by the lymphatics of the oral and pharyngeal cavity exceedingly important, for the purpose of making the absorbed mucous products harmless. He further believes in a beneficial influence exerted by carbolic acid upon the blood. A rapid amelioration of the disease always appeared with the excretion of dark, olive-green urine. The inhalations are made every two or three hours, or even oftener, and last from two to five minutes, according to the severity of the disease and the strength of the patient. As the patient improves, the inhalations are made less often, and are of shorter duration. If the urine change colour strikingly, or if gastric disturbances occur, the inhalations are reduced in number. If the urine become dark-coloured, they are discontinued for twenty-four hours, and other solutions, such as one containing from two to four per cent. of boracic acid, or five per cent. of benzoate of soda, are substituted, the carbolic acid treatment being recommenced when the urine has regained its natural colour. To hasten the separation of the diphtherial membranes, Dr. Oertel advises two methods: 1. The loosening of the membranes by suppuration; 2. The mechanical raising of the membranes by exciting increased secretion of mucus. The first method mainly involves the employment of heat, which promotes suppuration, and thereby demarcation and separation of the membranes. Hot vapours or steam are used, for a quarter of an hour at a time, from four to eight times a day, together with the carbolic acid treatment; and under these means the extension of the diphtherial deposits soon ceases. The hot inhalations are reduced in number when the separation is fairly progressing, but the carbolic acid is continued for two days, to prevent a renewed infection of the mucous membrane. Dr. Oertel finds other local remedies decidedly inferior to carbolic acid. Lime-water and lactic acid, though able to swell and dissolve fibrinous coagula, possess no antiseptic or disinfectant properties, and are not indicated in pharyngeal diphtheria, as in the mouth and pharynx there is no danger of stenosis. To stimulate the secretion of mucus underneath the deposits, and so mechanically to lift them up, and at the same time to remove the fungous growths and septic matters from the mouth, Dr. Oertel uses muriate of pilocarpin, which he gives in doses of one to five centigrammes (0.15 to 0.75 grain) dissolved in water. The rapid separation of the membrane, which took place in a case accidentally complicated by salivation, led Dr. Oertel to try this remedy. In adults, when the morbid process has lasted some days, he makes a subcutaneous injection of from one to two milligrammes (0.015 to 0.03 grain) of pilocarpin.—*London Med. Record*, May 15, 1881.

Pericarditis Treated by Incision into Pericardium.

Dr. ROSENTEIN, of Leiden, relates (*Berliner Klinische Wochenschrift*, No. 5, 1881) a case of purulent pericarditis, treated by a free incision into the pericardium much as we now treat some cases of purulent pleurisy. A boy, ten years of age, came under observation after having been attacked fourteen days previously with symptoms of gastric catarrh. On admission into hospital, the following was noted as the *status presens*:—"The patient lies by preference on his back, though on either side position does not cause any inconvenience. Nutrition is good; cheeks and mucous membranes remarkably pale; axillary temperature 99.8° Fahr.; pulse very small; respiration 40, costo-abdominal; ale nasi working strongly. The chest measures, at the level of the third dorsal vertebra, on the right side thirty-four, on the left thirty-six centimetres; at the level of the sixth dorsal vertebra, right side thirty-six, left side thirty-seven centimetres. The heart's beat is neither to be felt nor seen, nor are the heart-sounds audible at any part of the chest. On percussion, on the right side the percussion-sounds are normal as low as the sixth rib; on the left side, dulness commences between

the first and second ribs, and gradually extends to the xiphoid cartilage, passing obliquely towards the left as far as the mid-axillary line, and to the right as far as the nipple-line (thus presenting a somewhat triangular space, apex up and base downwards). There is no change in the dullness on altering the patient's position. . . .” A diagnosis of effusion into the pericardium was, of course, made; but its exact nature could only be determined by an exploratory puncture, and this was done. The presence of pus having been made certain, aspiration (between the fourth and fifth ribs, close to the margin of the sternum) with a Potain's apparatus was practised, and upwards of twenty-two ounces of pure pus were withdrawn. The relief afforded by this operation is compared with that which so often follows tracheotomy for laryngeal obstruction. The relief, however, did not last very long, and it became necessary to repeat the tapping on the third day, but the pericarditis was not found to be associated with a left pleurisy, which had developed since the first tapping. The pleura was accordingly tapped, and thirty-eight ounces of serous effusion were withdrawn. The pericardium was again tapped, and about four ounces of pus taken out. The patient's condition did not much improve: there was very considerable and increasing dyspnoea, with lividity, and some oedema of the feet and legs; sleep was much broken, and the general condition very low. Under the circumstances, it was determined to incise the pericardium, as the physical signs pointed pretty conclusively to a further accumulation of fluid within it. The operation was carried out under the strictest antiseptic precautions. An incision, about three centimetres long, was made between the fourth and fifth ribs, close to the left margin of the sternum, and each layer separately divided until the pericardium was reached. An opening was then made into it, through which a considerable quantity of pus escaped; two drainage-tubes were put in, and the wound dressed after Lister's method. The patient was, very shortly after the operation, able to lie on his back, and felt much relieved by it. It was not, however, until at least two hours later that the pulse became appreciable. On the day following, the temperature stood at 101° Fahr., but it then came down to normal and remained so. At the end of eight weeks, the pericardial wound, which had been gradually closing, was cicatrized. There were no further pericardial troubles. But the signs of the pleuritic effusion pointed to a fresh collection in this cavity, while there was still fever after removing thirty-five ounces of fluid; as the general condition therefore was not relieved, a free incision was made into the chest, and another fifty ounces were removed. Improvement now set in, and at the end of six weeks the wound had closed, and the patient was sent out of the hospital cured.

The author draws the following conclusions from his case:—1. The case teaches that purulent pericarditis, just as empyema, may at times run its course without giving rise to fever or oedema of the tissues, so that the nature of the exudation can only be decided after an exploratory puncture. 2. We must not abstain from removing the exudation on account of any supposed myocarditic changes. 3. In cases of considerable pericardial effusions, change of position may not influence the line of dullness; but this fact must not always be interpreted in favour of dilatation of the heart.—*Med. Times and Gazette*, March 19, 1881.

— *Adult Cephalic Murmurs.*

M. TRIPIER (*Revue de Méd.*, Feb. and March, 1881) points out that a cephalic murmur is found in adults, and that he has observed it in several chlorotic patients, and in one case of each of the following: metrorrhagic anæmia, pernicious anæmia, intra-cranial tumour, and hydrocephalus. It is a systolic murmur, and is best heard over the temples, especially on the right side. It is not at all