

of the disease ; the phenomena appear to spread upwards by involving the functions of the nerves higher up ; the erection of the penis, and soon afterwards the sexual appetite are lost, and the disease ascends ; the expulsive power of the bladder and rectum become impaired. All this occurs while little change takes place in the mental functions ; but in other cases the mind appears imbecile, the memory is affected, and there is distinct alteration in behaviour and conduct ; but there are no lofty ideas, no excessive excitement and garrulity, and in no case have I met with paroxysms of violence or libidinous ideas.

The differences may better seen in a tabulated form.

Paresis.

Runs its course in a few years.

Commences with mental symptoms.

Is attended with libidinous ideas.

The motor symptoms are secondary in the order of time.

Is only rarely complicated with pelvic difficulties.

There often is great violence.

Ataxy.

Is much slower usually, and may last ten or even twenty years.

Commences with pain in a distal nerve.

Is attended with absence of sexual feeling.

The motor symptoms are the primary phenomena.

Pelvic symptoms are a prominent feature.

The mental phenomena are imbecility and impaired memory.

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CLINICAL LECTURE ON A CASE OF PLEURISY.

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T. L., aged 16, an errand boy, was admitted under my care on June 18th. On June 9th, he left off his waistcoat, and in consequence, got a chill. On the 12th, he first felt pain in the left side, of a dull aching character. The pain was increased by exertion and by a deep breath ; and being unable to continue his work, he went home to bed. The pain continued ; and he lost his appetite, and felt weak. On the 18th, when admitted into the hospital, the left side of the chest had a rounded form, the intercostal spaces bulged, and the ribs were nearly motionless. The left side measured 14½ inches, the right 14 inches. The heart was seen and felt beating to the right of the sternum. The whole left side was dull on percussion from base to apex. No respiratory sound was audible, except an indistinct and distant blowing near the spine. Vocal fremitus was absent. On the right side, there were normal resonance and puerile respirations. Respirations 34 ; pulse 120 ; temperature 101.4 ; urine normal. The boy had a pale, deli-

cate, and emaciated look, and a malar flush on the face. Here we obviously had to deal with a very copious liquid effusion into the left pleura ; and, after watching the case for a few days, I determined, for reasons which I will presently explain, to have the liquid withdrawn.

On June 26th, the house surgeon, Mr. Duncan, introduced a fine canula through the ninth intercostal space in a line below the angle of the scapula, and drew off with an aspirator forty-one ounces of opalescent fluid. The wound was then closed, and no air admitted into the pleura. The admission of air into the pleura, if it do not increase the risk of suppuration within the cavity, certainly tends to compress the lung, and so to impede, if not entirely to prevent its expansion after the removal of the liquid. Within a few minutes after its removal, the liquid formed a firm gelatinous coagulum. The withdrawal of the liquid was attended with immediate relief to the breathing.

Two days afterwards, the left side of the chest had regained its normal form and size, and its movement was nearly as free as that of the right. From that time his progress towards recovery was continuous and rapid ; the normal resonance and respiratory sounds gradually returned ; and last note of him, on July 21st, just before he left the hospital, was to the effect the only remains of abnormal physical signs were some dulness on percussion and feeble respiration below the angle of the left scapula, the result, probal of false membranes over that part of the lung.

Now, I wish to point out to you that there are two conditions which greatly impede the absorption of the serous effusion of pleurisy. These are, 1, so copious an effusion of liquid as to distend the pleural cavity ; 2, a thick layer of unorganized fibrin covering the surface of the pleura. A very copious liquid effusion impedes absorption, partly by obstructing the flow of blood through the compressed lung, thereby causing a general fulness of the systemic veins, including, of course, the bronchial veins ; partly by directly compressing the subpleural veins, thus retarding the return of blood, and causing capillary engorgement beneath the pleura. When the pressure of liquid is sufficient to cause bulging of the intercostal spaces, such as occurred in this case, it is obvious that the intercostal venous circulation must be seriously impeded. The mechanical withdrawal of a sufficient amount of the liquid effusion to relieve tension of the cavity and remove pressure from the lung, and the veins beneath the pulmonary and the costal pleura, will usually be followed by a quickened absorption of the liquid which remains in the pleura. In like manner, when anasarcaous swelling of the legs has rendered the skin so tense as to impede the return of blood by the veins, and thus to favour the increase of the dropsical swelling, the discharge of some liquid through the skin is usu-