

appear to have been part of a general pyæmic condition and the late onset, nine days after operation, and the absence of peritonitis do not point to any connexion with the ulcer. As the patient had never had any vomiting or hæmatemesis can it be possible that the fall from the bicycle was the cause of both lesions?

Wellingborough.

FEVER, FOLIACEOUS DESQUAMATION, MORBILLIFORM ERUPTION, AND ALBUMINURIA FROM COPAIBA.

By J. C. MCWALTER, M.A. R.U.I., M.D. BRUX., D.P.H.

WHEN a patient presents himself with a copious rubelloid eruption, a temperature of 102° F., some congestion of the tonsils, and complains of being deadly sick, one naturally suspects scarlet fever. When, further, the patient is uncertain if he has ever had that disease, when he works in a large butter shop and lives in a lodging-house, and when his urine on being examined is found to contain albumin, the practitioner who decides that he is not dealing with a case of febris rubra undertakes a grave responsibility.

In the present instance, however, the whole phenomena were apparently due to the administration of copaiba in a case of acute gonorrhœa. The sufferer was a young man, aged 22 years, who had been taking 20 minim doses of copaiba whilst his affection was in the inflammatory stage. Although the rash which he exhibited was not unlike a copious copaiba eruption, the temperature of 102° , which had only abated to 101° by the next day after he had ceased to take the medicine and remained in bed, the general feeling of malaise, the throat conditions, and the fact that after three days a desquamation so considerable set in that foliaceous flakes of epithelium were shed off and regular casts of his fingers could be removed, led me to fear that I had been mistaken in attributing the eruption to the drug. This seemed to be the more likely as albumin was present in the urine in the earlier stage, though it quickly passed off. Finally, I sent the patient to the fever hospital but the staff concurred in the view that the symptoms were due to the copaiba and the patient got all right after four or five days though the desquamation continued somewhat longer. Evidently the disease plus the drug had produced a transient acute nephritis.

It is complacently laid down in text-books that when one has doubts whether a febrile eruption be scarlet fever it is safer to treat it as such. But the problem is nowadays not so simple. If a case is declared to be scarlet fever and a working man is sent to hospital and loses his situation he will have a legal remedy against the practitioner if there be any doubt as to the diagnosis. Should he work in a dairy or a butter shop the proprietors will have something to say if they are wrongly tainted with the suspicion of employing a scarlatinous servant; and, on the other hand, if the man really has an infectious disease in such a situation the danger is appalling.

Dublin.

A Mirror

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HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morhorum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

KING'S COLLEGE HOSPITAL.

A CASE OF PNEUMOTHORAX OCCURRING THREE DAYS AFTER INJURY TO THE CHEST.

(Under the care of Mr. F. F. BURGHARD.)

FOR the notes of the case we are indebted to Mr. Neville Hart, acting house surgeon.

A boy, aged six years, was admitted into King's College Hospital at 11.45 P.M. on August 31st, 1903 having been run over by a hansom cab with three people in it. The wheel, both from the marks on his coat and abrasions on his

body, appeared to have passed from about one inch above the right iliac crest to the neighbourhood of the left axilla. His lungs previously to the accident were probably healthy. When seen some ten minutes after the accident he was severely collapsed; he was pale, with blue lips and cold extremities, his temperature being in the rectum 95.7° F. and his pulse 154, small, irregular, and unequal. He was not unconscious but was in a restless and excited condition. His respirations were 40 and accompanied by an expiratory "grunt." His abdomen was full and moved only very slightly on respiration; it was very hard and tense but not particularly tender. The note all over the abdomen was decidedly tympanitic, the liver dulness being normal with the exception of a somewhat square patch below the ribs which was absolutely dull. His flanks were resonant; his spleen was unpalpable and its dulness was normal. On examining the chest the left side was seen to be immobile and flattened and several ribs on that side were broken. The epiphysis of the right clavicle was separated. On palpation the heart's apex beat was found in its normal place and the crepitus of the broken ribs was very marked. The percussion note was normal all over the chest and the cardiac dulness was unaltered. On auscultation a loud rasping sound was heard all over the left base which was probably due to the friction of the lung against a broken rib. In addition to this a loud "thumping" sound was heard even several feet away. With the stethoscope it appeared to be best heard over the epigastrium. Excessive tenderness was present all over the left side and this made examination difficult. There was no sign or history of blood being brought up nor did vomiting ever occur. The patient was at once put to bed in a partially recumbent position with hot-water bottles to his extremities, but he was very restless and there was a tendency to cyanosis. Oxygen was frequently administered and brandy was given diluted with hot water. At 1.30 A.M. his pulse was weaker and fluttering and strychnine was given hypodermically. Soon after this reaction took place and reached its height at 4 A.M. The skin got warm, the face flushed, and the eyes brightened. His pulse rose to 184 and at 4 A.M. it was full and regular. His temperature rose steadily, being normal at 2 A.M., 100.2° at 3 A.M., and 100.8° at 4 A.M. His general condition was much improved but the dyspnoea was accentuated and he sat straight up; whenever there were signs of cyanosis oxygen was administered. He was still given brandy, though in small quantities and less frequently. He now passed 14 ounces of urine which was quite normal and contained no blood. His respirations reached 48 and increased in rate till 2 P.M. on the next day when they were at 64.

On Sept. 1st at 10 A.M. the dyspnoea was still extreme. The dulness below the liver already referred to was not now found. The signs in the chest were unaltered in front; the back was not examined owing to the patient's critical state. His general condition varied enormously from time to time and his pulse was frequently very weak and irregular. He was ordered spiritus ammoniæ aromaticus and digitalis in a mixture, the benefit of the latter being apparent in the early hours of the next morning when his condition became very critical. Warm brandy and water were administered frequently throughout the day and he had nutrient enemata twice. The child took his milk greedily and without vomiting. On Sept. 2nd at 10 A.M. he was better, though his eyes were sunken and his dyspnoea was marked, but rather less so than on the 1st. There were a few râles at the left apex and weak breath sounds were heard there; at the base the breath sounds if present were still quite obscured by the rasping sounds already described. At the back of the thorax the breath sounds of the left lung extended rather farther down and there was a patch of absolute dulness at the left base. The sounds all over the right lung were louder and somewhat harsher than normal. The administration of oxygen was discontinued and though the patient still took the spiritus ammoniæ aromaticus the brandy was omitted. On Sept. 3rd at 10 A.M. the temperature was 101° , the pulse was 192, and the respirations were 84. The child, who had been beginning to take a lethargic interest in things in general, was cyanosed and again in great distress; he was irritable and restless and on examination the condition of his chest was found to be very different. The left side though flat was not so flat as before and was absolutely immobile. The heart's apex beat was seen in the sixth intercostal space just beyond the right border of the sternum. Vocal fremitus had gone completely from the left side, except over a small area at the left apex. The percussion note was high-pitched all over the left side and in