due to trauma of chemical or physiological nature—e.g., plasters, vesicants, mercury, &c., and cases due to sun exposure (heat eruption). For this class he chose the name "eczema." It was clear that the observation of the cases of mercurial dermatitis gave the chief impulse to this generalisation and influenced the description given, for Bateman recommended readers who wished to understand eczema to study works by Alley, Butter, and others on mercurial disease. So it was clear from the definition he gave that, for Willan, eczema was a traumatic, vesicular, non-infectious malady, and clearly Willan was not the founder of the eczema conception of to-day. Had his idea been followed we should possess to-day after 100 years, under the name "eczema," a most instructive and important chapter on traumatic dermatoses. The single inconsequence in the otherwise clear eczema chapter of Willan-Bateman was the admission—in addition to the two forms, eczema solare and eczema rubrum (hydrargyria)—of a third variety, eczema impetiginosum, to cover partly those cases that, starting, for instance, from a blistering plaster, spread over the body and partly those which in the form of grocers' and bricklayers' itch belonged to Willan's impetigo figurata and so to the eczema of to-day. This form was really included more on etiological than morphological grounds and, following Willan's definition, clearly did not belong to the class of eczema. The mention of these chronic occupation diseases that showed diffuse inflammation and notable itching and that were hard enough even now to separate from eczema proved in fact an Achilles' heel. Plumbe (1827) was a strict Willanist, stricter than Bateman, for he rejected Bateman's third variety, eczema impetiginosum. He was the last true follower of Willan, not only in England, but elsewhere. The English authors who followed came more and more under the influence of the rising Parisian school of dermatologists and notably of Rayer. Following the teaching of Biett, that Willan had erroneously only described acute eczema and had overlooked the chronic, Rayer added to the three varieties of Willan-Bateman, which, by the way, he largely remodeled, a fourth—namely, chronic eczema. This chronic eczema was an entirely new creation, pieced together by the master mind of Rayer from separate details that in Willan lay scattered principally in the chapters on Impetigo and Porrigo. His description was based on 11 cases of his own. He was the first to note and to describe the regional modifications, in which he had been since followed by most authors. This great service would have had far greater value had Rayer not mixed up his new disease with Willan's acute eczema and, in fact, taken the latter as its "acute beginning." This unhappy amalgamation was due to the fact that Rayer could not have studied Willan properly. Willan and Rayer were describing entirely different affections, and it was the failure of the last-named to appreciate this that led to most of the subsequent confusion. As a result of the French remodeling of English views on eczema it happened that a traumatic, rare, acute, not itching affection became converted into one that was non-traumatic, common, chronic, and itching. The naval surgeon Jonathan Green (1835) was the first victim of the confusion in England. He appeared to follow Willan in that he spoke of traumatic eczemas and even introduced a new one caused by sulphur, but he parted company entirely when he went on to say that such eczemas differed from the proper constitutional forms in their easy curability. Dr. Unna next referred to the early work of Erasmus Wilson (1842) and he showed that it was just a selection from other authors and that, owing to its great popularity, this book served to perpetuate the existing confusion. Anthony Todd Thompson (1850) who edited Bateman's work was a decided Willanophile, but he showed the influence of the French school when he spoke of an outer and an inner (i.e., constitutional) eczema. T. Moore Neligan (1852) drew attention to the fact that eczema of the face and scalp in children appeared in the strong as well as in the weak, in the scrofulous and in those not so tainted, in the well nourished and in the reverse. And yet he fell back on a constitutional cause for this type. Meanwhile a great step forward occurred in France. Devergie pointed out that Rayer's eczema by no means always commenced with Willan's clear-clustered vesicles and that it often did not show any vesicles in the whole of its course. Hence he separated the two and gave to Rayer's form four fresh symptoms—namely, redness, violent itching, a secretion that stained and stiffened linen, and a *status punctatus*—i.e., fine holes in the skin from which serum poured. It might be thought that, with the separation of Willan's and Rayer's eczema and with the entire removal of artificial inflammations, even as the "acute beginning" from the latter, that the *status quo ante* had been again restored. Such was not the case. Hebra, who appeared in the "sixties," had on English dermatologists even more influence than Devergie. On the strength of very insufficient experiments with croton oil and other irritants he managed to reintroduce into the eczema chapter the traumatic dermatoses that Rayer and Devergie had so carefully rejected, and his great authority covered for many years all that was untrue and incongruous in the muddle called eczema. Erasmus Wilson was entirely under Hebra's influence and this in spite of the fact that he was the first to introduce a chapter on traumatic skin affections. He freed himself, however, entirely from Willan in that he held, with Devergie, the vesicle as an inconstant, non-essential feature. Tilbury Fox (1873) believed himself a Willanist and in consequence announced his intention to oppose the authorities of his time. But his work was full of incongruities. He was no true Willanist, only the greatest Willanophile among moderns. McCall Anderson (1874) was the first, after Hebra and Wilson had already and occasionally recognised the scaling patch as the initial symptom of eczema, to declare it to be the most important form of commencement. Dr. Unna here pointed out how unfortunate it was that Rayer called his disease "eczema" and how unfair it was to ascribe to Willan the confusion that would have been avoided had his ideas been followed, and he then passed on to consider briefly his own work. Hitherto Willan's eczema alone had possessed a clear etiology, while that of Rayer was the plaything of unproved hypotheses and unfruitful theories. In 1890, before the British Medical Association in session at Birmingham, he declared Rayer's eczema on clinical grounds to be a parasitic affection. After 12 years in which he had confirmed his theory he had the satisfaction of knowing that in England Morris, in America Elliot, in France Leredde, and in Germany Bockhart, had in great part accepted and enlarged his views. Hence the future study must lie in bacteriological domains and the new century could already record a start. Possibly the progress in chemistry and physiology might be of even greater importance. Clinical study alone could do no more. It must proceed hand-in-hand with microscopical, bacteriological, and chemical investigation if the future development of the eczema conception was to be possible.—Dr. P. H. PYE-SMITH proposed, and Dr. H. WALDO seconded, a vote of thanks to Dr. Unna which was carried unanimously.

A fine collection of pictures illustrating interesting Skin Diseases was displayed. Among the exhibitors were Dr. H. RADCLIFFE CROCKER, Dr. STOWERS, Dr. E. G. GRAHAM LITTLE, Dr. E. STAINER, Mr. N. BISHOP HARMAN, and Mr. A. SHILLITOE.

Cases were sent for exhibition by Dr. STOWERS, Dr. P. S. ABRAHAM, Mr. T. H. KELLOCK, Dr. LITTLE, Dr. T. D. SAVILL, Dr. A. EDDOWES, and Mr. SHILLITOE.

CLINICAL SOCIETY OF MANCHESTER.

Enteroptosis.—The Treatment of Early Malignant Disease of the Larynx.—The Etiology and Pathology of Gall-stones.—Exhibition of Cases.

A MEETING of this society was held on May 20th, Mr. HERBERT LUND, the President, being in the chair.

Dr. ARNOLD W. W. LEA read a paper on Enteroptosis based upon observations of 54 cases met with in a series of 600 women patients. Several cases illustrating this condition were shown to the society. In enteroptosis there was, he said, general downward displacement of the viscera. The transverse colon often lay just above the symphysis and the greater curvature of the stomach might be found anywhere between the umbilicus and the pubes. The small intestines sank into the lower part of the abdomen and pelvis owing to elongation of the mesentery. Nephroptosis was present in 70 per cent. of the cases. More rarely also the liver and spleen were displaced downwards. Uterine displacements were commonly associated with enteroptosis and many cases of prolapse and chronic retroflexion occurred as part of a general ptosis of the viscera. In other instances this condition was associated with adhesions produced by pelvic peritonitis. Retroflexion was present in 42 per cent. and pelvic peritonitis with adhesions in 25 per cent. of these cases. The

etiological factors producing enteroptosis were the following: 1. Impairment of the general health and feeble muscular development. This was often associated with anæmia and dyspepsia. It might occur in young women but its frequency increased with each decade of life. 2. Increased size of the abdominal cavity, as after pregnancy, especially if repeated at short intervals with insufficient rest after delivery. This might cause (*a*) general stretching of muscular and fascial structures with impairment of elasticity or (*b*) wide separation of the muscles forming a ventral hernia. The distension produced by tumours, collections of fluid, &c., acted similarly. 3. The wearing of corsets. The compression of the waist and the weight of the skirts tended to force the viscera downwards and favoured the development of enteroptosis. Patients suffering from this condition could not wear the ordinary corset with any comfort. 4. Influence of peritonitis. The abdominal wall was relaxed and the coils of bowel distended after an attack of peritonitis. The great omentum often became adherent to the pelvis in cases of pelvic peritonitis. These adhesions might cause constant dragging on the colon, the stomach, and the intestines, producing descent of the viscera by traction. The symptoms produced by enteroptosis were very variable and did not depend on the degree of the displacement. Many patients were neurasthenic and showed evidence of general malnutrition and feeble muscular development. The most constant symptom was dragging pain in the abdomen and loins which was much aggravated by exertion and completely relieved by lying down. This appeared to be produced by dragging on the coils of bowel and mesentery and consequent irritation of sympathetic ganglia. Gastro-intestinal symptoms the result of gastro-duodenal dilatation were common. Obstinate constipation was usual, though sometimes attacks of diarrhœa occurred. The displacements of the individual organs gave rise to special symptoms referable to them. Many cases treated as moveable kidney were examples of general ptosis of the abdominal organs. Pain in the left hypochondrium was present in a large number of cases. The diagnosis was rarely difficult. The abdomen was relaxed and it bulged laterally. Marked epigastric flattening was observed if the patient stood erect. The abdominal walls were often thin and the movements of coils of bowel and of the stomach could be plainly seen. The abdominal walls might show (1) general muscular relaxation; (2) loss of elasticity and over-stretching of the fascia especially in multiparæ and elderly women; and (3) wide separation of the recti muscles. The linea alba might be from three to four inches in width. The latter was readily recognised if the patient breathed deeply whilst reclining or if attempts were made to sit up; the edges of the recti muscles then projected clearly on each side of the stretched linea alba. The stomach was frequently dilated, as shown by splashing sounds, by palpation, or by distension with gas. The liver was usually normal in position, though it might descend two inches on assuming the erect position. The kidneys showed various degrees of mobility and usually could be readily felt, although nephroptosis alone was not sufficient evidence of descent of the viscera (the right kidney could be palpated in from 45 to 60 per cent. of women). The transverse colon might be recognised much distended lying below the umbilicus. There was no certain physical sign indicating descent of the small intestines, although post-mortem evidence showed it to be usually present. In many cases aortic pulsation was very marked. The pancreas might also be felt as a flattened band lying just above the umbilicus. The treatment of enteroptosis must be directed (1) to improvement of nutrition and the removal of any causal factors, such as tight-lacing, over-exertion, &c.; (2) to the regulation of the stomach and bowels by careful dieting and medicinal treatment; and (3) to the restoration of the muscular and fascial supports of the abdominal walls. For the last-named purpose gymnastic exercises were of very great value and if carefully carried out did much to restore muscular and fascial strength to the abdominal walls. The following exercises were specially recommended: (1) the patient lying down with folded arm raises herself into a sitting posture; (2) the patient lying down and maintaining extension of the knees raises the legs to a position at right angles to the abdomen, each limb being raised singly, then simultaneously; and (3) deep breathing, especially movements of inspiration with a closed glottis, and after the lungs have been emptied by forced expiration. Each of these exercises should be carried out from six to 12 times night and morning. They were most efficient in general muscular weakness and relaxation but also were of benefit in wide separation of the recti muscles. It was usually necessary to support the abdominal wall by a properly fitting belt or binder. This must reach below the hips and the object was to lift up the abdominal viscera from below. Unless this was accomplished no relief was afforded. The straight-fronted corset which was designed to overcome suprapubic projection was specially suitable for cases of enteroptosis since the waist was not unduly compressed and the greatest pressure was applied below the umbilicus and in an upward direction. The belt and corset might also be combined in one. They should be applied whilst the patient was lying down before the viscera had descended. In some cases it was necessary to apply special pads if the patient was thin or the kidney was very mobile In some cases surgical treatment might be required. Nephrorraphy was of value if combined with treatment for the general ptosis of viscera. Hepatopexy for ptosis of the liver had been carried out with benefit. In cases of extreme gastroptosis with dilatation various operations had been practised, such as shortening of the gastro-hepatic omentum, gastrorraphy, or gastropexy. Gastro-enterostomy had been successfully performed for extensive dilatation with gastro-duodenal stenosis. Various operations might be practised on the abdominal walls, such as resection of folds of skin and fascia. The best method was to expose the edges of the separated recti muscles and to unite them in a common sheath. If there was evidence of traction from adhesions in the pelvis or elsewhere exploratory abdominal section should be carried out.

Dr. E. S. YONGE made some remarks on the treatment of Early Malignant Disease of the Larynx. He showed two patients upon whom he had operated for epithelioma, respectively nine months and eight months previously. In each instance thyrotomy, with excision of the diseased tissues, had been the procedure adopted and the results up to the time of exhibiting the patients had been excellent.

Dr. E. T. MILNER gave a brief account of the Etiology and Pathology of Gall-stones and reviewed the modern surgical treatment for the relief of this condition. He showed two patients who had undergone the operation of excision of the gall-bladder—one 13 months after cholecystotomy for empyema of the gall-bladder and gall-stones and the other a primary cholecystectomy in a woman, aged 59 years, for cholecystitis and gall-stones, with frequent biliary colic, &c. He expressed the opinion that the more radical operation of excision of the gall-bladder would ultimately prove to be justifiable in a larger proportion of cases than at present.

Dr. A. T. WILKINSON showed a case of a man with an Intrathoracic New Growth which involved the right lung and caused pressure on the superior vena cava, resulting in intense congestion of the head and neck. The apex of the lung was dull; immediately below there was natural resonance. but the lower lobe was dull. The superficial veins of the thorax and abdomen had become immensely enlarged and had to some extent relieved the blood stasis in the head and neck.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

Ascending Paralysis.

A MEETING of this section was held on May 16th, Sir CHRISTOPHER J. NIXON, the President, being in the chair.

Dr. W. J. THOMPSON exhibited a case of Ascending Paralysis. The patient had been a drayman for the last two years and came into hospital on account of weakness of his legs; he had no loss of sensation and the reaction to the faradic current was normal. Eleven days afterwards he was paralysed from his feet up to the superior border of the thorax. He could swallow fluids but not solids. He remained in this condition for weeks and then slowly recovered. At present he was able to attend to his duties and his patellar reflex had returned.

Dr. A. R. PARSONS read a paper on Ascending Paralysis. He said that the patient was suffering from what was known as "Landry's disease," one of those in which the spinal cord showed no lesion. He entered the hospital complaining of numbness of his arms and legs. He quickly became worse and in a week's time lost all power of his legs and was unable to get out of bed. He had been in the habit