24. 4. 44

Dear sir,

Thank you for your letter of 16th March for seats at the concert. I understand that they are available for £10. I have already purchased a ticket at £10. I have been asked to attend the concert on behalf of the university. I hope that you will be able to attend the concert on Saturday evening. I am looking forward to the concert.

Yours sincerely,

[Signature]
If there be need
in the dispensation
thanks in anticipa
tion and believe me
from truly

H. Wardale

J. O. M. Leland.
Addres 12 Torrington Square
‘Fibrous Plasie Bronchitis’
London.

To the Rev. Dr. B. Thud. 1885

By Henry Dartane Jr. B. Thud
Formerly Senior Assistant in Obstetric and Pathologic Anatomy. Edin. Univ.
Late Resident Field Officer
French Hospital, London.

Thus it scarcely in the whole
antology of disease, one which
is known under to many different
names as Fibrous Plasie Bronchitis.

In this country it is generally
called Bronchial Phlegm, Phlegma
Phlegma, Plasie, Bronchopneum. Fibri
mons Bronchitis and also
at times under the designation
of Rupthetitic Lung. This
latter name, however, having
been more used in France.

It is an doubt owing to its true
Pathology, being very imperfectly
known, until quite recently.

Nearly all the cases that
have been published have
been in England, Scotland
and Germany.
The French Physitians afterwards devoted much of their time and labour to the study of its true and exact pathology. Hippocrates, as far as I can ascertain, does not seem to have mentioned it in his classical works. Galen is perhaps the first one who remarked, that some of his patients, to his very great astonishment, used to expectorate a branch of the pulmonary vein, judging from his description, this could appear to be nothing else than fibrous casts. Tulpius and Plaen his master, and a Professor of Anatomy at the University of Bologna, were also of the opinion that these casts were some branches of the pulmonary vessels. Barthouin was also of the same opinion and considered with them in every respect. They were amazed and puzzled, at the thought,
that some of their patients, at times recovered and they all looked upon it as a miracle, in every sense of the word. This was at the time the current and prevalent view of the pathological nature of these fibrinous casts and all thought that they were true thrombi of the pulmonary vessels.

It was only a very long time afterwards, that any other step was made in the right direction and that they were called on the nature, the seat of their origin and the mode of formation of these casts. The first somewhat accurate description and which helped to considerably extend to attract the notice of the medical profession, was that of a certain man whose name was Clarke. His letter was adduced to as if he were present and it to be found
in the Philosophical tran-
sactions, January 14, 1779,
year 1697. The case is
shortly this: a man, a tailor
by occupation, had for 3 or
4 years, previous to that state,
been expectorating a large
amount of thin black mucus,
which, according to the descrip-
tion of Mr. Clarke, had the
appearance of little worms.
He used to cough during a
whole day before he could
expectorate one and suffered
from dreadful pains in the
chest. He was also very much
short of breath and after
the fit had lasted for some
hours he felt quite ap- 
 proxi mated. Dr. Safford thought and wrote in return, that the little
mucus which looked like
the little black mucus were
nothing else than the
viscous excretions of the
small (bronchial) glands
influenced to their size and
gave them the name of
"Polyphie. Of the lungs. This is perhaps the first accurate description of the latter that appears in the whole of the medical literature of that time. These, for a considerable number of years afterwards, were called Polyphie. Nothing was as yet known of their true pathology.

Dr. Burnett relates, in the Philosophical Transactions of the year 1700-1 Volume 2 p. 545, a case of considerable importance. At the post mortem examination, he states, that he found the pulmonary vessels normal. The lungs, according to him, consisted of the solution from the glands of the trachea and having been reduced to a jelly by the action of the putrid air, retracted the trachea and the bronchial tubes. He also, in this case, found a cast which extended from the larynx to the finest bronchial ramifications. He does not however, say whether
it was in one month lungs
at the same time.
Time that spoke, they were no
longer in this country, entitled
adventures of the Pulmonary tube.

In the Philosophical Transac-
tions of the year 1727 p. 262 Dr
Hunter gives the description of
a case, together with the operation
of the casts. He is the first
to mention that by the help
of this instrument he succeeded
to inflate the pulmonary cast,
and thus showed that they
were hollow.

I must here remark, that
the fact that these were so,
must have been known to
the Ancients. They would not
otherwise have taken the
casts, for true portions of
the Pulmonary vessels, for they
knew that vitreous were hollow
but thought that they were
always filled with air.

Richard in a letter addressed
to the President of the Royal
Society Phil. transac. year 1732.
Drunken.

The Case of Nicholas Talpinius, 1721, a 72 observation, which seems to be the one of
Dyspnea of the Lung and not a
Fortune of the Pulmonary Sticks
as Talpinius himself thought.
He also relates a case of his
own. He describes the symptoms
of his patient in a very able
and accurate manner. He
compares the latter, when
being floated in water to a
skin and having the same
extent and consistency as the
latter generally had. His pa-
ient had affected them
for seven years. Some of the
latter were quite white others
were deeply tinged with blood.
He was of opinion that the
diseased sections of the Tracheal
Glands which became con-
ecting by the heat developed
irreversibly contributed to their
formation.
In 1802, Dr. Pemberton related
in the London Medical and Surgical
Journal p. 360, the case of a sailor, who used to affectate Brachial Polypia.

Dr. Reavinge's case is also to be seen related at full length in the same journal and in the same year. He gives a very minute description of the case. He also mentions that no such case had been reported previous to his own one. This is quite a mistake on his part, and in this country at all events, it is not only Mr. Clarke's case which first attracted the notice of the Professor on the subject of Plastic Amputations.

Dr. Cheyne of Edinburgh, in the Edinburgh Medical and Surgical Journal of the year 1808, Vol. vi. p. 441, also gives the history of a case, he calls Dr. Clarke's case, a good deal to the further knowledge of the true Pathology of this rare affection. He divided the disease into
into two groups: 1st Cases where after haemoptysis, a cast is formed encompassed by pure coagulated blood which set as a mechanical agent in stopping the bleeding, the so-called "Hemorrhagic Bronchial Casts.
2nd Cases of Pure White Bronchial Phlegm. This second group is according to Cheyne manifestations of a very rare and being affection, of which very few cases have been reported. The casts he says are symptomatic of a rare disease which is usually preceded by catarrhal symptoms. He prepared them to denuded cellular tissue. He was of opinion that they were formed by denuded Bronchial Epithelium. Further knowledge on the subject has since proved that, so far as this is denuded, he was quite wrong. Just the others.
As authorities held a different view on the subject, Dr. Bäilie was of opinion that inflammation of the Perichondrial Membrane was not always irrevocably present. They thought the contrary and understood one adept that true inflammatory manifestations usually preceded the formation of the Fibrous Cyst. Dr. Bäilie, was better a very keen observer, and it is strange that he should have held such a view. Dr. John Hunter, in his treatise on the Blood (2nd Ed. 1826) gives a very good drawing of a cast effected by one of his patients. John Stark, in The London Medical Gazette of 1838 gives a full description of two cases. The cast, deemed to him, to look more like coagulated Albumen than Fibrous. He also mentions, that his two cases, together with those of
of Warren Acheson, Cheyne &
John Hunter, all deceased.
He gives a good prognosis in
such cases. I must here say
that all these were chronic.
It is obvious that he never
met with any acute cases
and perhaps thought that
such did not exist. Yet, he
says: a long time a long time
after the subsidence of the
ordinary catarhal manifes-
tations, the patient usually
begin to expectorate bronchial
casts.
Acute cases are according
to most authorities a very fatal
effect. Any form of cold was
a chronic one and I have
no personal experience of the
acute form.
Other cases have been published
by Fuller Salter and more
fully, of late by Hilton Magge.
[Pathol. Transact. Volume v, xvin
xxx.
There unimportant to give
the historical retrospect of
That the state, following state by state, the progress made from the ancient to the views which are generally held at the present time. Its pathology and anatomy have taken many a century to be stated and drawn up to the present state. There are many important and interesting points in connection with the Fibrous Plate, Periosteum, that still remain in the dark.

I shall now proceed to give the Anatomy of Fibrous Plate, Periosteum, and I must here follow the example of others, adding here and there what personal remarks I have made on the subject. I shall then relate any more lately, with its post mortem appearances of the morbidly in the morbidly intestinally, and I think especially interesting only what I personally witnessed, and without being influenced by what others have written on that part of the subject.
In conclusion I shall mention the treatment that is generally advised and the drugs which I generally found to be the first efficient in alleviating the sufferings of my patient both during the attack and in the short interval during which he was not troubled by the fits.

**Treatise**

1. Plastic Form Chute has been found to be more common in men than in women. In the male from the proportion usually given is 11 in the former to 3 in the latter. In the female from the proportion is 3 in males to 2 in females.

2. Acute Lumen is met between the 10th and 30th year of life. It seems to be oftener seen in children, for in the whole literature only 2 authentic cases are related. It has also returned in a patient 70 years old. My own case was a man of 68 years of age.
3. Ordinary Catarrh acts as a predisposing cause. What has been said that some patients have enjoyed good health previous to the appearance of the first manifestations of the disease. There is, indeed, nothing definite on this special point.

4. Hendy, several members of the same family, have in time, been affected.

5. This said to be more prevalent in the Northern countries. All the reported cases have been in England, Scotland, and Germany.

6. This more common during a certain season of the year. The end of the Spring for instance. This was true in every case. Atmospheric changes also are said to predispose to it.

7. Malarious, syphilitic, chronic, achlorhine, irritable, or predisposing causes. By lowering the state of the system. Women in childbed and while menstruating have been attacked.
It seems to me that out of the many supposed causes which I have enumerated at full length, but a single one "per se" is sufficient to cause the disease. This must, I think, be also present an element of constitutional predisposition. Thousands and thousands of people are year after year affected with neurasthenia and catarrh, yet in none of these does one meet with a case of fibrinous pleuritic pericarditis.

May I be permitted to observe, that the fluid which our patient exudated was either coagulated or became so in a shorter time than blood generally takes to undergo this process. May therefore the amount of fibrinous pleuritic pericarditis, or just the reverse of what one generally meets in pneumophlebitis, that is, the chest either coagulate very imperfectly or not at all.
(16) one, may therefore surmise, that the fibrine of the blood of patients affected with the fibrous elastic fibritis, is either in excess or that it has a greater tendency to coagulate owing to some particular or chemical change.

The fact that one meets with so many necroses and epithelial cells underlying the structure by a process of fatty degeneration, cannot satisfactorily account for such an abnormal manifestation of the coagulative properties of the fibrine. A time may come when more observation will be made that will succeed in clearing this, as yet very obscure, point. It is a mere hypothesis that I am now submitting. I was not at the time, that had the patient under my care, struck by the remark which I now venture to make.

My own case, had some of the predisposing causes which I have mentioned such as heredity,
habit, climate etc. In fact, no causes could be found.
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mental.  The patient was a
man named Timothe Petit
age. He had been
years a soldier in the
French army and had served
all his time in Africa. He
had taken no regular occupation.
He was admitted into the French Hospital, London, on the 18th of August 1873. On admission he complained of cough, shortness of breath, haemoptysis, and pains about the chest, both in front and behind between the two shoulder blades. His illness began 3 months previously, after allowing his clothes which had been soaked through with rain to dry on him. He remained after this for two days in bed and then deciding that he was not getting better consulted a medical man. He had no idea of the nature of the medicine that was given him. Since that time he had never been well and used to be troubled with occasional fits of coughing which were and again of a very severe nature. A month previous to admission he began to
Notice that after one of their fits his expectorations were
foul and blood and at times were very thick and
almost gelatinous in consistence. After one of the attacks
he used to feel better for a day or two and then he would
again suffer from another one. The attacks seemed to
increase to the sixtieth and in pregnancy. A week before
admission he felt about 4
th from June to July, dark, con-
solidated blood. He had from
then a very severe pain
across the chest and between
the two clavicles and this
tasted to him with a most
distressing cough, until he
had expectorated some very
thick and dark matter. He
then felt much relieved. The
pains disappeared and his
breathing became normal
again. Except occasional
rashes which seemed from
his description to be rheumatic,
He had always enjoyed good health. His habit had always been very regular and he never drank to any extent. There was nothing particular in his family history. His father died at the age of 78 from cerebral haemorrhage. His mother at the age of 70 from what he thinks was inflammation of the lungs. He had a sister who died in infancy. He remembers nothing about his grand parents. He had an uncle who used to suffer from asthma and who died during the year of the Franco-British war.

The patient was tall (5ft 10) and very emaciated, his weight by now was 12 stone and his asthenia was nyctopenia. His features were sharp and prominent, his malar flush somewhat paler and there was a certain fast pulse that was difficult to describe.
His appearance and ordinary expression was that of one accustomed to suffer from mental and physical pains. His lips and ears were slightly cyanotic. His face was pale and at times had a very anxious appearance. His temperture was slightly diminished. His pulse rate was dilated and more full freely with each inspiration. The veins of the neck were dilated. He had a few spots of blood on the nose and forehead. His temperature was normal.

Respiratory System.

On inspection the mobility of the chest was seen to be markedly deficient more bilaterally than unilaterally upward. The sternocostal muscles stood in rigid relief on each side of the neck and could be seen to contract on inspiration. In form and aspect the chest
On percussion the whole of the chest in front, was tym-
potic and especially on the left side and at the
junction of the ribs with the sternum. Behind remarka-
ut to well marked. The
small chested from the
right side the breath was
somewhat labored. Nothing
abnormal about the vocal
resonance and resonance.
On auscultation, there was
vivacity and increased res-
piration both in front and
behind in fact over the whole
chest. On the right side
and at the back the breath
vibrating murmurs not
very distinctly heard. Vocal
resonance seemed perhaps
here to be slightly impaired.
Some coarse and peculiarly
large respiration, to the head
on the right infra-scapular
region.
Circulatory system. The pulse
was regular, full, inexpressibly and beating at the rate of 100 per minute. The radial arteries seemed somewhat dilated and they were very tortuous. The Augebeats could be felt in the 6th fat fold just above the cartilaginous line. The heat seemed still to be there and neither the superficial nor the deep cardiac dullness could be clearly made out owing to the emphysematous state of the lungs. The ribs and other abnormal sounds prevented the cardiac ones from being heard. The alimentary system the teeth were black and the jaw that was left was decayed. The tongue was large and flabby. The papillae were very prominent and there were here and there a few superficial ulcers. They were also coated with a white fur except at the edges and
The subject presented a marked contrast to the rest of the organ. He had, he said, some difficulty at times in swallowing solid food and this seemed to have increased since the last fortnight or so. He had no marked sensations either when fasting or after meals. His appetite was good and had always been so. His bowels had always been regular. The other symptoms presented nothing abnormal.

On the 22nd of August, precisely 4 days after the patient's admission into the hospital, I was hastily summoned to go and see him. He was then suffering from intense dyspnoea and was apparently on the verge of suffocation. His face was ashen. His forehead was bathed in a profuse, cold perspiration. His eyes were hollow and sunk to such an extent that they would come out if their orbits.
The smelles of great inspiration (25) were acting powerfully. Both hypochondriacal religious acted during each inspiration. His breathing was shallow and accelerated to about 50 per minute. His voice could scarcely be heard and the patient complained of pain and a sense of pressure in the epigastrium and between the two shoulders. He was troubled with an intermittent and most harassing cough and occasionally his voice would be relieved by the expectoration of a small quantity of thick, greenish, offensive mucus. His pulse was very rapid, faintly synchronous, inextinguishable. Suddenly his face became quite black and he gasped for breath. His body was shaking with the most terrible fit of coughing that ever intimated tracheotomy seemed to have become inevitable in order that the patient's life might...
he said. However, with the utmost effort, he succeeded in expelling a little black ball, which he might say, by a cherry stone. This was followed by a couple of full handfuls of black semi-clotted blood. He felt instantly relieved and sank back exhausted.

On floating into water, the little black ball which he had just expelled, it turned out to be a perfect cast of a middle-sized bronchus with its subdividing bronchial ramifications. It was yellowish in color and measured 3½ inches in length. I must here admit, that up to now, I had not thought of the case as one of fibrous plastic anemiation. And there was no possible doubt left as to the nature of the disease.

During the attack, the inhalation of an a. e. e. mixture gave great relief to the patient. He had a fairly good
night and suppressed himself as feeling better than before the attack.

On the 23rd and 24th patient continued to spit a thick, black, tarry, mucus, black semi-coagulated blood. His breathing was much labored.

There were still numerous vomiting also violent and enormous rales to be heard all over the chest both in front and behind. Vocal resonant and sounds still slightly impaired at the back and especially at the right side. The pain across the chest and between the shoulders which troubled the patient so much had dis- appeared to a considerable extent. His voice could be better heard. During these two days he did not expectorate any casts. Pulse regular, 80

Persistant. Breathing at the rate of 30 and temper-

ature normal.
On the 25th patient died more blood than he had done on the two previous days. No change noticed. On the 26th at 9 a.m. the patient complained of some pain in the epigastrium and also of that peculiar sense of fullness, which I have before mentioned. The amount of stool that he used to defecate had been reduced to about half an ounce. The small excitation by palpation from the right side behind was somewhat dull and the respiratory movements were less distinctly heard. Flicks and coarse respirations were present both in front and behind. He complained of chilliness, his face was cold, and his breathing 40 per minute. He was extremely nervous and felt very weak. At 6 P.M. he was seized with another attack of dyspnea and suffocation. This came on very suddenly. It
Lasted about 20 minutes and (29) was cast to live as the first one had been. He also being this attack appeared to feel a sense of physical and cerebral it to as if his chest was compressed between the two laps of a railway carriage. The pain was not so severe as before. On this occasion, he perspired about 20 casts, the largest of them, although reduced one in the length and they were very soft and fine. They looked white than the large one previously estimated. He felt more exhausted than on the previous occasion. His face was pale and after the subsidence of the attack, turned a ghastly pale. On auscultation the respiratory murmurs were better heard at the back behind. Some of the coarse respirations could be longer near the heart. Samuel then mention that these respirations were different to what
one is accustomed to hear
in other Pulmonary affections.
They had a peculiar smell
of their own, great difficulty
to describe. Some authors have
called them "the Dried Air
Epiglottis." His urine was free
from albumen.

For a week after this, he still
could not complain of pains, simply
of great coldness. He could
speak to spit some fluid, this
seemed to diminish in quan-
tity, as the days passed by.
He had occasional fits of
vomiting, and in his spile
vomitus there were as casts
to the small. His temperature
all the time was normal.

On the morning of the 20th
of September, the patient
complained of pains and
also of purura across the
chest. He had not slept
very well during the night
and had that about 4
ounces of dark coagulated
blood. He seemed weaker.
and his patience had (31) an expression of great distress and anxiety. He said, that he felt that another attack was coming on. His voice and it scarcely he heard. His temperature was normal, his pulse was weak and unresilient and was beating at the rate of 90 per minute and his breathing 35. This was at 9.36 A.M., at 12 noon, there was no change in the state of patient. Respiration resumed at the night, although it was very reluctantly heard. Pelletier's carbonate of bicarbonate all over right lung. He also got the first time complained of the throat and his voice was very indistinct. At 3 P.M. the patient had an other attack and died very suddenly. By artificial respiration was tried for an hour but in vain. I thought at the time, that the patient had
seen choked by one of the Casti, acting as a foreign body and thus constricting the glottis. I shall now proceed to describe the post-mortem appearances which I observed 24 hours after death and paying special attention to the aspect and characters of the casts.

The body was subsequently dissected. Cataractae rigide present were especially in the lower cataractae. Cataractae rigide marked at the back in all adjoining regions. The thoracic cavity having been opened, all pleural adhesions were seen filling the anterior surface, that of the apex of right lung with the adjacent thoracic walls. The left lung was free. Both the upper lobe were the right upper lobe were inflated and the left one. The thoracic vessels were unrest "in life."
together with the trachea, tubes, and other organs, on shutting the latter open, a soft, invaginated, growing mass was seen infiltrating its walls and pushing the trachea forward and firmly adherent to the latter. The centre of the growth in the old phlegm was at a point exactly opposite the bifurcation of the windpipe, but extending for about an inch both above and below. It was abnormally soft. The trachea just above it, just below the bifurcation and where it was most pulled by the tumor, could hardly admit a little finger. A small, but tolerably strong, firm bundle of the right bundle of the trachee. Measurements exactly 2 inches in length and was silvery white in color. On tracing the branch to their finer divisions, one was struck with the intense congestion presented by the
while tracheal tree. No other casts were found with the exception of a very small one and this again was in one of the right tracheal tubes. Both lungs were expec-
tant but distinctly congested and the right interlobe especially so. No trace of tuber-
cles. The tracheal glands were enlarged and congested but were otherwise normal. The pericardium contained about 2 ounces of clear serum. The heart was enlarged and weighed 15 ounces. The right chamber contained about half an ounce of dark semi-coagulated blood. Left ventricle empty and contracted. Heart substance was soft, cobby and fatty. The central and arterials were atrophied, but con-
sistent. The pulmonary artery contained a long soft fluid curtain clot. Nothing worth mentioning about the other
systems. The brain and spinal cord were emphyseled and so also were the other organs. The liver was slightly cirrhotic and fatty. The appearances and nature of the casts indicated:

The casts in Plathylobites, are usually said to be either: (1) Lamellibrachell and (2) Bifurcal and then may often fill from the calyx to the finest branchial ramifications. In my case, which was a chronic one, they were most likely of the Lamellibrachell variety. They are rather adherent throughout to the branchial walls and membranes, partially or quite free. The number of the superfitted during life might have been. They may at times, at the first examination, be found to the aliment. In the case that came under my personal notice, only
The shell he found. They first appeared black, then either by immersion or by means of a little ball surrounded by a circle of a drug resembling a jet or bone. Their color after they had been floated in water was of a pale yellowish hue sometimes tinged with gold, thus giving them a gem-like appearance. The original form could be seen to evolve itself into a series of divisions and then once again resolve into smaller and smaller ramifications. The ends of these were club-like and thus showing that they had attached to the infundibula. The largest cast appeared to be 3½ inches in length. The brain stem was not thicker than a goose quill. It could be easily inflated. Bismarck has rightly remarked, that he can at a rule learn
From the base of the Casto whether it came from the
upper part-tranched in
Michi or from the
inner and near tranching
into. In any case, their origin
was from the latter source.
The upper and inner part=
ness of the Casto was
usually stiff, the middle
part always hollow, but
some wells filled in the
middle and null. The further
stream was always flat, with
its surface made wet,
shiny and smooth. There were also true bulgings
and this most likely being
caused by the rare salt
irregular deposit of pitchy
in a few section of one of the
Casto, intermittent layers of
a cavernal pitchy, the
structure was long and
true showing that the
deposit of pitchy had
faken place at intervals.
The constancy of the Casto
was literally emaciated and included a certain amount of elasticity. The struck tissues were left to swell up, then...
and highly impacted. Their (34) epithelium in all the sections was flatter and more granular and gaty. Here and there they appeared to be normal but very rarely.

Bisceir found in one case the epithelium still adherent in the testis. He also put his hand on the testis to whether it was normal or otherwise. But Chay, on the other hand, related a case where no trace of the epithelium was left. These are statements entirely contradictory to each other. He found epithelium on the testis that was de-differentiated but none in the epididymis.

According to him, the cementing substance of the testis is utilized from the blood. It is at once like a sort of conglomeration made of the epithelium as was once thought. The whole process according to him is simply
The intracranial tubes were swollen and seemed to be infiltrated with serum.

The air cells were largely filled with a frothy, thick, serous fluid. The air cells appeared swollen. Some were quite distended. The air cells were thick-walled and pigmented in the same pigment. Here I may be permitted to suggest, after carefully studying the pathology of this disease, that the immediate and apparent cause of a parotid swelling is due to the fact that a "symptom" of the infiltration against which the mast cells, the latter when they resist form its attachments to the intracranial tissues, membrane, would cause the same irritation as what a foreign body
When fluid in the air bag over the coats generally causes the little growths, i.e., the cysts and the thick membrane which underlies them, epithelial tissue which has undergone fatty degeneration is generally seen in great quantity. This fact would give a certain amount of justifiability to the hypothesis which I now venture to submit.

A few words, perhaps, about the aetiologic and complication of fibroid placetic amebhites before coming to its first important point, i.e., its treatment. I may before going any further cautiously admit, that in the case I have related, placetic amebhites was never thought of till the patient had, after a serious illness, which is, truly, the only pathognomonic sign of a disease, and one is not justified in diagnosing the disease, until a cyst.
Has been afflicted with a headache. The patient affirms that he has been so in a previous attack. It can be made
real, and mistaken for either
1st L Foreign body or 2nd General
Catarhal Stomatitis. The
history of the case must be
carefully studied. It has
also been taken for Cephal,
Pneumothorax and Pneumonia.
The chief complications that
were present in the case that
raised were General Catarhal
Stomatitis and Empyema.
Drum's state that such
cases, are never followed by
tuberculous. Please and explain
why this should be so. The
same statement has been
once made in a different study. It
may only be a mere coinci-
dence and nothing else.
The prognosis in the Chronic
Case, is good. The majority
of patients where no serious
complications were present
In the acute form, (437) half the number of these affection, is said to have died in the case of my patient, the epithelium of the esophagus, by pressing on the trachea and narrowing its lumen to an incredible extent, and doubt contributed to the sudden death of the patient. The growth had not yet penetrated the windpipe. I have not, though I have carefully studied the whole of the literature, met with a case where such a complication was mentioned to the patient. Fibrous plate tumours is generally met with in patients at an age when basal cancer is very rare recurrence indeed. The treatment generally adopted is: 1st. Remove the tumour, then place a rubber and prevent their formation. In the case of my patient I found that the B.L.C. mixture...
I gave him an immediate relief during the attack. Then I was certain that the case was one of Typhoid Malaria. I asked to inspect 1 teaspoonful of the hypertonic solution of hyposmotic syrup, inhaling it into the nose while the patient was exhaling 1 tablespoon of true water, as is generally recommended in these cases, and thus with an apparent relief to the distressing symptoms of any patient. The attacks were, by their nature, very much shortened. During the interval and to prevent the recurrence of the attack, he used to inhale true water 4 or 5 times a day, for 15 minutes at a time. I also gave two capsules of 15 minims each every 3 hours. This seemed to extend the duration of the attack. The patient was not able to eat or drink anything smaller amount. Then, for the sake of improvement, the treatment
was stopped for a day or two, the expectoration again became very profuse and the quantity increased. This being in this case, proved itself to be very useful. Instructed by Bichat, we also tried giving one of the paroxysms but without noticeable advantage to the patient. Wundt placed a remainder potassium iodide. Bichat, a mechanical treatment like the inhalations of lime water. I have no experience as to the efficacy of these things. Throatotomy may be undue to save the patient from a fatal termination of the disease, and in such a case, one should be prepared to operate. Intubation seems to one to be impossible and certainly in any more case it was do. There are sufficient as far as intubation is concerned.
The authors have not been
state, that every thing that
have mentioned occurring
his case, has been observed
by myself both at the Bell
Clith and at the Post Hoc,
state of animation. I have
somewhat described the
Physical and subjective
symptoms of this case at
full length, perhaps too
much so. The case for
writing of, is the rarity of
this to date and the great
interest that I took in the
case. The name of Fibrous
Plastic Masses, which
I have used and which I
venture to propose for the
designation of this affection,
seems to run in harmony with
it a true knowledge of its
Pathology and also the action
of one of its complications i.e.
the plasticity of its casts.
True of the masses, other
while, it is generally called
just on a popular foundation.