

pleurisy, and tubercle can all give rise to fibroid lung; but of one import—for wherever you see a somewhat advanced condition of the contracted lung you may be sure that nature is attempting prolongation and cure, and that chronicity is likely to be the stamp of the affection. Remember also that the *acute* lung affections, pneumonia and tuberculosis, are the only ones in which we do not find fibrous changes. Where rapid resolution or disease-products is possible, or where continuous destructive changes throughout every tissue of the lung are inevitable, there you have no fibroid formations. The chronic conservative changes in cases of old disease of the lung and pleura are intimately and necessarily associated with fibroid development, and this element is the active opponent of extension. Only remember the normal state of a lung, exquisitely elastic, permeated by countless air-currents, the seat of a double circulation, delicately balanced in an air-tight cavity in which the uttermost freedom of play is secured by a pellucid and smoothly oiled membrane, and conceive what would be the consequence to its tissues and its functions if, when a portion is blocked, all the air and vascular supplies were to have their usual access to the diseased part, and its movement to remain unrestrained. We can enumerate easily the important effects of a hyper-development of a fibrous contractile tissue. It lessens the air and blood supply; walls round the diseased product; limits the movements of that portion of lung, and ties it down through the pleura to the chest-walls. It thus guards against hæmoptysis and against pneumothorax, lines and circumscribes cavities, and shuts up the injured portion of lung. There is no case of chronic disease of the lung in which fibroid changes do not occur, and you will now apprehend my reasons for declining to recognise "fibroid" as a distinct variety of phthisis. I shall describe to you the most characteristic form of modification of old phthisis which fibrous change affords; but you will remember that you are looking at an old phthisis all the time, and not at a new disease.

Let us take, then, a well-marked specimen of fibroid alterations in the living subject, and consider its *characters, symptoms, and pathology.*

You will find a patient, generally beyond the age at which phthisis is most prevalent, who has had a chronic cough perhaps for years. He has had all the symptoms of phthisis of a protracted kind: gradual but slow marasmus, hæmoptysis, febrile attacks with long remissions. And when you first see him in these wards, he is perhaps free from any of the more urgent symptoms, for his temperature may be normal, his cough moderate, and his digestion unimpaired. He complains most of dyspnœa. Most generally he has no hereditary predisposition to phthisis; but if you examine into his history, you will find that either he was the subject of pleurisy or of pneumonia in an acute or sub-acute form, or his occupation had been dusty.—*i. e.*, he had worked in a mill or factory, or been a stone mason or a collier; for dusty occupations, which help to impact the lung mechanically, produce this form of phthisis. Watching your patient for months, as we do here, you will discover in him a certain immunity from the common events of phthisis, as spreading destruction of lung, copious hæmoptysis, diarrhœa, night-sweats. He remains, in fact, pretty stationary in our wards, and does our treatment little credit; while he does not, on the other hand, slip down into the hopeless condition of marasmus with fever. If you examine him in the final stage of all, you observe that he becomes exhausted by gradually impaired sanguification or by intercurrent disease of the opposite lung, which had remained sound for many years. Now strip and examine him, and what do you find? You are struck at once with the contraction of one side, flattening and retraction of the walls to a considerable extent, and, of course, lessened movements. The affection then is unilateral, and, curiously enough, it is by far most commonly seen on the left side (in 31 instances out of 39). Examine more carefully, and you will find that not only is the lung contracted, but the adjacent parts are displaced. The heart is perhaps drawn up to the extent of two inches, or it is drawn round into the back part of the left axilla, as in the patient in Eldon ward. Should the affection be right-sided (the rarer form), you may have the heart's apex beyond the right nipple; the diaphragm is drawn up on the