

the feet, legs, and arms which were thought to be rheumatic pains. Evidently her feet felt hot and uncomfortable, for she wanted her shoes always off. The child was too young to describe her subjective symptoms, so that it was necessary to rely on the objective ones. Her face was flushed, her eyes were watery, and there was a slight running from her nose. The cutaneous symptoms were as follows. There was no pigmentation of the face, neck, thorax, axillæ, abdomen, or groin. Erythematous areas existed over the arms and forearms in the region of the elbows, being most marked on the extensor surfaces. The palms of the hands were red, especially over the thenar and hypothenar eminences and about the tips of the fingers. In the lower extremities there was marked erythema over both knees, and on the right side above the patella there were several distinct, irregular, brownish patches, evidently due to pigmentation in the superficial layers of the skin and not arising from effusion of blood. There were similar pigmented spots above the left knee, but neither so well-marked nor so extensive. There was erythema of the soles of the feet and the toes, with a distinct border to the erythema along both sides of the feet and around the heels. As the child sat on the lap of a relative the feet looked "dropped" as if the extensors were parietic, but there was no distinct paralysis. There were no impairment of the tactile sensation, no muscular hyperæsthesia, no plantar reflex, and no dorsal extension of the toe; the knee-jerks were absent.

Remarks.—The child's father keeps a public-house, and although so young she was accustomed to get little "supps" of beer from the kindly disposed customers at the bar. I have carefully tested samples of the beer and have found arsenic present. In four distinct cases of peripheral neuritis occurring in Bacup I have examined the beer and have found arsenic in each case. Out of 14 different samples of beer no less than 11 showed distinct traces of arsenic. No doubt many cases of peripheral neuritis due to arsenicated beer have been overlooked.

Bacup.

NOTES OF TWO CASES OF FOREIGN BODY IN THE AIR-PASSAGES.

By E. F. SYRETT, M.D. DURH., M.R.C.S. ENG.

THE following two cases occurring within a few months of one another are of interest on account of the entire absence of urgent symptoms, and the fact that in neither case was the presence of a foreign body suspected.

CASE 1.—On May 12th, 1900, I was called to see a boy, aged 13 years, who, I was told, had been ailing for three weeks. The symptoms complained of were cough, fever, and pain over the base of the right lung. His temperature was 103° F. and his cheeks were flushed. Examination of the chest showed a markedly impaired percussion note over the whole of the right lung. The vesicular murmur was deficient, and at the apex of the lung, both behind and in front, moist sounds were heard. The left lung showed nothing but increased breath sounds. The sputum was abundant and blood-stained. Cough was frequent, but there was nothing remarkable in its character. The patient was kept in bed for two weeks and was allowed to get up when the temperature fell to normal. The physical signs remained unaltered and the cough continued, but the patient seemed quite bright and well. I continued to see him about once a week during the next two months, his condition remaining unaltered. On July 26th, whilst trying to pull a stick away from a large dog he had a violent attack of coughing and he coughed up a small smooth pebble a little larger than a cherry-stone. On cross-examining the mother she said that at the time the cough, &c., commenced the boy while playing football had put the stone into his mouth "to keep his wind." On returning from the game he told her that he had swallowed the stone, but beyond an attack of coughing at the time he had felt no ill-effects. The symptoms which supervened she attributed to catching cold during the game. The stone was, therefore, retained in the right bronchus just 13 weeks.

CASE 2.—This patient, a married woman, aged 33 years, came to me on account of toothache on Sept. 12th, 1900. I sent her to a dentist and a lower wisdom tooth was extracted on the next day under gas. On the 14th she came to me with complaints of cough and hoarseness. She said that on recovery from the gas her lungs felt blocked up, and she had

been coughing considerably all night. On examination of her chest I found universal rhonchus, with a few moist sounds, both lungs being equally affected. There was no dulness. She was expectorating blood-stained sputum. I advised her to go to bed and an elaborate treatment for bronchitis was carried out. In spite of everything the bad symptoms increased. On the 25th, 12 days after the extraction of the tooth I called to see the patient, and she told me that she was better. A violent fit of coughing had expelled the wisdom tooth, which I at once recognised as the old offender.

Nayland, Colchester.

A Mirror

OR

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et nobiliorum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

CITY OF LONDON HOSPITAL FOR DISEASES OF THE CHEST, VICTORIA PARK, E.

A CASE OF ABSCESS OF THE LIVER DIAGNOSED BY THE
PRESENCE IN THE URINE OF CRYSTALS OF
CHOLESTERIN, LEUCIN, AND TYROSIN.

(Under the care of Dr. VINCENT DORMER HARRIS and
Mr. J. F. C. H. MACREADY.)

THE association in the following case of the presence of leucin, tyrosin, and cholesterin in the urine with impairment of the percussion note over the lower part of the right lung, was strongly suggestive of some active process in the liver. We are not aware that it has been noticed that abscess of the liver is often accompanied by the presence of these abnormal constituents in the urine. It is not improbable that they might be found in small quantities in many acute morbid conditions of the liver if they were specially sought for. For the notes of the case we are indebted to Dr. J. G. Emanuel and Dr. E. W. Martin.

A sailor, aged 48 years, was admitted into the City of London Hospital for Diseases of the Chest, Victoria-park, E., under the care of Dr. Vincent D. Harris on Jan. 15th, 1900, complaining of pain in the right side of the chest and of having lost flesh. The symptoms had started insidiously and without any obvious cause some three months previously and had been getting gradually worse up to the date of his admission. In October, 1899, the patient's weight was 12 st. 7 lb., whilst on his admission he only weighed 9 st. 10 lb.—i.e., the patient had lost nearly three stones in three months. The pain on the right side was not severe, but it was constantly present and of a gnawing character, and was evidently telling very seriously on the patient's general constitution. The pain was not affected in any way by eating, by respiratory movements, or by exertion. It was localised to the right side of the chest, over a somewhat indefinite area, corresponding to the lower part of the right axilla. There was no tenderness of the painful area even on deep pressure.

The previous history showed uninterrupted good health till the year 1896, when the patient was laid up in South America for four weeks with a severe attack of dysentery. Twelve months or so after this, when in England, he had another less severe attack, and again in 1898, whilst in South Africa, he was laid up, this time for three weeks with dysentery. In each attack diarrhoea with blood in the stools was a prominent symptom; in the intervals between these attacks the patient's health had been excellent and he had enjoyed perfect health since the last attack in 1898, up till three months before his admission into hospital in 1900.

On examination the patient was found to be a middle-aged man, emaciated, and with a somewhat ashy-grey complexion, lying comfortably in bed in any posture. He had a rather cachectic appearance, suggestive of malignant disease, but otherwise he presented no obvious morbid appearance. The