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Selections: Medicine.

PULMONARY PHTHISIS.

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GENTLEMEN—To-day I wish to ask your attention to catarrhal phthisis, which is the outcome of catarrhal pneumonia, and depends upon the fact that the exudation, instead of being gradually removed by a process of softening and expectoration, passes more or less entirely into a state of cheesy change, that this has crumbled down, that the walls of the air vesicles have become involved, and thus the destructive process has been established in the lung. The first division that we must make of catarrhal phthisis is into the acute and chronic forms, and this depends upon two elements or chief reasons: first, upon the violence and extent of the original attack; and secondly, upon a weakness of the individual constitution, by which it yields more or less readily to the attack of disease. Thus, for instance, we have a form of catarrhal phthisis which, fortunately, is not very common, popularly termed galloping consumption, which is in reality a general catarrhal pneumonia, rapidly passing into a state of cheesy degeneration. In speaking thus of acute catarrhal phthisis, I do not refer at all to acute miliary tuberculosis.

This latter disease is a very rare affection. It has altogether a very peculiar history and course. It is much more like one of the acute infectious zymotic diseases in its course than it is like a local affection. It has a peculiar temperature curve, a peculiar state of the nervous system and of blood intoxication, while the local signs in the lung are comparatively slight and obscure. It runs its course in from seven to fourteen days, terminating invariably in death. As a rule, it comes from the absorption of some infectious matter, from a previously existing centre of cheesy degeneration, although, in a few cases, it has exploded in an individual who has no such centre, but who has inherited a virulent degree of the tuberculous diathesis. Generally, in such cases, the disease appears early in life.

Acute catarrhal phthisis is, as I have said, the outcome of an acute catarrhal pneumonia, and runs a course whose length is dependent upon the severity of the attack and upon individual peculiarities. This affection is not recognized as constantly as it should be. This is because the physical signs are not well marked, and are not the ordinary physical signs of pneumonia, as we have come to consider it; that is, lobar pneumonia. Usually, when a patient is attacked with catarrhal pneumonia, he will not have very violent fever, marked dulness, bronchial breathing, and the other marked symptoms that we have in croupous pneumonia, and thus many cases are entirely overlooked. The affection may involve a very small area of the lung, or it may involve the whole of one lobe, or portions of both lungs.

Let me illustrate this by a case I saw a short time ago. A patient comes into my office and states that he has a bad cold, and that he had a slight rigor forty-eight hours previously. I find him distinctly feverish, with rapid pulse and respiration, and on examination of the chest there is found a left-sided broncho-pneumonia. Râles are heard pretty much all over