

sion by collar and axilla straps—patient's toes just touching floor—it was observed that the fingers and palm of the left hand became and remained of a dead white hue, and about the conclusion of the process, not unusually prolonged, she complained of being faint. The face was observed to be extremely pale but in a couple of moments the angio-tetany gave way to paralysis and the vessels of the face became turgid and distended, consciousness was lost, slight muscular contractions occurred with opisthotonos, a gurgle in the throat or low cry was uttered and the tongue bitten. The patient was immediately let down and laid upon a contiguous bed and in two or three minutes consciousness returned, and nothing remained to mark the occurrence save a little nausea and faintness lasting about an hour. The jacket was unbroken and the patient returned home after relating that twice before she had fainted during the application of a jacket, and once before during self-suspension.

Selections: Medicine.

THE CLINICAL FEATURES OF PLEURAL EFFUSIONS.

Dr. Broadbent read a paper upon "Some Points in the Clinical History of Effusion into the Pleural Cavity." He first enumerated and explained the relative importance of the physical signs of pleural effusion, and pointed out that the curved line of dulness was due to the manner in which the lung shrinks around its root, and as the fluid rises the vocal resonance and vibration become exaggerated over that part of the chest-wall where the lung is still in contact. When the cavity is full of fluid the respiratory murmur may be conducted for a short distance across the back from the unaffected lung. Sometimes, however, the lung was prevented from collapsing by adhesions, by consolidation, or congestion; and he believed the persistence of bronchial breathing in such cases was due to imperfect collapse of lung, although the fluid was in large amount. The chief point he wished to urge was that while the ordinary signs of effusion into the pleural cavity—dulness, extinction of vocal fremitus,

diminution of vocal resonance, the limitation of bronchial breathing to the region of the root of the lung—show that the lung retreats and shrinks before the fluid, loud tubular breath sounds at the base of the lung posteriorly and over the lateral and anterior aspect of the chest show that the lung has not entirely retreated, but that it retains a certain volume, and is more or less deeply immersed in the fluid. The patency of the bronchi and the partial condensation of the lung, favour the transmission of sonorous vibrations. It is in these circumstances that oegophony is heard most distinctly and widely—from the thin layer of fluid intercepting some vibrations and transmitting others—conditions which ordinarily exist only in the earlier stages of effusion. In some of these cases there may occur some degree of vocal vibration at a period when the amount of fluid is sufficient to give dulness on percussion over the entire lung. Paracentesis would be of comparatively little value in such conditions, for the quantity of fluid is small, and the consolidation of the lung would persist after its removal; and most cases of this sort get well without resort to paracentesis. In one such case only 30oz. of fluid could be withdrawn. The conditions are met with in the pleural effusion of renal disease, often accompanied by congestion, and partial consolidation of the lung preventing its collapse; also, in effusions which rapidly became purulent, as in empyema in children. Apart from these cases, the signs indicative of a large congested lung deeply immersed in the fluid are prognostic of rapid absorption, and Dr. Broadbent had seen this now in a sufficient number of instances to enable him to predict with considerable confidence the recovery of the patient without paracentesis and in a comparatively short time. One of the first steps towards recovery is a rather sudden disappearance of the tubular breathing and the substitution of the more ordinary signs of simple effusion; and it is probable that the congested lung has relieved itself by diffusion of serum into the pleural cavity, and that the amount of fluid there is actually increased. In conclusion, Dr. Broadbent stated the rules which guide him in recommending paracentesis. It should be resorted to at once when