healthy. On squeezing the consolidated lower left lobe, however, a few small branchiographic casts were expelled. The pleura were both rather firmly adherent from old pleurisy. The right side of the heart was much engorged, and a firm ante-mortem clot was found in the pulmonary artery, extending for a considerable distance into the branches of the right and left divisions. This curious condition of the sputum seems to be very rare. Personally I have never seen it before, though I have examined nearly two hundred cases of pneumonia since 1888; indeed no case of expectoration of branchiographic casts has occurred in any of the 4500 cases of all kinds admitted to the medical wards of the Manchester Royal Infirmary since January, 1887.

Jürgensen in Ziemssen's Cyclopedia of Medicine and Lépine in the "Dictionnaire de Médicine et de Chirurgie pratiques," in speaking of the expectoration of pneumonia, states that Remak first discovered small, almost microscopic, ramified cylinders, casts of the finest bronchi. These he obtained by shaking up the sputum with water, when the little greyish-white particles could be easily separated. He thought that they were formed of the fibrineum des bronches," and shows that in these cases the formation. Lepine, in describing the anatomical varieties of pneumonia, gives one the name of "variété avec moules ou plis," and shows that in this variety of pneumonia, the blood always is noticed, and compared to elder pith from the deep fascia, I determined, after consultation with my colleague, Surgeon-Major Magill, to make a deep incision in the middle line of the neck in the interval between the two sides of the neck had steadily increased, and passed across to the left side. The swollen tissues felt brawny, and inclined to sleep, and his respiration assumed an irregular character. Three deep inspirations, during which a deeply drawn breath followed, to be succeeded by the same alternation of a series of deep and shallow inspirations. On the 8th, at 2.30 A.M., the respiration remained of the same character, and his condition gave rise to much anxiety. The swelling of the neck had, however, decidedly decreased, since the incision was made, and he was able to swallow.

An evening temperature of 104°3" on the 25th. A fresh crop of rose spots was noted on the 28th. This relapse subsided on Jan. 13th, 1888. A further relapse occurred on Jan. 23rd, the evening temperature registering 104° on the 30th, and a fresh appearance of rose spots being noted on the 31st. This relapse subsided on Feb. 10th. He gained ground in March, and on April 20th he was able to be up all day in the ward. Early in May the skin appeared a little jaundiced. On May 5th the patient complained of sore throat. On examination nothing was observed beyond a slight swelling in the glands of the neck. The patient was greatly relieved of his throat feeling more uncomfortable, the tonsils appearing a little swollen. Early on the following morning the medical officer on duty was summoned to see the man in consequence of difficult and noisy respirations. Two large casts is noticed, and compared to elder pith from the deep fascia, I determined, after consultation with my colleague, Surgeon-Major Magill, to make a deep incision in the middle line of the neck in the interval between the two sides of the neck had steadily increased, and passed across to the left side. The swollen tissues felt brawny, and inclined to sleep, and his respiration assumed an irregular character. Three deep inspirations, during which a deeply drawn breath followed, to be succeeded by the same alternation of a series of deep and shallow inspirations. On the 8th, at 2.30 A.M., the respiration remained of the same character, and his condition gave rise to much anxiety. The swelling of the neck had, however, decidedly decreased, since the incision was made, and he was able to swallow.

At 3.30 A.M. an enema, composed of milk, an egg, brandy, and a drachm of spirit of ether, was administered, and a dark blush was present below the jaw on the right side of the neck. With a view of relieving the tension which evidently existed beneath the layers of the fascia, I determined, after consultation with my colleague, Surgeon-Major Magill, to make a deep incision in the middle line of the neck in the interval between the two sides. The swelling was passing down to the front of the chest, and a dark blush was present below the jaw on the right side of the neck. With a view of relieving the tension which evidently existed beneath the layers of the fascia, I determined, after consultation with my colleague, Surgeon-Major Magill, to make a deep incision in the middle line of the neck in the interval between the two sides. The swelling was passing down to the front of the chest, and a dark blush was present below the jaw on the right side of the neck. With a view of relieving the tension which evidently existed beneath the layers of the fascia, I determined, after consultation with my colleague, Surgeon-Major Magill, to make a deep incision in the middle line of the neck in the interval between the two sides. The swelling was passing down to the front of the chest, and a dark blush was present below the jaw on the right side of the neck. With a view of relieving the tension which evidently existed beneath the layers of the fascia, I determined, after consultation with my colleague, Surgeon-Major Magill, to make a deep incision in the middle line of the neck in the interval between the two sides.
wrung out of cold water were applied over the chest, abdomen, and legs, and renewed at frequent intervals. Ten grains of quinine were ordered to be given at once, with five-grain doses at intervals of an hour until twenty grains had been taken. After 9.30 P.M. the temperature was 104-3°; pulse 128; respiration remained of the same character. A cold wet pack was applied and renewed at 6.30 P.M. with pounded ice sprinkled over the body and legs. At 7 P.M. the temperature had risen to 105°; pulse 112; respiration 36. There was some diarrhoea. Ten grains of quinine were given again in the evening. At 9.30 P.M. the temperature was 102-4°; pulse 123; respiration 35. The breathing had been very fair during the night. The skin was moist and the man's aspect better. The bowels were loose. The oedema of the neck and chest had almost entirely disappeared. The general signs of consolidation of the apex of the right lung were more marked. The uvula and fauces remained red. At 7 P.M. the temperature had risen to 104-6°; pulse 122. He had a slight diarrhoea. Ten grains of quinine were ordered to be given at once, and to continue the ten-minim doses of tincture of perchloride of iron every four hours which had been commenced in the afternoon. On the 11th, at 8.30 A.M., the temperature noted had shown 105-2°; pulse 95; respiration 28. Astringents had been administered to check diarrhoea. Returning crepitation was audible over the apex of the right lung. At 7.15 P.M. the temperature had risen to 103-°; pulse 112; respiration 42. Ten grains of quinine had been given in the afternoon. On the 12th, at 8.30 A.M., the temperature had fallen to 100°; pulse 98; respiration 28. He had slept during most of the night. Sputum yellowish, clear, and tenacious. He complained of some pain in the right side of the chest. In the evening the temperature had fallen still lower—namely, 98-5°; pulse 86; respiration 21. He was sweating rather profusely. The tongue, which had been dry, still remained so. He had slept much during the night. From this time he had steadily improved. On May 23rd the pulse at the right side of the neck was 80. The right lung had almost disappeared, and on the 30th he was quite convalescent. On June 8th he was discharged from hospital to join his corps at Aldershot.


drug was applied to the interclavicular notch, and (2) the line along the posterior border of the sterno-cleido-mastoid muscle, taking care to avoid the spot where the muscle is crossed by the external jugular vein. The lines are drawn to Mr. Bickersteth's paper on this subject in the 'Liverpool Medical and Surgical Reports,' vol. iii., Oct. 1869. A recent paper by Surgeon G. H. Young, A.M.D., will be found in the "Transactions of the Liverpool Medical and Surgical Association," vol. xxxii., p. 244.

In its early stages leprosy may be recognised by certain cutaneous changes or by anesthetic patches. One looks instinctively to the forehead, especially the superciliary ridges. If leprous, the skin is somewhat thickened in this position, dusky in colour, but not necessarily irregular. The hair of the eyebrows is scanty. Sometimes the forehead is free, and on the face a raised, slightly indurated, reddish area, perhaps on one cheek, is the only sign. In this case the differentiation from syphilis is not always easy. But even here, in a certain proportion of patients, impairment of sensation at the feet and legs will be found. Speaking broadly, there are two main types of leprosy in the Valley—the anesthetic and the tubercular. I have seen one striking case of macular leprosy with a wide area of anesthetic patches varying in size from a farthing to a five-shilling piece, and darkly pigmented at the borders. Anesthesia was, however, associated, and not unfrequently one may see patients presenting at one and the same time anesthesia, macules, tubercles, and ulcerations of soft tissues and bone. It is by far more common to find a patient with anesthetic patches, but without tubercles, than the converse. Take, for example, the case of A.M., a patient who was under my observation for more than two years. About five years ago his sciatie nerves were destroyed for anesthetic leprosy. Scarcely has there been any new manifestation of the disease. His general health improved, and he was regarded as practically cured, but, I believe, by the nerve stretching, which only alleviated and favourably modified the disease in the lower extremities, whereas the ulceration of the ear in relation to the auricular hillocks and the morbid elements. This patient died quite recently from acute but obscure symptoms—possibly a perforating ulcer of the stomach or intestines.

Anesthesia seldom remains for any length of time in the leprosous, but is apt to form, and then local death of tissue and ulceration. This process is no doubt partly trophic. Perforating ulcer of the sole is a common and early symptom in leprosy. Wide tracts of superficia health and nerves are able to remain intact on the sides of the legs and feet. Two seats of election are the outer aspect of the forearm and the soles of the foot. From the former the leg over and immediately below the head of the fibula, and over the ulnar aspect of the upper third of the forearm. Exposure to friction partly determines these facts, but withdrawal of nerve influence is concerned, as the beneficial results of nerve stretching demonstrate. In later stages the quiet necrosis of phalanges is probably due to the same cause. Portions of bone removed by operation are spongy, and appear to have undergone a process of rarefying osteitis. In all these cases the nerves supplying the part are found on clinical examination to be thickened and sometimes tender; while if inspected, as in nerve stretching, the trunks are markedly enlarged, and usually pink and of firm consistence. If a portion be excised, a great excess of fibrous tissue is demonstrable by the microscope. Apart from the observations of Tschiriev, on the Morbid Anatomy of the Spinal Cord in Leprosy, showing atrophic changes, there seems every reason to suppose that trophic changes are of primary importance. Sensation is abnormally decreased, and sometimes participates in this change. For stretching of one sciatie nerve is found occasionally to favourably affect the sensibility of the opposite side. The nerves most often involved in leprosy are, in order of frequency, the sciatie, musculo-skeletal, and umbilical. In leprosy, anaesthesia is much more common than the opposite nerve. In leprosy, anaesthesia is much more common than the opposite nerve.