

all the features are gradually developed which render it undistinguishable from chronic phthisis. You will have indurated patches of lung, with dulness, tubular breath-sounds and voice, proceeding to formation of one or more cavities or dilated bronchi, and the patient will emaciate, have febrile accesses and hæmoptysis. When you see such a case, with such physical signs more evident about the base and middle of the back part of the lung, and with progressively contracting side, you call it "fibroid lung" in modern terms; but is it not really a phthisis? Those who advocate the unity and idiopathic character of this affection point to its being left-sided and unilateral, and assert that it may be so distinguished. But in time the opposite lung will get affected, and in many instances it is a right-side disease.

Again, tubercle, properly so-called, will originate this form, and when retrogressive, as opposed to the progressive, the ordinary events of softening do not take place. The result is very commonly fibroid degeneration, with all the characters which I have described. Indurating pneumonia and pneumonic patches around tubercle are not to be distinguished by the scalpel or the microscope, and a combination of true fibroid changes with tubercle is daily seen in our autopsies. In the single limited cavity, with collapse of chest-walls, we have fibroid changes well marked in the lining and covering of the cavity, in the obliterated vessels crossing it, and in the interlobular thickenings around it. It is only in acute tuberculous, with universal impaction of grey tubercle, or in the rapidly ulcerative phthisis, that you notice the entire absence of fibrous changes. *Bronchitis* is a less common origin of fibroid changes, but it is observed in children and others; in the former after pertussis or rubeola, when collapse of a portion of lung is apt to occur, followed by contractile fibroid proliferation. These phenomena may have modern names, but if you like to study the early observers you will find that they were not unnoticed by Laennec, who described the dilatation of bronchi and the tough fibrous state of lung around tubercular cavities. Andral described the inflammatory thickening and ultimate contraction of the lung; while the

"cirrhosis" of Corrigan, and the "melanosis" of Bayle, referred to a like condition, only under varied forms. Corrigan's "cirrhosed" lung cases had cavities and ulcerated intestines, and other phenomena of phthisis. We must not then dispute about names, especially in this difficult transition period of pathology, but let us be careful observers of facts. It is remarkable that the greater number of these cases of fibroid change occur in *males*, and that the *age* of the patients is generally greater than in ordinary progressive phthisis.

The *diagnosis* of these cases is not difficult. The displacement of the heart and liver, and expansion of the opposite lung, may be due to other causes than fibroid change. In effusions into the pleura the heart is displaced to the opposite side of the chest; in fibroid it is drawn to the affected side, or drawn up. Again, in effusion the side is enlarged, and the intercostal spaces are prominent. The opposite conditions prevail in fibroid changes, and the liver is depressed in right-sided effusion, but drawn up (as is the diaphragm) in fibroid. The viscera are not commonly displaced in cancer of the lung, as the side is not contracted. The situation of the dulness, which is not unilateral, but crosses the middle line, and encroaches irregularly on the parts lying about the mediastinum, is characteristic of this disease, and not observed in fibroid phthisis. There is a curious condition of the ends of the fingers and toes called clubbing, which is intimately associated with fibroid change. I show you here the cast of a hand taken from life. The fingers are enormously expanded at the ends, somewhat like the "clubs" on playing cards. This is not merely a thinning of the upper parts of the fingers, which spares their extremities, but it is a new growth; it is, in fact, a growth of fibro-cellular tissue, and in some cases there is hypertrophy of the bones of the phalanges. You have here fibroid growth under your eye. Trousseau associated it with cyanosis and adherent pericardium, and so it is found; but in this hospital I have proved its connection with chronic phthisis and fibroid changes in the lung. It seems to be a result of lowered nutrition and imperfect arterialisation of blood, and a direct growth of fibro-cellular tissue. In 46 of my own