such distress that she was obliged to rest after taking a few steps, from a feeling of syncope coming on. On proceeding to examine her chest, my attention was drawn to a visible pulsation which existed a little below the right clavicle, at its sternal end, and which gave a strong impulse to the stethoscope. A double sound, but without any abnormal murmur, was heard over it with marked clearness. The loudness of the sounds diminished as the stethoscope receded from the seat of pulsation, until it approached the heart, when they again became fully audible. The heart, however, was not in its normal place, being felt to beat under and a little to the right of the sternum. The carotid arteries pulsated visibly, but without any bruit. A paroxysm of coughing augmented considerably both the pulsation and the sounds. On percussing the chest, dulness was found to exist from the right clavicle as far as the mamma, below which, for about two inches, the sound was morbidly clear; in this latter space respiration was inaudible, and in the part where the sonoriety of the chest was diminished it could only be heard feebly upon a forced inspiration, except immediately beneath the clavicle, where it was tubular, and the voice very loud and clear. Posteriorly, dulness and deficient respiration existed below the spine of the scapula; inferiorly and laterally, however, the sound became resonant, as it was below the mamma. At the left side the respiration was puerile, and remarkably so under the clavicle. The dyspnœa was persistent, becoming aggravated at times, but attended with little pain. Decubitus was chiefly on the right or affected side.

The cough was constant, the expectoration thin and viscid, and occasionally streaked with blood. Some œdema of the face and feet existed. Her pulse was generally over 100, sometimes rising to 120. It was curious that no loss of energy existed in the digestive organs, her appetite remaining good until a short time before death.

On reflecting upon the symptoms and physical signs of the above case, my first impression was that the disease was tubercular; still there were anomalous features which threw a doubt upon the diagnosis. The stethoscopic signs pointed clearly either to a cavity or a largely dilated bronchus under the right clavicle, and the dulness on percussion over so large a portion of the right side of the chest, and the feebleness of the respiration, approaching in some parts to complete absence, in the subjacent lobes, might be explained by copious and sudden deposition of tubercles. Still the tympanitic clearness in the infra-mammary and lateral regions, unaccompanied by the usual signs of pneumothorax, and the obvious displacement of the heart to the right side, the left lung remaining healthy, presented symptoms not usual in phthisis. Besides, the countenance of the woman had not the expression which often enables the medical physiognomist at a glance to predict tubercle; it had a sallow, greasy kind of aspect, something like the anemic appearance of a person suffering from long-existing disease of the spleen. Another embarrassing symptom was the throbbing under the right clavicle, whether it was to be regarded as aneurismal,—the concurrence of aneurism and tubercle being, as Rokitansky has observed, so rare, that he only met with five cases of tubercle in 108 of aneurism,—or whether it arose from contiguity with a solid body, presenting an exciting and unyielding surface to the pulsation of the heart and its larger vessels.

This woman continued in hospital for six weeks, death having occurred on June 3; still the progress of the case left the diagnosis unsatisfactory. The tubular respiration and pectoriloquy which were heard under the right clavicle gradually

extended over a wider area, and below this point no respiration was finally audible, showing that the solidification of four-fifths of the lung was complete. Towards the close of the case the pulsatory appearance above noticed diminished remarkably, being only appreciable upon a violent fit of coughing. The parietes of the thorax at the right side, and especially under the clavicle, became depressed. At the left side some changes also ensued, respiration of a tubular character being heard under the left clavicle, and bronchial murmurs throughout the lung. At this period dysentery came on, and being anxious to return to her friends, she imprudently, and without my sanction, made an effort to leave the hospital. She was brought back in a state of syncope, and sank rapidly afterwards. Her intellect was clear to the last.

Autopsy.—The muscular and adipose tissues of the thorax were much attenuated, while the rest of the body was not much reduced. On opening the chest, the heart lay along the sternum, encroaching considerably upon the right side. The left lung did not collapse, but, on the contrary, was greatly engorged, not only filling its own cavity fully, but pushing the mediastinal septum considerably to the right, so that when the sternum was removed, the margin of the left lung extended into the cavity of the right side. The superior portion of its upper lobe was hepatized, and contained two or three small abscesses holding pus; the rest of the lung was loaded with serum deeply tinged with blood, and the mucous membrane of the bronchial tubes was red and swollen. No adhesion of this lung existed. The right was closely united anteriorly with the costal pleura by a thick fibro-cartilaginous membrane; on dissecting this away, the lung appeared to occupy about three-fifths of the cavity, not extending beyond the right mamma. Corresponding to the parts where the sound on percussion was clearer than natural, a large space existed between the inferior surface of the lung and the liver, which viscus did not ascend into the thorax. No air was perceived to escape from this cavity, and a small

quantity of serum, with gelatinous shreds, lay at the bottom of it. On detaching the lung, it presented an ovoid form, about five inches long, by from two and a half to three in width and thickness, the widest portion being at the division of the right bronchus, whence it tapered downwards to a point. Adhesion of the lobes had occurred, so that the whole looked as if it had been fused into a mass. On trying to separate the upper lobe the knife entered a large cavity from whence issued about a couple of ounces of genuine pus. The walls were thin, and there was no false membrane lining the inner surface. The rest of the lung was converted into a firm, fleshy texture, very heavy, which, on a section being made with the knife, appeared whitish and dry, not exhibiting a trace of blood. In some parts of it the grey colour predominated, in others the blue, or rather slate colour, was interspersed. The right bronchus was greatly dilated, and its branches in proportion. The tube going to the lower lobe ended abruptly in a cul de sac; the subdivisions of the others penetrated as far as the pleura. A section of the inferior lobe exhibited scarcely a vestige of bronchial branches, but in the middle and upper lobes they appeared more numerous. No sign of tubercle, as far as we could discover, existed in either lung.

The pericardium contained a small portion of yellow serum. The heart was small and its walls flaccid, the right auricle being so much softened as to seem almost gelatinous. The aorta was rather dilated at its transverse portion, without any breach of surface either there or in any of its large vessels.

The above case presents so many points of resemblance to the affection described by Dr. Corrigan, in the thirteenth volume of the first series of this Journal, under the name of cirrhosis of the lung, that I felt some hesitation whether I should not be justified in designating it as an example of that disease. Thus the close resemblance to phthisis, which he has noticed to prevail in the symptoms and signs of cirrhosis, existed in this case, such as hemoptysis, dulness of sound, flattening of

the walls of the side affected, pectoriloquy, and bronchial respiration; while again we had in it some of the signs which he regards as contradistinctive, for example, the augmented volume of the opposite lung, and the displaced heart. But in looking to the chief morbid alteration of the lung found in Dr. Corrigan's cases, namely, dilated bronchial tubes, ending in oval or rounded pouches, a sufficiently marked difference exists; in the above example, purulent abscess at the apex being a characteristic feature. In the complemental lung, which was hypertrophied, both in Dr. Corrigan's second case and in the above, morbid changes of a similar character were noticed, indicative of chronic inflammation, viz., hepatized spots and small isolated abscesses. In the symptoms and signs, however, of the two cases, though a general similarity exists, yet there are also some important points of difference. Thus, Dr. Corrigan, in his valuable memoir on cirrhosis, marks the absence of constitutional irritation, as being in striking contrast to the intensity of the local signs; while in the present case a degree of hectic fever continued throughout, with an excited pulse. Again, the throbbing sensation under the right clavicle did not exist in any of his cases. From these circumstances, and the general appearance of the lung, the above would seem to be rather a case of chronic pneumonia, with the rare occurrence of abscess in the superior lobe. Dr. Stokes observes that he has seen several cases of chronic abscess of the lung, but he assigns the lower lobe as the seat. "An abscess, sometimes of considerable size, occupies the lower portion of the lung; its walls are firm, and of an iron-grey colour, and the surrounding lung is in the state of chronic induration"(a). But we are informed likewise, by the same high authority, that *acute* pneumonic abscess may take place in the superior lobe(b); and there would seem no adequate pathological reason, why a part of the lung occasionally liable to the acute, should be exempt from

(a) Stokes on Diseases of the Chest, p. 317. (b) *Op. cit.* p. 314.

the chronic form. Perhaps the greater degree of fever noticed in the above case, than in the instances witnessed by Dr. Stokes, may arise from the seat of the disease, inflammation of the upper lobes being, as Andral has observed(*a*), more dangerous than of the lower. We must also take into account the sympathetic fever which usually attends the formation of pus, the total inutility of one lung as a respiratory organ, and the asthenic condition of the muscular power of the heart, as concurring causes in the present case to lead us *a priori* to infer rapidity in the circulation.

The occurrence of a cavity in the upper lobe might lead to the suspicion that it was of tubercular origin; and the similarity of the physical signs of pneumonic and phthisical abscess during life, and the want of specific marks of difference in the appearance of their cavities after death, might be supposed to favour this opinion; but in the present instance, besides the purulent nature of the contents of the cavity, seemingly identical with undoubted abscess, no appreciable sign of tubercle existed in the surrounding lung, or of the tuberculous constitution in other organs. No doubt phthisical cavities occur surrounded with pneumonic induration, but sufficient traces of the scrofulous diathesis generally exist to detect their true nature.

The nature of the throbbing in the subclavian region, and its diminution as the disease advanced, renders it a sign of peculiar interest; indeed, both in strength of impulse and correspondence with the systole of the heart, it counterfeited aneurism very closely. The occurrence of pulsation as a sign of pneumonia was noticed in an interesting case bearing some resemblance to the above, published in the Dublin Hospital Report by Drs. Graves and Stokes(*b*), and there explained to arise from the impulse conveyed from the dilated right ventricle. More recently Dr. Graves has drawn attention to the same

(*a*) Clinique Médicale, translated by Spillan, p. 407.

(*b*) Dublin Hospital Reports, vol. iv. pp. 80–84.

circumstance, for which he has proposed a different explanation(a). As yet it appears to have been noticed only in pneumonia and cancer of the lung.

ART. XIII.—*On the Chronic Diseases of the Laryngeal Mucous Membrane.* By EBEN WATSON, A. M., M. D., Fellow of the Faculty of Physicians and Surgeons of Glasgow, Professor of the Institutes of Medicine in Anderson's University, &c. &c.

IT is usual to arrange the chronic diseases of the laryngeal mucous membrane according to their remote or proximate causes: but the constant plurality of such causes in the same case, and the difficulty of ascertaining with sufficient exactness to which the disease owes its origin,—a difficulty almost insurmountable in regard of remote causes,—render these and most other etiological classifications useless in practice. The cases which have occurred in my practice might, I think, be more conveniently arranged in two groups, according as the chief complaint of the patient was laryngeal cough or alteration of the voice. Doubtless, both these symptoms do sometimes occur in the same case, and at the same time; but even then it is by no means difficult to discover which is the more severe or important of the two. The patient himself, on applying for advice, at once directs attention to one or the other, as that which he would have removed, and which, being present, constitutes his disease.

I do not mean, in the following essay, to write a systematic account of the varieties of chronic laryngitis; but the fact which I have just mentioned presents itself so constantly to me in my daily experience, and appears to me so well suited to become the basis of a practical classification of these diseases, that I can-

(a) Graves' Clinical Medicine, by Neligan, vol. ii. p. 39.