

axillary line, when it either changes into the full percussion sound of the lungs or joins the dullness of the heart. This dullness is heard best over an area as large as a crown piece, which extends about three fingers' breadth from the angle of the scapula. On auscultation at this point where dullness is most marked, bronchial breathing, increased vocal fremitus, and in the centre of the dullness distinct bronchophony can all be discovered. No friction sound can be distinguished in the area of dullness. If the patient bent forward, after a few minutes, the above-mentioned percussion sounds will have changed considerably. The dullness does not reach up to the angle of the scapula, but at the area of the former dullness, about three fingers breadth below the scapula, there is full resonance. At the point of the former absolute dullness the percussion sound is tympanitic, and the bronchial breathing has wholly or partially disappeared. The same changes in percussion and auscultation, although less definite, take place if the patient is placed on his left side. The changes are also very characteristic in the knee-elbow position, if the dyspnoea will allow it to be assumed. After a few minutes in this position the dullness, up to a small line at the periphery of the lung below, will have nearly all disappeared. Where bronchial breathing was heard crackling sounds are present, but disappear after a few respirations, giving place to normal vesicular breathing. When the pericarditis has existed several days these phenomena are not present. They disappear with the amelioration of the subjective symptoms. They last from three to six or more days, according as the case is acute or not. Dr. Pins ascribes these new physical signs to a backward displacement of the heart, producing a compression of the lower lobe of the left lung, and are chiefly found in young adults of slender build, in whom the chest is flattened antero-posteriorly. This condition is distinguished from pneumonia or pleurisy by the changes in the physical signs when the patient assumes a new position.—*Mitth. d. Wien. Med. Doct.-Coll.—Satellite.*

#### THE INCOMPATIBLES OF ANTIPYRIN.

If extractum cinchonæ liquidum be added to a solution of antipyrin in distilled water a dense reddish-brown precipitate is formed. Upon examination this precipitate is found to contain tannic acid and antipyrin. The liquid extract of cinchona is, therefore, incompatible with solutions of antipyrin, because the cincho-tannic acid present in the extract precipitates it in an insoluble form. The greater part of this precipitate dissolves on the addition of dilute sulphuric acid, the insoluble portion being probably the coloring matter of the bark, for if a solution of tannic acid be used instead of the extract cinchonæ liquidum as a precipitating agent, a

pure white precipitate forms, which entirely and easily dissolves on the addition of the dilute sulphuric acid. It follows, therefore, that decoctions, infusions, and tinctures containing tannic acid would act in the same manner. The effect, however, produced by these preparations is very small compared with the liquid extract of cinchona. Antipyrin is not precipitated by solutions of the alkaloids, quinine, cinchonine, cinchonidine. Therefore it can be prescribed in a mixture containing quinine sulph. and acid. sulph. dil. When strong solutions of chloral hydrate and antipyrin are mixed together a white precipitate is formed, which soon becomes resolved into globules of oily-looking liquid, which sink to the bottom and form a distinct layer. This layer, in the course of some hours, changes into a crystalline mass, from which the clear upper liquid can be drained off. These crystals are soluble in water, but considerably less so than antipyrin or chloral hydrate. They have a distinct taste of chloral without its pungency, and they are not so bitter as antipyrin. In solution they give with ferric chloride the characteristic color reaction of antipyrin, and heated with liquor potassæ they evolve chloroform. It would seem, therefore that this crystalline mass is a compound of antipyrin and chloral, which has been thrown out of solution on account of its sparing solubility. This precipitation does not occur in dilute solutions, and it is possible to mix together a solution containing sixty grains of antipyrin to the fluid ounce with one containing the same amount of chloral hydrate without any precipitate being immediately formed, although in a few hours small crystals begin to appear. A solution containing fifteen grains each of antipyrin and chloral hydrate to the fluid ounce appears to be a permanent one, for at the end of a week there is no appearance of crystalline matter. Clinical experience alone can determine whether mixtures of these two bodies possess any therapeutic properties different from those of the constituents. In prescribing them together it is to be borne in mind that the solutions must be dilute.—*Brit. Med. Jour.*

#### TREATMENT OF PRURITUS VULVÆ.

Dr. Percy Newell recommends the following lotion for pruritus vulvæ :

R Acid. Carbolic,	gr. xvi.
Tr. Opi,	f ̄ ss.
Acid. Hydrocyan, dilut.,	f ̄ ii.
Glycerini,	f ̄ ss.
Aquæ destil. q. s. ad.,	f ̄ iv.

Dr. Scanlan recommends the following :

R Cocain,	gr. i.
Lanolin,	̄ i.
M. Ft. unguentum.	

—*Medical and Surgical Reporter.*