

bronchi, generally few in number, they have a firm consistence, a yellowish colour, a dryness which distinguishes them from most other morbid products, of very variable dimensions, but which seldom surpass that of a hen's egg. As a rule they coexist with a sclerous induration of the parenchyma, disposed around them in rings or fibrous spheres. The large bronchial tubes are often ulcerated, and the caseous substance, of which the glands are largely composed, may be spontaneously eliminated through the apertures of communication. This mode of evacuation has elsewhere been pointed out for some time in most of the chronic processes of destructive form of mediastinal adenopathy.

In all this there is nothing very new if attention is paid only to the nature of the lesion. But after reviewing all the observations published up to the present, it is not without profit to remark that the gummatous form of pulmonary syphilis shows a certain predilection to canton itself in the neighbourhood of the hilum, in order to further propagate itself from within outwards towards the deep parts of the parenchyma. One may indeed ask if this anatomo-pathological variety of gummatous degeneration is not in principle a kind of peri-bronchial mediastinitis. The inter- and peri-bronchial glands represent, as we know, chains which follow the course of the bronchi up to the third and fourth divisions; in the pathological state these glands may be seen as far as the fifth and sixth divisions, which is very probably due to a simple hypertrophy of the small glandular nodules invisible in a healthy state to the naked eye.

So while not at all denying the possibility of a primitive gummatous pneumonia, are we not right in admitting that the peri-bronchial gummatous adenopathy is the more ordinary process? The degeneration of these gummatous glands would very amply explain that of the adjacent parenchyma, finally all the constituent parts of the lung surrounding the centre of origin

would undergo the same fate to very nearly the same extent.

From these anatomical observations are deduced important points for clinical application. The great difficulty in diagnosis almost always resides in the differentiation of syphilitic and tuberculous lesions. These give rise to lesions equally destructive, to symptoms of the same character, to very analogous consumptive phenomena, to inflammatory or congestive symptoms (broncho-pneumonia, bronchial catarrh, hæmoptysis), equal in quantity and quality, solely their topographical distribution is different, and this is not a simple shade of difference in a diagnostic point of view it is of prime importance, and it must be placed far higher in value than the frequency or abundance of the hæmoptysis. It has been said that in pulmonary syphilis these are more even and less abundant than in tuberculosis. This is quite inexact as may be seen from the observations; and again how many consumptives succumb without even having an hæmoptysis.

The explanation is that the presence of a destructive centre occupying the middle portion of the lung, putting gangrene aside, may have given rise to hesitation or timidity in the diagnosis. Now it is almost constant that a subject who dies of syphilitic pneumopathy has other specific lesions in the viscera, particularly in the kidney, in the osseous system, or on the surface of the body. If these accessory lesions are manifestly recognised as products of the pox, and if on the other hand the pulmonary localisation has not the usual characters of common phthisis, the chances are greatly in favour of the lung like the rest of the viscera being affected with the specific lesions.

We should not then recoil before the diagnosis of syphilitic phthisis, especially if we consider the advantages the patient will derive from a correct diagnosis. The treatment is always the best touchstone, and to its happy influence is due the rarity of autopsies.