DOUBLE EMPYEMA FOLLOWED BY
RECOVERY.

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DOUBLE empyema is so rare that I think the following case may be of interest. The patient was a girl, eleven years of age, who was admitted to the Royal United Hospital on Sept. 14th, 1896, her illness having commenced on the 11th with pain in the abdomen and vomiting. On admission she looked acutely ill and had a flushed face, marked dyspnoea with orthopnoea, and a rather tuberculous aspect. Her temperature was 102.6°F ., the respiration was 40 and shallow, and the pulse was 114. There were signs of pneumonic consolidation together with friction at the right base. Three days after this friction and signs of consolidation were present at the left base also. The respirations rose to 66 per minute, the pulse to 160, and the temperature to 105° . There were considerable distress and continued crying out from the pleuritic pain. On Sept. 24th signs of fluid at both bases were present, the heart's apex being in the fifth space immediately outside the nipple line. On the 30th the left side of the chest was explored with a syringe and pus was withdrawn. On the next day an incision was made in the ninth space and a soft indiarubber tube was inserted, whereupon much flaky, sweet pus escaped. On the following day the pleura was washed out with 1 in 80 carbolic solution. On Oct. 6th, pus having been discovered on the right side by means of a small exploring syringe, an incision was made in the ninth space and an indiarubber tube was inserted. From this side also a large quantity of "laudable" pus escaped and the side was washed out next day. I regret to say that the pus was not examined microscopically. At both operations the A.C.E. mixture was administered and no unfavourable symptoms occurred. Both sides were washed out daily with iodine water until Oct. 30th, when the tube on the right side was removed and that on the left side on Nov. 9th. On Nov. 25th the girl was up and about; she was putting on flesh rapidly, both wounds having healed up. The temperature was normal and there was no deformity of the thorax, but at both bases there was a want of resonance, together with distant breath sounds which were probably due to thickened pleuræ. The heart's apex came back to its normal position.

From Sept. 14th to 20th inclusive the patient's temperature varied between 100.4° and 103.8° , with the exception that on the evening of the 17th it was 105° . From the 21st to the 28th inclusive it varied between 98° and 101° , with the exception that on the evening of the 25th it rose to 102° and on the evenings of the 27th and 28th to 101.6° . From the 29th to Oct. 13th inclusive it varied between 98° and 102.4° , with the exception that on Oct. 7th it was 97.4° at midday and 103.4° in the evening. On the 14th it varied from 97.6° to 100.6° . From the 15th to the 21st inclusive it varied from 97° to 100° , with the exception that on the 17th it was 100.2° and on the 19th 101.2° . From the 22nd to the 25th inclusive it varied from 97.4° to 99.6° . From the 26th to Nov. 15th it varied from 97° to 99.4° .

It will be admitted, I think, that double empyema is extremely rare—in fact, this is the first case which I have seen during twelve years' connexion with hospitals. Walshe, in his "Practical Treatise on Diseases of the Lungs," writes: "Cases of double empyema are, as a general rule, unfit for operation unless evacuation be rendered necessary for the prevention of asphyxia." Treves, in his "System of Surgery," vol. ii., p. 441, writes: "Double empyema is a very grave condition and, happily, not common. The two sides should not be opened at the same operation, but an interval of a few days or a week should elapse between the two operations." He concludes thus: "It is a striking and apparently a paradoxical fact that an operation (opening both pleuræ) which, if performed on the healthy, would be invariably fatal in its effects is a valuable means of saving life when employed in conditions of disease." That this child should have recovered in the way in which she did was a great surprise to me, for her condition on more than one occasion was extremely critical.

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A CASE OF ACCIDENTAL OVERDOSE OF
CHLOROFORM.

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THE events now described took place between 8 and 9 A.M. on June 9th, 1898, at the Afzulgunj Hospital. The patient was a male native, thirty-six years of age, upon whom an operation was to be performed for cario-necrosis of the lower jaw. He had not had any food since 6.30 A.M. Immediately before the operation his pulse was found to be 128 per minute and weak; his respirations were 28. The chloroformist was Mr. Hamid-ud-Din, a third-year student of the Hyderabad Medical School. The notes were taken by Lieutenant-Colonel Lawrie until anæsthesia was complete.

Administration commenced in one-drachm doses on a cap as follows (the figures give the hour with the minutes and seconds):—

H.	M.	S.	
8	23	15	Cap applied, natural breathing, patient told to blow into the cap if he had a feeling of being choked.
8	24	0	Chloroform added to the cap; one breath of air taken.
8	24	55	Patient struggling, but breathing regularly.
8	25	0	Chloroform added to the cap; one breath of air taken.
8	25	50	Patient spitting.
8	26	0	Chloroform added to the cap; one breath of air taken. Patient struggling very violently but breathing regularly and deeply.
8	26	45	The patient was struggling so violently and taking such deep inspirations that although they were regular the chloroformist was told to remove the cap and give nothing but air. The patient took three full breaths of pure air and the cap was then reapplied.
8	27	10	Chloroform added to the cap. Two breaths of air taken. The patient became quiet and began snoring before the cap was reapplied.
8	27	25	Cornea insensitive; the cap removed. (It was never put near the face again. The notes were now taken by the assistant house surgeon.)
8	28	0	The patient's breathing stopped suddenly; his eyes were staring, his pupils were widely dilated, and his skin was pallid. The surgeon sprang on to the table and, kneeling astraddle the patient, commenced artificial respiration. The chloroformist pushed forward the patient's lower jaw and opened his mouth, and the house surgeon pulled out his tongue. There was great delay and difficulty in doing this as the teeth of the right half of the lower jaw were all loose, and there was a piece of loose dead bone. Another assistant poured some nitrite of amyl on to a handkerchief and held it over the patient's face, while the artificial respiration was going on, in such a way that it was freely inhaled.
8	30	40	Natural breathing restored. Artificial respiration stopped.
8	32	30	Consciousness returning.
8	35	15	Operation finished. Patient walked out of the room.

In this case the overdose was taken in during the struggling stage, which was due to intoxication, the breathing being quite regular. Overdosing with regular breathing, even if it be abnormally deep, is the rarest form of chloroform accident which is met with clinically, and it is more than ordinarily dangerous because the regularity of the respiration puts the chloroformist off his guard. The fault in the administration consisted in not at once giving the patient more air when the struggling became violent and the breathing abnormally deep. At 26 minutes 45 seconds past 8 o'clock when the chloroformist was told to give the patient air alone—because it was evident that he was inhaling the chloroform too freely—the cap should not have been reapplied until the breathing became normal and it was known