

pulse was 124 and the temperature was 104.6°. I gave a powder of fourteen grains of phenacetin and ordered seven grains to be given every four hours, a mixture containing acetate of potash and tincture of aconite, and an iodoform pessary to be introduced. There was no marked abdominal tenderness, but some tenderness of the fundus was present. Vaginal examination showed a slightly retroflected uterus with puffy cervix. There was no difficulty in reducing the flexion. No malodour was apparent in the scanty discharge. I called on the district professional nurse and asked her to administer night and morning an injection of hot solution of Condy's fluid and an enema of one pint of plain water, also hot. I diagnosed the case as puerperal influenza.<sup>1</sup> The tongue was of the influenza variety, moist and slightly furred. On July 16th, at 12.30 P.M., the temperature was 100.8°, at 2.30 P.M. it was 104.6°, and in the evening it was 103°. Subsequently the temperature was as follows:—

Date.	Morning.	Evening.	Date.	Morning.	Evening.
July 17th ...	101.0°	98.6°	July 22nd ...	99.8°	100.2°
" 18th ...	100.0°	99.0°	" 23rd ...	99.8°	98.8°
" 19th ...	101.4°	103.4°	" 24th ...	98.4°	99.0°
" 20th ...	100.2°	102.2°	" 25th ...	98.4°	—
" 21st ...	100.2°	101.4°	" 26th ...	98.6°*	—

\* Became subnormal.

On the 17th and 18th she had nocturnal delirium and I prescribed 30 grains of bromide of potassium and one drachm of ammoniated tincture of valerian in two ounces of water; this was to be repeated night and morning when the restlessness was extreme. On the 19th she had diurnal as well as nocturnal delirium. On the 21st I gave her a sulphate of quinine and hydrobromic acid mixture. From the 16th to the 21st the pulse varied from 110 at first to 140; it was generally about 132. On the 22nd I reduced my visits to one each day and the nurse took the evening temperature. On the night of Aug. 26th–27th the patient had chills and pains all over. The temperature was 100.8°. No puerperal condition could be made out. I ordered the mixture of acetate of potash and aconite together with the phenacetin powders. On the 27th, at 10 A.M., the pulse was 108 and the temperature was 99.6°; at 10 P.M. the temperature was 102°. On the 28th, at 10 A.M., the pulse was 108 and the temperature was 99.4°; at 9 P.M. the temperature was 98.4°. On the 29th, at 11 A.M., the pulse was 72 and the temperature was 98°.

*Remarks.*—Owing to the preliminary diagnosis of influenza I was led to make inquiries about previous illness. The hypothesis is that if there is no influenza at the time of labour or delivery the puerperal trouble begins at the end of the fifth day; if the patient has influenza at the time of labour there is a respite for two and a half days, and the influenza then reappears, generally in a different form, and frequently in a puerperal form.<sup>2</sup> I found that the patient had had chills and pains all over on July 9th, and she had noticed that her feet were swollen on the 7th. The labour was before the expected time, a common occurrence in influenza, and began about 1 A.M. on the 14th. The temperature chart shows on the 16th the rise beginning about 12.30 noon and a high temperature by 2.30 P.M. Except for absence of streptococcic serum treatment I treated the case on general puerperal fever principles, keeping the parts disinfected by Condy's washes and iodoform, while I treated the fever as an influenzal condition, avoiding stimulants and narcotics at first. When the patient was nearly out of danger, and her sister was congratulating herself and me on her recovery, I told her they must look out for a recurrence of the attack in seventeen, thirty-five, or fifty-one days from the commencement,<sup>3</sup> but that if they let me know at once on its recurrence we should probably be able to cut it short in three days. The tongue at that period was of a distinctly influenzal character. Now seventeen days from the 7th, when she noticed her feet swell, brings us to July 24th, when the patient was weak but convalescent in bed; thirty-five days, to Aug. 11th, on which date no new symptoms occurred; and fifty-one days to Aug. 27th. On the night of the 26th the temperature rose to 100.8° and the case ran as described above. As these cases occur so frequently in a more or less distinct form one is disposed to look upon them as a puerperal catarrh of an influenzal nature. The deaths from them are rare if treated as a catarrh. Out of a very considerable number of such cases I can remember only once losing a patient, and I believe that was a case of true "puerperal" fever engrafted on the influenzal catarrh, due to want of

cleanliness on the very unprofessional nurse's part and general inattention to directions, the patient from the beginning having to attend to most of her wants as best she could. I cannot call to mind any similar cases anterior to the influenza of 1889, when they became frequent. The milk-supply also is generally unaffected, and if there is any malodour about the discharge it is of a peculiar mousey nature, which I cannot call to mind as occurring in any other complaint. I saw my patient on Sept. 11th and sent her into the country. She nursed the flourishing infant until the middle of October. At this time the child was taken from the breast owing to the nervous condition of the mother, who is to-day (Nov. 16th, 1897) doing well.

There are so many points in common between Dr. Rawlings's case and the above, and the injections of anti-streptococcic serum were in his case, so ineffectual, that it is suggested that we have a catarrhal germ infection not of a streptococcic nature. If the relation of these cases make us all more careful in future to look for the streptococcus it will be the means of our learning to distinguish between the various forms of puerperal fever.<sup>4</sup>

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## A CASE OF ABSCESS OF THE LIVER; RUPTURE INTO THE LUNG; RECOVERY.

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FOR the notes of the following case I am indebted to Mr. Charles Lamplough, resident medical officer.

A man, aged thirty-five years, costermonger, was admitted to the City of London Hospital for Diseases of the Chest on Aug. 5th, 1897, complaining of diarrhoea and pain in the right side. He had never been out of England. His bowels had acted two or three times daily for two years, but with little or no abdominal pain or tenesmus, nor had he noticed any blood in the evacuations. He had had a slight cough for twelve months, and during the three months prior to admission he suffered from "shooting" pains down the front of the right chest with shortness of breath on exertion. On examination the patient was found to be a well-developed man, though emaciated and anæmic. No jaundice was noted. He had a slight cough with scanty mucoid expectoration and complained of a sharp pain over the right lower ribs in front. The chest was of good shape and expanded fairly well and equally. Anteriorly there was comparative dullness from the lower border of the fourth right rib in the nipple line to two inches below the costal margin; behind, the percussion note was comparatively dull below the inferior angle of the right scapula. Over the dull area the breath sounds, vocal resonance, and fremitus were much diminished, though not entirely lost, but no moist sounds were audible, nor was the voice of ægophonic quality. The heart's apex beat was in the fourth left interspace half an inch "inside" the nipple line. The sounds were free from murmur, the pulmonic second sound being accentuated. The pulse was 92, regular, and of fair tension and volume. The abdomen was slightly distended and tympanitic, not tender, but very resistant. The lower edge of the liver could be indistinctly felt about two inches below the costal margin. The spleen was not palpable. The bowels acted two or three times daily, the stools being large, fluid, and very pale, containing no blood or mucus. The temperature varied from 99° to 101° F. daily. The diarrhoea, pain over the upper part of the hepatic area, the enlarged liver with great abdominal resistance, the diminution of breath sounds, and the slight elevation of the heart without lateral displacement towards the right, together with the remittent temperature, suggested the diagnosis of abscess of the liver. Three exploratory punctures were made into the lower part of the right chest over the painful area, but nothing excepting a little blood was withdrawn. The patient gradually became worse until Aug. 16th, when suddenly at about 3 A.M. he had a fit of coughing, lasting on and off for about two hours, during which he expectorated about six ounces of dark fluid,

<sup>1</sup> Vide Dr. Gray's Influenza (H. K. Lewis), pp. 37 to 44.

<sup>2</sup> Op. cit.

<sup>3</sup> Op. cit.

<sup>4</sup> Compare also Dr. Groth's case in THE LANCET, Aug. 14th, 1897.

of the typical anchovy-paste appearance; this was carefully examined by Dr. J. J. Perkins with a negative result, except that numerous torulæ were found. For the next ten days the man continued to bring up blood-stained purulent liquid, measuring about fifteen ounces daily and of a faint pinkish colour. During this period the temperature fell to subnormal, varying diurnally from 97° to 98°; the diarrhoea continued in spite of careful dieting and the administration of intestinal astringents and antiseptics. It was noticed also that the muscles of the right loin were much smaller than the corresponding muscles on the left side of the spine, though the former reacted equally with the latter to the faradaic current. This condition of the muscles, strange to say, seemed to give the patient no inconvenience in raising himself in bed.

After this the patient began to recover slowly, the expectoration diminished in amount, the cough became less troublesome, and the appetite began to improve. On examination of the chest the physical signs had also notably altered; the upper limit of dulness extended only to the sixth rib in the nipple line, though it remained high in the mid-axillary line, but again descended as it reached the spine, and the lower edge could now be felt just below the costal margin. On auscultation loud friction sounds with râles and rhonchi were heard over the fourth and fifth right ribs anteriorly. On Sept. 8th the patient had another sudden attack of coughing, and this time he expectorated several ounces of bile-stained fluid; excepting that his cough was rather more troublesome for the following fortnight, with an increase of moist sounds over the right lung, his condition was not materially altered. By Sept. 22nd the patient had ceased to expectorate bile-stained fluid, and from this time until his discharge, a fortnight later, his recovery was rapid and uninterrupted, his temperature again reached the normal level, the diarrhoea entirely ceased, the lumbar muscles recovered their normal size, and the patient gained 9 lb. in weight. The man left the hospital apparently quite well nine weeks after his admission and seven weeks after the date of the rupture of the hepatic abscess into the lung.

*Remarks.*—This very complete case is a good instance of a hepatic abscess occurring without any assignable cause. It also illustrates the fact that cases of abscess of the liver usually terminate favourably after rupture into the lung.

## ON THE CLIMATIC TREATMENT OF PHTHISIS.

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A MAN who is phthysical, or in danger of becoming so, is sure to be recommended a change of climate; but the diversity of climates reputed to be useful to such a patient is at first sight very puzzling. He may be sent for a sea voyage or to an Alpine health resort, to a high and dry tableland or to a low-lying seaside place; and bracing and relaxing, hot and cold places alike, are said to be useful in this same disease. How, then, are we to account for this diversity? Probably in part by corresponding differences in the form of the disease and the constitution of the sufferers, but mainly by the essential climatic factors being comparatively few in number and climate itself but one out of many matters of importance.

We may disregard for the moment the actively inflammatory stages of the disease, which, being usually treated indoors, will do almost equally well in any climate. We may also disregard the advanced incurable forms, in which the utmost that can be done is to prolong life or to render it more supportable. Confining our attention to the places with an established reputation for the cure of phthisis we find that with much diversity of minor details they all agree in the possession of certain common characters which we are justified in regarding as the really essential features. 1. In the first place, all such health resorts have a pure air, unvitiated by decaying organic matter or by the impurities inseparable from a large and crowded population. 2. Their atmosphere is free from dust and smoke. Dusty occupations are a fruitful source of lung disease. The dust and smoke

of towns are highly injurious to phthysical patients, both from their mineral and organic particles and from the pyogenic and other bacteria which they contain. Even country dust is hurtful, and the most successful health resorts for phthysical patients have a large proportion of grass land or large sheets of water which help to purify the air. 3. These health resorts have a fresh and bracing as well as a pure atmosphere. In the Alpine and hill sanatoria the air is cool even with a hot sun; in the high tablelands the dryness of the air makes it more bracing, while the mornings and evenings are cool and refreshing; by the seashore or on the ocean there is always a cool breeze to temper the noonday heat; so that they all agree in being more or less bracing. 4. But if these health resorts are breezy they must have abundant shelter, for strong winds are very bad for phthysical subjects, exhausting their strength, interfering with respiration, and increasing the risk of chills. Many of the more favoured places are protected against the colder and more boisterous winds by surrounding hills or mountains; in others the necessary protection is obtained by means of forests. 5. These health resorts are also alike in having sufficient fine weather to make it possible to live almost entirely out-of-doors. "If pure fresh air and plenty of it" be the best prescription for phthysical patients, an indoor life should be absolutely forbidden them. Many people are only out-of-doors for two or three hours out of every twenty-four, and spend the former in the vitiated air of towns and the remainder in close and ill-ventilated rooms. A scarcely perceptible breeze out-of-doors supplies a hundred times as much fresh air as enters an ordinarily well-ventilated room. It can therefore be readily understood what a powerful curative agent we have in an out-of-door life in a favoured country or seaside place, and how much depends on the manner of life. Sunshine is very helpful to the phthysical patient, not only because of its anti-bacillary properties, but also (and mainly) because of its stimulating influence on nutrition generally. On the other hand, if rain does not keep people indoors it is also advantageous, as it cleanses the air and lays the dust. Moderate atmospheric moisture is useful in soothing irritable mucous membranes, but it is apt to render warm places relaxing and cold and windy ones depressing. Some of the health resorts for phthysical patients are extremely dry, but others have a moist, cool, still atmosphere, while some are foggy and damp at certain seasons of the year without any very obvious injury to the patients. We may therefore safely conclude that a moderate proportion of wet weather is no serious disadvantage provided that it does not interfere with an outdoor life. Much may also be done by the provision of shelters in the open air to overcome such drawbacks. 6. Prevailing temperatures of themselves have probably only a secondary importance in the treatment of phthisis, as we find a great diversity in this respect among the different health resorts. Very cold places are depressing unless dry and free from wind. Very hot places are relaxing unless dry and breezy. The more robust patients do best where the air is cool and dry, with a fair range of temperature, while more delicate patients require a warmer air and greater equability, which is intelligible in the light of hydropathic analogies. The temperature to be chosen will depend in part on the original home of the patient. French soldiers from the north have been found to be especially liable to contract rapid forms of phthisis when brought to the warmer regions of the south.<sup>1</sup> According to Meissen, North German patients seldom do well at the Riviera; and English authorities agree that the records for English patients are not so good there as at some colder health resorts. Warm sunny lands are extremely pleasant and are very useful in tempting people out-of-doors; but where there are sufficient powers of reaction a colder climate is more likely to cure. There is a mistaken impression in certain quarters that an equable climate is essential to the cure of phthisis. But some of the most useful climates—such as those of the elevated tablelands of South Africa—are far from equable, owing to the extreme dryness of the air; while phthisis abounds in some which have a very small range of temperature. 7. But if a warm and equable atmosphere is not often advisable it is quite otherwise with warmth of soil. A warm, dry soil is essential to a health resort for phthysical patients. It has been clearly proved that phthisis is more common on damp soils and that efficient drainage has lowered the phthysical death-rate. A

<sup>1</sup> Colin: Phthisie Galopante, Paris, 1874.