sis. Here is a wax model of the lesion; they call it *syphilide palmaire*, but there is no propriety in calling it that. Now, you notice I have made this diagnosis without a word from her. I do not care whether she had the primary lesion or not; there are characteristics which are absolutely positive. You will see the spots are solid, and are erythematous, and disappear on pressure; they are not stains; they may be acute and new, and there are also some stains left from the former lesion. There is some little analgesia, or loss of sensitiveness to pain, during the early acutely developed phases of syphillis. It is more common in women than in men. I have patients on this platform into whom I could stick a pin without their knowing it. There is entire loss of sensitiveness. We have here a general diffuse papular syphilide on the face, as well as on the body, and I should suspect the face if there were none on the hands. There are features here which might be mistaken for those of acne, and might be something else; but one point would lead us to diagnosticate syphilis, and that is the scattered appearance which the lesions present —I mean covering the whole face. You see an acne group, but never see an acne on the lip in that way.

She is under the "mixed treatment." I believe in giving her a slight amount of hydrargyrum early in the disease, and I believe occasionally a little iodide added to it will help the disappearance of the eruption. She is taking a mixture with a little iodide in it, because it does hasten it, in my judgment. She has been under the treatment only a week or ten days, and the eruption is getting somewhat less than it was.

ON THE TREATMENT OF CARBUNCLE BY COMPRESSION.

Dilivered in the Hospital of the University of Pennsylvania,
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Reported by LOUIS J. LAUTENBACH, M. D.

This man has been already before some of my ward classes; but, as there are many present today who do not meet me in the wards, I am glad to have the opportunity of bringing him before you. He presents one of the most instructive cases which we have had in the hospital this winter.

This patient was admitted to the ward on Wednesday of last week, being ten days ago, with a very large carbuncle of three weeks' duration. It began as a pimple, and gradually increased in size. This is the usual history of a carbuncle: first, the presence of a pimple, which soon develops a central vesicle, and then, either with or without irritation, such as scratching or pricking with a pin, begins to spread, the carbuncle in a week or ten days attaining its maximum size, seldom more than four or five inches in diameter. Yesterday a week ago, measuring this carbuncle we found its dimensions to be nine inches by eight, independently of the large amount of indurated tissue around the livid mass itself. The dimensions of the carbuncle, including this indurated tissue, were at least eleven by ten inches, and it was fully three inches in depth.

A carbuncle is in reality nothing but a large boil: there is no absolute distinction between a furuncle and a carbuncle. This carbuncle is now smaller than it was when the patient came to the hospital, and it is subsiding every day, though up to the time of the patient's admission it had been steadily increasing in size.

There are some pecularities about the ulceration of a carbuncle which have not been understood until quite recently. It had long been observed that carbuncles were apt to ulcerate at numerous distinct points, giving the surface a sieve-like or cribriform appearance; but the anatomical explanation of this condition has only been furnished within a few years by an American surgeon, Dr. Collins Warren, of Boston. By microscopical examination of the skin of the back, where carbuncles usually occur, Dr. Warren has found little processes or tubes of fat connecting the deeper tissues with the surface; he has named these tubes the fatty columns, or *columnæ adiposæ;* and it is along these columns that the pus of the carbuncle, which originates as a phlegmon of the deep cellular tissue, begins to make its way to the surface. In this case there are as yet but two openings, which lie close together and probably will soon coalesce. A slough—what is popularly called the *core*—is beginning to protrude from one of these openings: it is a slough of the deep cellular tissue.

Carbuncle, while a very painful and annoying affection, is usually not a very dangerous one when properly treated. Death does, however, occasionally follow, and I have recently seen the statistics published by a German surgeon, who treated eleven cases of carbuncle by incision, six of these proving fatal by pyæmia. I have myself seen no death from carbuncle, nor do I recall any in the practice of other surgeons, unless in cases where there was some grave constitutional complication.

Carbuncle in one part of the body, the face, is considered particularly dangerous. It is said that but one case in nine gets well; but my own observation would lead me to think this an exaggerated estimate. This is a comparativly rare form of the disease, but I have seen two or three cases of facial carbuncle, all of which have ended favorably; it is true, however, that none of them were very severe. Death in facial carbuncle results from transference of the inflammation to the sinuses of the dura-mater, or from pyæmia. But in ordinary carbuncle, unless the patient has Bright's disease, or diabetes (an affection which predisposes to carbuncle), or unless the inflamed mass is so situated as to endanger internal organs,—peritonitis may follow abdominal carbuncle,—death will