

The last case of nævus to which I have to refer was in an infant about ten months old. The nævus was in the fore-part of the neck, and immediately over the larynx. It was of the size of a half-crown piece, and not much raised. It was troublesome to treat on account of two complications. In the first place, after the vascular structure seemed to have been entirely destroyed, it reappeared in small points not larger than the head of a pin. In the second place, whenever the ethylate was freely used, so as to destroy a large surface of the growth, a very peculiar, sharp, croupy cough was set up, which indicated the necessity of limiting the application. These obstructions, combined with the desire not to produce a scar, caused the treatment to be very prolonged, and to extend over several weeks. Fortunately it has, I hope, ended successfully, and I apprehend without leaving evidence of scar, though that remains to be proved.

(To be concluded.)

SIX CASES OF PARACENTESIS THORACIS.

By A. W. MAYO ROBSON, F.R.C.S.,

DEMONSTRATOR OF ANATOMY, LEEDS SCHOOL OF MEDICINE.

SINCE the subject of paracentesis thoracis in pleurisy with effusion has been thought worthy of being discussed lately by the Medical Society of London, the following cases I venture to hope may prove sufficiently interesting for publication, especially as they bear on the possibility of cure by once tapping, and on the danger of rapidly drawing off a large volume of fluid at one operation. Moreover, the cases have not been selected, but are reported as they occurred, being the only pleuritic effusions which I have had to treat in my own practice during the last two years.

CASE 1.—Mr. C—, aged thirty-two, with a phthisical family history, consulted me, saying that he had been well up to three weeks before, when he began to suffer from a "stitch" in the left side, that he was now very short of breath, and had difficulty in ascending a hill; his appetite had become impaired, and he was losing flesh rapidly. I found the left side dull as high as the inferior angle of the scapula, with an absence of breath sounds and vocal fremitus, but there was no disease of the lungs or other viscera. I ordered a blister to the side, and gave digitalis and iodide of potassium, but after a fortnight the fluid had reached the spine of the scapula. I advised a dry diet, and that as little fluid as possible should be taken, at the same time giving small doses of elaterium. For a few days the fluid diminished a little, but after a week it remained stationary, and my patient became tired of his rigid diet. I advised paracentesis, but, before operating, asked Dr. Clifford Allbutt to see the case with me. He fully endorsed my recommendation.

By means of the aspirator I drew off two pints and a half of clear straw-coloured fluid through the eighth intercostal space. My patient was at once relieved, and forthwith began to improve. Although a little fluid collected again during the next ten days, under the use of an iodine liniment externally and iodide of iron internally it became absorbed; and at the end of five weeks he went to Torquay for change of air. On returning a month afterwards he had gained 10 lb. in weight, and the lung seemed to have fully regained itself.

CASE 2.—Mrs. K—, aged thirty, with a family history of phthisis, told me that she had caught cold two weeks previously, and had been suffering from pain at the side and shortness of breath ever since. She had lost flesh and was looking distressed and haggard. The right side was dull up to the fifth rib, and presented the usual signs of fluid in the pleura.

A blister was applied to the side and digitalis, iodide of potassium, &c., were given, but the fluid still increasing, the dry diet treatment was adopted. No improvement resulting, tapping was advised, but as the patient and her friends said that she should not undergo an operation if it could be avoided, medicinal treatment and iodine externally were tried for several weeks, at the end of which time the dulness had reached to the clavicle, and the heart was pushed to the left; the pulse was small and intermittent, the lips were livid, and the patient had to be constantly sitting up in bed in order to breathe. At last she consented, and I drew off by means of the aspirator four pints and a

few ounces of a clear straw-coloured fluid. The pulse at once became fuller, more regular, and slower, the heart assumed its normal position, the lividity disappeared, and she could bear to lie in the recumbent posture. Vesicular breathing could now be heard in the infra-clavicular region, but not below. Although her condition improved daily, some fluid returned, and a fortnight afterwards the dulness reached the mammary line; however, under the use of iodine externally and iodide of iron internally it gradually disappeared, and six weeks after the operation she was able to go into the country for change of air, there being a little dulness and some falling in of the right thoracic wall. After being eight weeks in the country she called on me, and I found she had gained 9 lb. in weight. There was vesicular breathing all over the right side, and but for the slight falling in opposite the eighth, ninth, tenth, and eleventh ribs, no evidence was left of her attack.

CASE 3.—The above patient, Mrs. K—, continued quite well for fifteen months, when she caught cold, was seized with pain in the left side, and was in every respect similarly affected as she had been in the previous attack, excepting that she could now only bear to be on the right (sound) side. Effusion came on very rapidly, so that a week after hearing a friction sound over the front of the chest the dulness had advanced as high as the clavicle, and the heart had become slightly displaced to the right; the distress in breathing, though severe, was not so great as when the effusion was on the right side. She begged to be tapped, and I at once drew off by means of the aspirator and a large needle five pints of clear fluid. She was seized with a violent fit of coughing before the needle was withdrawn, became livid in the face, and breathed with great difficulty; for a few minutes I was very anxious, as the pulse was small and fluttering, and she seemed to be in great distress. I gave one-sixth of a grain of morphia by injection, which soon relieved her. From this time she had not a bad symptom, was out of bed in a fortnight, and able to leave for the country in a month. Two months afterwards she called to see me, and appeared to be in very good health; both lungs were doing good work, and the left side of the chest had not become depressed in the least.

CASE 4.—A. B—, aged thirty-six, got wet through, shivered and felt a pain in the right side; the temperature reached 102° 6' and 103° for several days in succession, and there were the physical signs of pneumonia of the right lower lobe. A distinct crisis never occurred, the temperature for nearly a month rising each evening to 100° and 101°, and night sweats coming on. At the end of a month the dulness still continued, but as vocal fremitus had disappeared and he could only bear to lie on the sound side, I feared an empyema was forming, and explored by means of the aspirator. Finding the fluid clear, I drew off a pint and a half, giving my patient great relief. Some fluid returned, and at the end of three weeks I again drew off a pint, and in a fortnight three-quarters of a pint more, after which recovery was steady but sure, and he was well in three months from the commencement of his illness.

CASE 5.—Mrs. H—, aged twenty-seven, with a family history of phthisis, became debilitated by suckling, and caught cold. She called to consult me for a pain in the side which had existed for a fortnight, and for shortness of breath. On examination I found signs of fluid in the left pleura as high as the fifth rib. After twelve days' medical treatment, there being no improvement, but rather an increase of the effusion, I drew off a pint and three-quarters of clear straw-coloured fluid. She was at once relieved. After a few days a little fluid returned, but under the administration of iodide of iron and cod-liver oil, with the external use of iodine, it gradually disappeared, and she was able to go out in a month. Some dulness, evidently due to thickened pleura, remained for some time, and the lung expanded slowly, but at the end of three months (she having in the meantime spent a month at the seaside) I found the lungs doing good work, and the dulness scarcely perceptible.

CASE 6.—Miss M—, aged twenty-one, called to consult me, saying she had been ailing for several months, but that during the last few weeks she had been suffering from pain in the side and shortness of breath. She had lost flesh considerably. On examination, I found the left side of the chest dull up to the spine of the scapula, with the usual signs of fluid. As the temperature was 101°, I advised rest in bed and poultices to the side, and gave ammonia and chinchona internally; the fever subsiding in four days, she was ordered to take iodide of potassium with the bark

mixture. At the end of ten days, there being no further improvement, but a slight increase of the fluid, I aspirated the chest in the sixth intercostal space, and took away two pints of clear fluid. My patient was at once relieved, and able to lie in the recumbent posture, she having been only able previously to be semi-recumbent and inclined to the right side. She improved rapidly under iodide of iron, with the external application of iodine liniment, was up in six days, and able to go out a fortnight after the tapping, feeling quite well in every respect, the lung having fully expanded, and very slight dulness remaining.

From the foregoing cases, and from others which I have observed in hospital and in private practice, I am as fully convinced that paracentesis thoracis, properly performed, is the best treatment in pleurisy with effusion, if the fluid be in any quantity, as I am that the administration of medicine to cause absorption is for the most part only waste of time to the doctor and disappointing and dangerous to the patient; for every additional day during which the lung is exposed to pressure, and time is allowed for cells to multiply in the fluid, lessens the chance of a complete cure, tends to permanently impair the lung, and to give rise to empyema with all its dangers; besides which, where there is extensive effusion there is more or less interference with the action of the heart, and great danger of sudden death.

Leeds.

SOME REMARKS ON THE TYPES OF PNEUMONIA WHICH ARE MET WITH IN NORTHERN INDIA AND IN NORTH-WESTERN AFGHANISTAN, ETC.

By C. P. COSTELLO,

SURGEON-MAJOR, BENGAL MEDICAL DEPARTMENT.

As regards the northern and north-western parts of India these remarks are founded on twenty-one years' experience, and are offered to the profession solely because many of the facts are not as generally known as could be wished, and are therefore likely to be of use to practitioners whose lot may be cast in India, and to whom, on first commencing practice there, some knowledge of the peculiarities of pneumonia as found in Northern India may be useful.

As generally met with, this disease both in Northern India and in Northern and Western Afghanistan presents an asthenic type, and is often "latent." Persons who have suffered much from intermittent fever are, as a rule, more liable to pneumonia than others, and, on this account, there may be a "malarious" cause in such cases; it may also be added that just at the end of the fever season, before intermittent fever has ceased to fill the hospitals—that is, about the latter part of September and in October—this disease becomes very prevalent indeed. As usually seen, it runs through the first and second stages pretty regularly, but rusty sputa are not always found, and often the stethoscope detects the disease when there has been no cough or expectoration, pain in chest, &c.; it is then, of course, "latent," and this, as a complication, is most usually met with in "remittent fever," or in enteric fever, &c. When not "latent," it does not always commence at the base of the lung and travel upwards, but often begins in the middle of the lung, or perhaps at the apex, although the latter is rare. Frequently it does not pass beyond the first stage. "Latent" pneumonia is, as a rule, found to be in the second stage when first observed; this may be, and probably is, due to the delay which occurs before it is observed. Pleurisy, to some extent, is not an uncommon accompaniment of the disease, and it has often occurred to me that the case under treatment might be correctly named pleuro-pneumonia. At first I expected that this pleuro-pneumonia was contagious, and, acting on the idea, I made it a rule to isolate all such cases. In 1875 an event happened which confirmed me in this idea as to the contagiousness of some forms of pneumonia, and especially, and almost always, of pleuro-pneumonia. This was when I had charge of the 1st Punjaub Infantry at Dera Ghazi Khan, and before proceeding further, I should state that pleuro-pneumonia was very fatal amongst cattle in the Punjaub, and in the north-western

frontier districts—more markedly in the lower Derajat—in that year. The 1st Punjaub Infantry, on being relieved by the 5th Punjaub Infantry at Abbotabad, marched through many of the affected districts to Dera Ghazi Khan; and the latter regiment, which took the same course to Abbotabad, had an identical outbreak, with even more fatal results, with that which I have now to describe as having occurred in the former. On joining the 1st Punjaub Infantry at Dera Ghazi Khan towards the end of March in 1875, the regiment was in a state of consternation at the number of deaths which had within a short time prior to my arrival occurred from "pneumonia." It was then rather warm at Dera Ghazi Khan, and there was not much variation of temperature in the twenty-four hours, or much difference between the day and night temperature, which made the continuance of the disease all the more inexplicable. At least from thirty to forty men had died from it in a few weeks out of a strength of about 550—as well as I can now without my notes recollect. On inquiry into the particulars &c., of the outbreak, I found them rather peculiar—viz., it was confined, almost, to two companies; when it began in the married lines, it spread from one to another of each family; in the hospital other patients not previously affected took it; and even the hospital servants, including a hospital assistant, got it apparently from patients suffering from it on whom they were, at the time of becoming ill, attending. It spread quickly through each lung, and from one lung to the other; there was scarcely ever a second stage, as the disease ran from the first stage quickly into the third, and into gangrene of the lungs. In most cases the nervous system was from the outset prostrated; the tongue dry, brown, and hard, there were sordes about the teeth, and in fact all the usual symptoms called "typhoid;" and there was in each case a "catching" pain in one or both sides—generally in a line under the axilla. I commenced by having the regiment removed from their barracks to tents; all persons affected with the disease were removed to a separate camp, where they were isolated from all others except their attendants; the attendants were forbidden from all communication with other persons or cases; and the barracks, married lines, &c., were thoroughly disinfected. Besides, everything was made ready for a march from the station should the outbreak not disappear with the above precautions. Soon after—almost at once—the above measures were taken the outbreak ceased, no new cases occurring, and within a fortnight there was not a case of the disease in the regiment. The 5th Punjaub Infantry at Abbotabad lost, I believe, sixty men from a similar outbreak; and although it was attributed to the sudden change from the warm climate of Dera Ghazi Khan to the cold and hilly climate of Abbotabad, I think that the cause was the same in both regiments—i.e., infection caught when marching through districts known to be affected with the cattle plague—pleuro-pneumonia—as met with in the year 1875 in the Punjaub and north-west frontier districts. The 1st Punjaub Infantry being chiefly "Pathans," had a great objection to post-mortem examinations, but I have had frequent opportunities in gaols under my charge on the north-west frontier of examining fatal cases of pleuro-pneumonia, and the appearances in the lungs were pretty uniform—viz., almost complete disorganisation of each lung with numerous and separate abscesses, and often gangrene of parts of the lung affected. Both lungs were usually involved, and there was a good deal of dirty soft lymph on the pleura of the affected lung, with a sanguineo-serous fluid in small quantities in the cavity of the pleura. The blood found in the left cavities of the heart was generally dark and thin.

In the type of pleuro-pneumonia just noted I found that the most successful treatment was that which in erysipelas is found most effectual—i.e. quinine, chlorate of potash, and tincture of the sesquichloride of iron, in fifteen-minim doses, along with, in this case, expectorants, antispasmodics, &c. Stimulants and good nourishment were given from the outset, and with success. In the ordinary form of pneumonia, as met with in our part of India, &c., I find quinine in small doses combined with Dover's powder (one to two grains) and ipecacuanha the best internal remedies to begin with, combined with sinapisms, followed up by "jacket" linseed-meal poultices. Good nourishment has to be given from the outset. Very soon it is generally necessary to give ammonia, squills, quinine, and compound tincture of camphor, instead of the Dover's powder, quinine, &c., above mentioned, and port wine or brandy has to be ad-