such would afford basis for the construction of a Report analogous to that compiled by the distinguished gentleman who made the subject of the topography of stone in Great Britain* a principal theme of his admirable address at the last meeting of the British Medical Association.

ART. XV.—*Select Clinical Reports.* By J. MAGEE FINNY, M.D., Dubl.; F.K.Q.C.P.; Physician to the City of Dublin Hospital.

- I.—ACUTE STHENIC PNEUMONIA, ENGAGING THE WHOLE OF THE LOWER LOBE OF THE LUNG IN A BOY TEN YEARS OLD; EXTREME PAROXYSMS OF DYSPNŒA; CRISIS ON EIGHTH DAY; RECOVERY.
- II.—ACUTE STHENIC PNEUMONIA OF UPPER LOBE OF RIGHT LUNG; MENTAL DELUSIONS; DELIRIUM; CRISIS BY SWEATING ON EIGHTH DAY; RECOVERY.
- III.—PNEUMONIA OF RIGHT LOWER LOBE, EXTENDING TO UPPER LOBES; PLEURITIS OF LEFT SIDE; APHONIA; DELIRIUM; COLLATERAL ŒDEMA OF THE LUNGS; VENESECTON; DEATH.
- IV.—PNEUMONIC ABSCESS OF THE LOWER LOBE OF RIGHT LUNG; CASEOUS CONSOLIDATION OF UPPER LOBE; HECTIC; TREATMENT BY COD-LIVER OIL; RECOVERY.

THE following cases present, I consider, some points of interest worthy of being recorded. They all, with the exception of Case I., occurred in the month of April—a fact worth noticing, as, in the June quarter of the present year, pneumonia was more than usually common in this city; “and the deaths from this disease were 55, against an average of 48 in the preceding ten years.”^b

CASE I.—*Acute Sthenic Pneumonia, engaging the whole of the lower lobe in a boy of ten years of age; Paroxysms of extreme dyspnœa; Crisis on eighth day; Recovery.*

Robert F., aged ten, was sent into the City of Dublin Hospital on the 27th March, 1874, as a case of fever, being five days ill.

* Only a few Irish hospitals are alluded to, of some of which it is stated they furnished no cases (vide *Lancet*, vol. II., 1874), so that the question of the disease in this country may virtually be said to have been left untouched.

^b Report on Public Health. By J. W. Moore, M.D. *Irish Hosp. Gaz.*, Nov. 2, 1874.

On admission, his face was very much congested, the cheeks purplish-red, skin hot and dry; tongue dry, and covered with creamy fur; alæ nasi moving rapidly, with a short, catching respiration—60 in the minute. He had frequent cough, and when the cough came on in paroxysms, he became almost suffocated, as, gasping for breath, he would start up from the semi-recumbent posture, and throw himself towards his right side until the fit of coughing was over. The expectoration was reddish-yellow, very viscid, and frothy.

Physical examination elicited, on percussion, a flat, high-toned sound under the left clavicle, and dulness over the posterior part of the same side, extending from the base to the level of the third rib; while in the same region tubular breathing and bronchophony were exquisitely well marked. There was no crepitus audible anywhere, but over the front of the left side and the whole of the right side exaggerated respiratory sounds were observed.

The urine, which was free from albumen, was scanty, and gave, on standing, a copious deposit of lithates; the chlorides were not absent on admission, nor were they at any of the qualitative examinations which were made during the progress of the case.

The treatment consisted in keeping the side enveloped in a jacket poultice, and giving a mixture containing syrup. scillæ, vinum ipecac., and carb. ammoniæ.

March 28th.—The next day the fever was less in the morning, but the temperature rose to 104° in the evening, while the dyspnœa was unaffected. This state continued the following day also; but on 30th—the eighth day of his illness—defervescence set in, and the temperature fell from 104° on the morning of the seventh day to 98·5° on the evening of the ninth day; the pulse coming down, in the same time, from 132 in the minute to 84, and the respiration from 60 to 40.

With this change the general condition of the boy also rapidly improved; his aspect became natural; his tongue cleaned; his appetite increased; and he slept better. The lung, however, showed no signs of resolution until the thirteenth day of his illness, when over a small region near the inferior angle of the scapula crepitus was heard with inspiration alone; the day following it assumed the character of crepitus redux, being audible with both inspiration and expiration, and rapidly extended over the whole of the lower lobe. The improvement in the condition of the lung was, however, more judged by the percussion note than by the

stethoscope, as each day the sound approached that of health more and more. Resolution was completed on 10th April. During resolution it was noticeable that there was no expectoration at all. The patient left hospital a few days afterwards quite convalescent.

The treatment adopted in this case was simply expectant, no medicine being given except a stimulant expectorant at first, with ziii . of wine in the 24 hours, and after crisis the citrate of quinine and iron.

Remarks.—The points which deserve a passing notice in this case are the occurrence of acute sthenic pneumonia in a boy of only ten years of age; that it engaged the whole of the lower lobe; the absence of any bronchitis, which, in children, more commonly precedes pneumonia, and the well-marked defervescence commencing on the seventh day and completed on the ninth.

The rapidity and shallowness of breathing was perhaps the symptom most marked, and at times became most distressing, as the poor child—judging from the gasping for breath, and the purple hue of his face—seemed on the brink of suffocation.

It is not my intention to enter at large into the question of the causation of such a symptom. I would, however, attribute its occurrence to the suddenness of the attack, the high febrile condition, the deranged innervation, and altered state of the blood produced thereby, rather than to the large extent of aerating surface which was engaged, or to any co-existent bronchitis.

CASE II.—Acute Sthenic Pneumonia of the apex of right lung; Mental delusions; Delirium; Crisis, by sweating, on the eighth day; Recovery.

William M., a labouring man, tall and well made, aged twenty-two, was sent into hospital under my care, by my friend, Dr. Chapman, on the evening of 21st April, 1874.

Eight days before admission he was taken ill, while at work, with severe rigors. He left his work and went home, feeling very cold, and shivered the whole day, nor could he get warm, “not even,” as he expressed it, “if he could get behind the grate.” The day before he came to hospital his mother noticed him to be “very queer” in many little ways, and in the evening to get out of bed, and kneel down at the door of his room; and when questioned as to his curious behaviour, he replied “he was going to heaven.” He strongly objected to being brought to hospital. He was

admitted after seven o'clock, the hour of my usual evening visit, so I did not see him until the following morning, but the nurse and the patients in the ward reported that he spent a most restless and wakeful night; asking to be taken away, and saying that he could not dare to sleep; as he was under the delusion the nurses were determined to hurt him, and would beat him were he to close his eyes. On the 22nd, when I saw him at 9 a.m., he was sitting up in bed, imploring, with tears in his eyes, to be taken away anywhere from "them girls," and refusing, for fear of being poisoned, to take either food or medicine. His face was red and flushed, mostly on the malars; eyes bright, wild-looking, and watchful, with congested conjunctivæ; pupils not contracted. The corrugator supercilii muscles and those of the angle of the mouth were constantly twitching. He was very restless, and inclined to throw off the bed-clothes, and get out of bed. His breathing was quick, 40 in the minute, and there was a short hacking cough, accompanied occasionally by sputum of a red jelly-colour, and of a very viscid consistence; temperature 103.5° ; tongue was thickly coated with yellowish-white fur; bowels confined. The history of the case, by which it appeared the man was of sober habits, along with the symptoms of thoracic engagement, directed attention to the lungs. The apex of the right lung, and down as low as to fourth rib anteriorly, was in a state of consolidation, as evidenced by dulness, well-marked increase of vocal fremitus, tubular whiffy respiration, bronchophony. Posteriorly, the dulness was not so marked, nor did it extend below the supra-spinous fossa.

As he had not slept for the last two nights, and was so very excited, I gave him a 20 gr. dose of chloral hydrate, with instructions to repeat the medicine if it should fail to quiet him. Half an hour after taking the draught he sprang out of bed, when the nurse's back was turned, and ran up stairs to the wards above—those of the female patients—asserting loudly that a wrong medicine had been given him, and that the nurse had tried to poison him. I happened not to have left hospital when this occurred. He was brought back to bed, after a little gentle persuasion, by one of our students, and 10 grains additional of chloral hydrate were administered. This had the effect of quieting him, and he was further re-assured by his mother sitting beside his bed. He now took beef-tea and wine, and became calmer, although he did not sleep. The only other treatment consisted of the constant application of large jacket poultices to the affected side.

In the evening he was much more composed, and promised to take any medicine I would order him. He had not slept all day. A mixture containing quinine in 5 grain doses was ordered, of which he took two doses before my visit next day. The poultice to the side was renewed, and shortly after he fell asleep, and slept well through the night.

April 23rd.—Aspect less wild, though still a little excited; no frowning or twitching of the face; is quiet, and no longer wants to go home. He is bathed in perspiration; the breathing is easier, respiration having fallen from 44 the night before to 32, and the *alæ nasi* are no longer moving. Pulse 84, softer; temperature 98.2° . Defervescence had evidently occurred, and that in the course of twelve hours, the temperature sinking from 103° to 98.2° . The tongue was still thickly covered with a yellowish-white coat.

Hepatisation of the upper lobe was absolute, as femoral dulness existed anteriorly to the third rib, and, in a less degree, to the fourth. Over this region no respiratory sounds were audible, but bronchophony was typical, and the sounds of the heart were conveyed most distinctly to the ear; there is no expectoration. As the bowels were confined, a mild purgative pill was given, but no attempt was made to act freely on them; the quinine mixture to be continued.

24th.—Diaphoresis has continued ever since, and is so great as to wet the sheets and pillow. Aspect is natural; patient slept well, and took beef-tea and medicines regularly. Two herpetic vesicles have appeared on the left side of his lower lip. There was no expectoration at the morning visit to-day, but in the evening the spitting-cup contained several frothy, viscid sputa. Resolution, as was thus evident, had commenced, and the diagnosis was further confirmed by the dulness being less absolute, and by its being limited inferiorly by the second rib; while bronchial respiration and a few râles on deep inspiration were audible in the same region.

The pulse continued to descend, and fell from 84, on the morning of the 23rd, to 68 in the evening, and to 60 this morning. The respiration has come down to 24 in the minute.

25th.—Perspiration still very great; resolution rapidly going on; only slight dulness is elicited by percussion to second rib, while air is entering freely, without crepitus or tubular breathing; there is almost no expectoration.

I now changed his medicine, and gave him 25m. doses of tinct. ferri perchloridi, three times a day, and wine $\bar{z}$ vi.

27th.—Much improved; appetite good; sleeps well; no cough. The lung has not quite cleared up, but no abnormal sounds are audible on auscultation. Pulse sank to 56 on 26th, and continues to-day at same rate. The pulse remained at this low rate till—

May 1st.—When the pulse rose to 72. A careful examination to-day, of right apex, freed my mind of all anxiety of any remains of the pneumonic process being left. Patient was allowed to go out in the air, and he left hospital on May 4th, quite well.

Remarks.—Authorities are now, more generally than formerly, agreed as to the clinical importance of an attack of pneumonic inflammation of the apex of the lungs. By many it was thought to be an indication of danger, not only because of the type of the disease being (as it very often is) adynamic, but also on account of the serious results which follow from it. By Grisolle* it was held in peculiar distrust. He states that the mortality of pneumonia in patients under forty, so affected, as compared with the base of the lungs, was in the proportion of 5 to 3.

Sthenic pneumonia, it is known, much more commonly engages the lower lobes, and the inflammation of the apex, primarily, in adult life, is a comparatively rare occurrence. The case detailed above conforms, however, with the general rule, that pneumonia of the upper lobe is singularly more common in the right than the left lung, as shown by Grisolle, Ziemssen, Barth, and Briquet—the latter stating it to be in the proportion of 18 to 4.^b

The symptoms, for what reason we cannot well say, very often assume a serious type, and one quite out of proportion in its gravity to the extent of the tissues involved. Nevertheless, recovery of such cases by a normal and rapid defervescence is to be expected equally as in consolidation of the lower parts of the lungs. In saying this, of course, I except those subacute cases of the catarrhal type which run into caseation and phthisis, as well as those of the typhoid nature, where the inflammatory process creeps up from below, or simultaneously develops in the apex and other parts of one or both lungs. Pneumonia of the apex, writes Trousseau,^c in his “Clinical Lectures,” is serious in tubercular subjects, but otherwise is not more dangerous than elsewhere.

* Quoted by Dr. Wilson Fox. Reynolds' Syst. Med., Vol. iii., p. 690.

^b Ibid., p. 673.

^c Clinique Médicale, T. 1^{er}, p. 792.

Delirium is, not uncommonly, a symptom of pneumonia of the apex. According to Heintze, it occurred twice as often when the apex was engaged as contrasted with the lower lobe.^a And the same view is expressed by Flint.^b Huss, on the other hand, believes it is not especially common in such cases, but considers it to be rather due to the large extent of lung structure engaged, producing cerebral congestion—a view entertained by Sir Thomas Watson also. Niemeyer^c states it is due to either derangement of nutrition to the brain, or to the high temperature of the blood which flows through the brain; while Heintze contends that excessive temperature has little, if any, influence in its production. This view the case detailed might be taken to exemplify, as, except on one evening, the thermometer never marked more than 103·5°.

The significance of this symptom, which occurs, according to Grisolle, in 8 to 12 per cent. of all cases, will vary naturally with the time of its occurrence and with the type of the disease. Niemeyer^d asserts that delirium at the beginning of the disease is a matter of no gravity. I would, however, incline to the view taken by Flint, “that it is an evidence of the gravity of the disease in proportion as it is prominent and persistent.”

Its character is, in like manner, liable to variations; though rarely violent, except in patients of dissipated habits (Grisolle), when it may assume the type of *delirium tremens*, it may occasionally appear in so sudden and severe a form as to be mistaken for acute mania.^e Hence it will be seen that delirium may present itself in any form, from being slight and incidental to the febrile movement, to the violence of mania—or to the typhomania of fever.

In the foregoing case delirium, at the time of, and for twenty-four hours after, admission—was the most prominent symptom. I made careful inquiries as to the patient's previous habits, but failed to satisfy myself that he was a man of intemperate habits, or that he had lately indulged in any debauch. I attribute it, therefore, to the deranged nutrition of the nerve centres, due to the febrile movement.

The want of prominence of cough, thoracic pain, and dyspnœa, might have easily misled one, at a cursory glance, to believe he had

^a Reynolds' Syst. Med., p. 638.

^b Practice of Medicine, p. 179.

^c Text Book of Practical Medicine, vol. I., p. 183.

^d Ibid., p. 183.

^e Reynolds' Syst. Med., p. 638.

a case of *delirium tremens* to deal with rather than pneumonia, and this view was, I understand, entertained by some of our students who saw the patient before my visit, and before any examination was made. It is, however, hardly credible in the present day that the sad picture of gross ignorance and negligence, drawn by Niemeyer, would be applicable, or any justification given for the following words:—"Many a patient has died in a strait-waistcoat, with a diagnosis of *delirium tremens*, whose real disease has been pneumonia."^a

The disappearance of the delirium synchronously with the onset of defervescence, is in accord with what usually occurs, although, as Dr. Wilson Fox^b shows, it may continue forty-eight hours after crisis.

This mode of crisis, by sweating, I have never seen so well exemplified as in the case of William M. He was literally bathed in perspiration for three days, and on the second day presented a copious crop of sudamina, such as one finds in rheumatic fever. As a mode of recovery this is not uncommon, and Todd, in his *Clinical Lectures*,^c mentions a parallel case where marked improvement took place on the seventh day of the disease; "indeed," he writes, "there was something like a critical sweat," and "hence" (p. 297) "the treatment I employ in all cases of pneumonia is that which tends to promote sweating."

The depression of the pulse to 56 in the minute, on 26th April, and its continuance in this state for five days, was remarkable, not only as having occurred when no cardiac depressant medicine had been employed, but also in the absence of all symptoms of collapse—that condition so well known to be one of the great dangers of this disease. It reminded me much of the cardiac depression which occurs after crisis in typhus. This sinking of the pulse is noticed by Niemeyer,^d and it has been as low as 40 in the minute, although no digitalis or other sedatives were employed.

CASE III.—*Pneumonia of right lower lobe, spreading to upper lobes; Pleuritis of left side; Aphonia; Delirium; Collateral Œdema; Venesection; Death.*

James F., a stout, strongly-built young man, aged twenty-two, was sent into the fever wards, on the afternoon of 19th May, 1874, as a case of enteric fever with delirium.

^a P. 176.

^b Reynolds' Syst. Med. p. 652.

^c P. 306.

^d P. 174.

It appeared that a fortnight before admission he came into possession, through his father's death, of a public-house, and that ever since he had been drinking very freely, and had exposed himself, while in a state of intoxication, to cold and wet. On 13th inst. he was attacked with rigors, which, according to the account he gave me on the second day after admission (when the delirium had ceased), were very severe. On 14th he took opening medicine, which was followed by diarrhœa. This was then stopped by medicine, but while under treatment he used to get out of bed, and go out to drink. He became delirious on 18th, and the bowels were still free on his admission to hospital on 19th. When I saw him at the evening visit, he was lying propped up in bed, breathing noisily and rapidly. He was constantly changing his position, picking at the bed-clothes, and getting out of bed. He was, however, easily restrained, and, when questioned loudly, answered intelligently. His voice was reduced to a whisper. His face was greatly flushed, the ears and lips being purplish in colour; tongue was dry and brown in the middle, not cracked, while the sides were clean; the bowels had not moved since his admission; the abdomen was not much distended, nor was there either tenderness or gurgling on pressure, nor increased splenic dulness on percussion. No spots could be detected, though carefully looked for. Pulse 128, temperature 104°, and respiration 40 to the minute. There was complete aphonia. The throat was red and congested, but there was no false membrane visible.

Physical examination revealed consolidation of the lower lobe of the right lung—by dulness on percussion, which did not vary on change of posture, bronchial breathing, and the absence of vesicular sounds. There was no crepitus, and the loss of voice precluded the confirmation of the diagnosis by means of vocal vibration or bronchophony. There was no expectoration. He was extensively dry-cupped, front and back, and 10 grain doses of sulph. quiniæ, in dil. sulph. acid, were administered three times during the evening and night, and ʒiv. of whiskey ordered for the night.

20th May.—Up to 3 a.m. he was very restless, did not sleep, and was frequently getting out of bed; after 3 a.m. he slept, and has been quiet since. His face is less flushed, and the pulse and temperature have both fallen, the former 16 beats in the minute, and the latter 1 degree. The condition of the lung is unaltered. To continue the quinine mixture, and to have the side enveloped in a jacket poultice.

21st.—Slept better; was quiet, and did not get out of bed; raved a good deal. The aspect is better, the ears and lips being less suffused, and his voice has returned. He answers questions intelligently, and is able to give a much clearer account of his illness than before. He coughs a good deal and strongly; sputum bloody and rusty. He complains of no pain in the chest. Although the temperature is the same as yesterday morning, the pulse has risen from 112 to 120; he passes less urine, and the skin is dry.

Physical examination shows pleuritic friction over the left side, while pneumonic crepitus is heard over the middle lobe and the posterior part of the upper lobe of the right lung. In both lungs fine mucous and muco-crepitant râles are heard over the upper lobes of both lungs in front, betraying a bronchitis, or, more probably, a serous effusion into the vesicles from collateral œdema.

In the evening his aspect was very much worse, lips, cheeks, and ears purple; eyes heavy, hands cold and purple; respiration very shallow with noisy expiration—48 in the minute; while the feebleness and rapidity of the pulse (130), as well as cardiac dulness to the right of the sternum, led me to fear that death by asphyxia, or by failure of the right side of the heart, was imminent.

In the hope—at best a very faint one—of relieving the overloaded heart, I bled him to 16 ounces. The blood at first was very dark, but afterwards changed to a more natural hue. Immediate relief was felt by the patient, and his aspect showed the same; and even while the blood was flowing his respiration was slower and deeper, and his lips lost their blue colour. Having given him some brandy, I left with orders to administer stimulants freely, and 15 m doses of ol. terebinth. every third hour. This I ordered with the object of clearing the tubes, as the stuffed condition of the apices of the lungs, while the greater part of the right lower lobes were consolidated in pneumonia and the left engaged in pleurisy, threatened suffocation only too plainly.

One dose of the turpentine was taken, when the temporary improvement, following on the venesection, passed away. He broke out into profuse perspiration, the breathing became more noisy, and he died at 10 30, four hours after I saw him.

No *post-mortem* examination could be obtained.

Remarks.—The foregoing case presents a sad contrast to Case II., having regard to the nature of the inflammation, the complications or the termination. From the first the prognosis was bad,

inasmuch as the nervous symptoms were those of a patient in advanced typhus fever, and the patient was one of the worst subjects to battle against so ataxic a type of disease.

So fatal and so common a termination is pneumonia to the life of a drunkard, that it has been designated as a special form, under the name of *Pneumonia Potatorum*, by Huss.

The aphonia, which was a symptom quite new to me, I consider to have been another evidence of great nervous depression; and the absence of all diphtheritic complication or other physical cause for its production, and its disappearance on the patient's second day in hospital, simultaneously with the signs of improvement in other respects, confirm me in this opinion. I am unaware if this symptom be one which has been met in pneumonia; but I have searched through many authorities—namely, Todd, Niemeyer, Aitken, “Reynolds’ System of Medicine,” Tröusseau, Watson, Flint, and have failed to find any notice of such a complication—nor is it mentioned by Huss^a in his table of 29 complications in 959 patients.

In diagnosing the case to be one of pneumonia, rather than enteric fever with pneumonic complication—for as such it had been sent to hospital—I was unable to avail myself of the aid the thermometer would have given in the earlier stage of the disease, as has been pointed out by Dr. Grimshaw.^b I based my diagnosis on the history of severe rigors having occurred seven days before admission, and on the absence of the usual characteristics of enteric fever, such as splenic enlargement, ilio-cæcal gurgling, tympanites, and the typical eruption.

The improvement on the 20th, following upon large doses of quinine, was unfortunately but temporary, and was quickly followed by alarming symptoms of suffocation, due to collateral œdema. There is no symptom, according to Niemeyer,^c so fatal in the first and second stages as this; and it was in the hope of averting so dangerous a complication, and of relieving the overloaded and laboured heart, that I was led to perform venesection. The immediate benefit it produced, as evidenced by the patient's expressions of relief, the deeper inspirations, the diminution of the cyanotic aspect of the face, and the fulness of the pulse, made me for a

^a Reynolds’ System of Medicine, p. 657.

^b Grimshaw—Thermometric Observations in Pneumonia, Dublin Quarterly Journal of Medical Science, May, 1869.

^c Loc. cit., p. 177.

moment hope that the relief thus obtained might be the forerunner of other improvements. I was, however, doomed to disappointment, as, in spite of the oil of turpentine (than which I know nothing better as an expectorant when the smaller tubes are stuffed with secretion), the patient's condition returned to what it was before the operation, and he sank in four hours.

Reflection in this case compels me to ask the question—might not the patient have recovered if venesection had been performed sooner?—and would it have prevented the serous effusion into the bronchi? While I would be far from advocating venesection indiscriminately in pneumonia as a curative means, I think it might be employed, with real advantage, more frequently than it is; for, as Niemeyer^a puts it, we may bleed, “not because of pneumonia, but in spite of pneumonia, and for fear of certain complications.” The rational use of such a powerful remedy is certainly hardly enough entertained at the present day; and the language of Dr. B. W. Richardson, within certain limits, is not a whit too strong when he says:—“Of this I am certain, that in giving up blood-letting as a means of cure, it sacrifices both skill and duty to ignorant prejudice and ignoble fear.”^b

CASE IV.—*Pneumonic Abscess of the lower lobe of right lung; Consolidation of upper lobe; Hectic; Treatment by cod-liver oil; Recovery.*

Margaret F., aged forty-five, a married woman, having several children, the youngest ten months old, was admitted on 14th April, 1874.

She had suffered from cough, profuse perspiration, and debility, for six weeks, becoming each day weaker and more emaciated; and yet up to the last week she continued to nurse her baby. She was so weak on admission as to be hardly able to walk up stairs to the ward, while the black circles round her eyes, the rapid movement of the alæ nasi, combined with her emaciated appearance, told too plainly of some great drain on the system, and the probability of extensive lung disease. This assumption, the pulse (140), the high temperature, amounting to 104.2° , and physical examination, further confirmed. The latter showed advanced disease in the right lung; for, from the angle of the scapula down to the base

^a P. 184.

^b Medical Times and Gazette, Oct. 3rd, 1874, p. 398.

there was comparative dulness on percussion, and slight tubular breathing, while anteriorly very little air entered the upper lobe, and at the nipple, crepitus, coarser than that of the first stage of pneumonia, and in character more resembling that of crepitus redux, was heard. On the left side there was compensatory respiration. It was only too evident that the lung tissue was breaking down. As she complained of diarrhœa and of profuse night sweats, I put her upon sulph. quiniæ and dilute sulphuric acid; the diet consisting of milk and lime water, beef-tea, and eight ounces of wine.

For the first week after admission there was little change in the symptoms, except that the bowels were checked, while the pulmonary mischief seemed on the increase, as coarse crackling râles were heard at the angle of the scapula; and the right clavicle became comparatively dull on percussion. Pain was now complained of under the right breast, and in this place pleuritic friction was discovered; the expectoration was more copious, and muco-purulent.

The temperature continued high, ranging from 100° to 103°, the evening temperature being usually higher by 2° than the morning. There was, however, no such regularity as one finds in the thermometric observations in enteric fever. The pulse ranged from 100 to 120, but with less difference between morning and evening. Respirations from 36–44.

As soon as the temperature came down to 101° in the evening, and the tongue (which, on admission, was clean, glazy, and dry, with extremely prominent papillæ) became at all moist, I put her upon cod-liver oil three times a day, followed by a sixth part of the following mixture:—

R.—Acidi phosphorici dil. ℥. 60.
Liq. strychniæ, ℥. 30.
Tinct. aurantii f 3 ss.
Aquæ flor. aurant. ad. f 3 vi.
M. ft. mistura.

The acid and strychnia prevented any sickness following the oil. Wine to 3 viii. was daily administered.

On May 1st, a fortnight after admission, the report showed improvement:—

“Aspect improved; the black circles round the eyes less marked; cough less; better nights, with much less perspiration about the head and chest; bowels regular; and expectoration less in quantity,

and that only in the morning; respiratory sounds more natural in affected side, 32 in the minute; pulse 90; temperature 98.2° in the morning, and 98.6° in the evening.

"The subclavicular dulness is less evident, and, though the lower is still dull, it is limited to an area of $1\frac{1}{2}$ -inch square at the inferior angle of the scapula, while the coarse, crackling râles, which were audible on inspiration in this place, have given way to a more clicking sound, conveying the impression that it was dry in character, and that the mucus was thick and scanty.

"To continue the cod oil in increased doses, and the acid mixture, substituting hydrochloric for phosphoric acid."

From this time to the end of May she steadily progressed, more solid food being given as her appetite improved, and as she was able to bear it; her appearance and general condition also improved, so that she gained flesh and strength, and looked ten years younger than when she sought admission.

She left hospital on June 6th, after a stay of seven weeks and a half, cured of the attack, although with an impaired and injured lung.

The following note was taken a day or two before she left:—

"Pulse 80; temperature normal; respirations 24; tongue clean; no nocturnal perspirations; appetite very good; no perceptible difference on percussion under clavicles; dulness at inferior angle of scapula, less evident and limited to an area corresponding to a five shilling piece; breath-sounds absent over this spot, normal elsewhere. The wine has been omitted and porter substituted the last ten days. The oil and acid mixture have been steadily persevered in."

Remarks.—No case came under my care, during my months of clinical duty in the hospital, which gave me more real pleasure and satisfaction than the foregoing. The prognosis on admission, and for many days after admission, was of the worst nature; it seemed quite hopeless to expect she could live more than a few weeks. The breaking down of the lung in the lower lobe, the extension of pneumonic process to the apex, the copious expectoration, the great exhaustion and emaciation, the profuse perspiration, and the diarrhœa, all combined, sufficed to make me expect a rapid and fatal termination. In this I was fortunately mistaken. Rest, good air, judicious and supporting diet, and, as soon as the stomach could bear it, the constant employment of cod-liver oil, did wonders in this case. The abscess diminished in size; its contents became less;

the extension of caseous inflammation was arrested; the diaphoresis was checked; sleep was procured; strength returned; and, when she left hospital, she had gained in flesh and weight.

This case is the more interesting, as it is just one of those cases which, some years ago, would have been set down as quite incurable, I might say necessarily so, as the result of the views which were then held respecting the nature of tubercle and its *deposition* in the lungs.

To Niemeyer and Dr. Williams is due the credit of plainly showing how many of such cases, by timely and judicious treatment, may be arrested in their progress to a fatal end, and how life may be prolonged in comparative strength and vigour for many years.

The employment of a mixture containing an acid and a vegetable tonic, with small doses of strychnia, immediately after the cod oil, I adopted from Dr. Williams, and I can bear my testimony to its efficacy in many similar cases in aiding the stomach to a tolerance of the oil.

To the tolerance and constant use of this oil I attribute very much of the success in this class of cases, and I can fully corroborate the statement of Dr. Williams,^a that in order to obtain the greatest benefit from the cod oil, it should be persevered in regularly and for a sufficient length of time; for months, even for years.

I cannot close these remarks without gratefully acknowledging the help my clinical clerk, Mr. Robert Taafe, gave me in making *accurate* diurnal thermometric observations, and in seeing that the treatment adopted was carefully and rigidly carried out.

^a Pulmonary Consumption, 1871. P. 345.