by exuded blood); but hemorrhage as such is not a feature in the case.

I think we need not discuss the question whether hemoptysis is of pulmonary or of bronchial origin. It is almost always pulmonary.

Whether the first steps in the lung induration be an inflammation or tubercular, we may, I think, concede that, excepting in the slowest and most insidious forms, it is accompanied by congestion of lung-tissue, and hence the great prevalence of hemoptysis. It will be remembered that the earliest changes in phthisical lungs are shedding of alveolar epithelium and block of the air-cells, with consecutive small cell changes in the walls of the cells and in the intercellular tissue, in which lie the blood-vessels and lymphatics of the lung. Engorgement is sure to follow an impeded return of venous blood, while the tissues become softened and disorganized.

The occurrence of congestive hemoptysis at the beginning or in the progress of phthisis is accompanied by a high temperature, running up to 104° or 105°. Its persistence may also be gauged by the thermometer and by the pulse. Should a more or less sharp hemoptysis subside, the temperature falls and the pulse becomes soft.

Should the bleeding initiate a lung attack—that is, occur to a person apparently in good health—we may expect it will be followed by the signs of consolidation of a portion of lung and the events of phthisis. There is a form of rapid phthisis, of which I have given an instance, which proceeds with great activity after an initial florid hemoptysis of some extent; and we must be on the look-out for such, and remember that it proceeds by progressively causing patches of consolidation in the lung, of which you will have the usual physical signs.

Should congestive hemoptysis occur (as it generally does in the course of chronic phthisis, you may have a long pause, or suspension of the active symptoms following its cessation. I have so often had occasion to observe this event that it seems well worth bearing in mind when called on to deliver an opinion on the result. How often also do we witness repeated attacks of rather profuse hemoptysis at long intervals in the same patient? That a second and third hemoptysis may succeed is almost certain, and that an appreciable amount of relief to the lung is produced by the bleeding I have no doubt. All these events bear strongly on the proposition that the local congestion of the lung has much to say to the clinical history of phthisis. I shall afterward speak of its bearing on the treatment.

DIAGNOSIS OF ADHERENT PLACENTA.

Dr. A. C. Air writes to the *Lancet*, February 5th:—

I have met with several cases of morbidly adherent placenta during the last fourteen years, and am inclined to believe that the diagnostic problem may be solved with almost absolute certainty; although, from my experience being limited to so short a time, I would desire to write with all becoming modesty.

The diagnosis is, I think, to be founded upon two symptoms, one of which is mentioned by Dr. Churchill, the other by Dr. Barnes, viz., that at some period of pregnancy, generally between the third and fifth month, a fixed pain, generally of a dull, aching character, is felt over some part of the uterus; and this is converted into a severe *dragging* pain when the patient attempts to turn over to lie on the side opposite to the placenta site: so much so that patients with an adherent placenta will never (as far as my experience goes) voluntarily lie on that side. This pain I believe to be of the same nature as that mentioned by Dr. Barnes as being experienced when the cord is drawn upon; and is due to the dragging on the cord by the child, when, from gravitation, it sinks through the liquor amnii.

Theoretically, it may be objected to this explanation that usually the cord is sufficiently long to prevent any such dragging; but I think it will generally be found that when the cord is long it is twisted around the neck or limbs of the child, and produces the same effect as a short cord would.

No history of this dragging pain on the patient's turning to the side opposite to the placental insertion will be obtained when the retention of the after-birth is merely due either to the inertia of a wearied uterus, or from irregular contraction; if there is hemorrhage in either of these cases, one would be justified in trying the effect of cold, compression, etc., before introducing the hand, but in cases of true placental adhesion, trying these and similar means leads to dangerous loss of precious time.

GLYCERINE IN THE TREATMENT OF FLATULENCE, ACIDITY, AND PYROSIS.

Drs. Sydney Ringer and William Murrel write, in the *Lancet*, for July 3, 1880:

An old gentleman, who for many years suffered from distressing acidity, read in a daily paper that glycerine added to milk prevents its turning sour, and he reasoned thus: "If glycerine prevents milk turning sour, why should it not prevent me turning sour?" and he resolved to try the efficacy of glycerine for his acidity. The success of his experiment was complete, and whenever tormented by his old malady he cures himself by a recourse to glycerine. Indeed, he can now take articles of food from which he was previously compelled to abstain, provided always that he takes a drachm of glycerine immediately before, with, or directly after his food. He recommended this treatment to many of his friends—sufferers like himself—and one of these mentioned the above circumstances to us.

We have since largely employed glycerine, and find it not only very useful in acidity, but also in