

The expressed juice of beef answers very well, and can be obtained by cooking a piece of steak so as just to crust the two surfaces, and then cutting it into pieces and squeezing the juice out with a lemon-squeezer. The broths are given rather as diluted food in the early part of the disease, when it is supposed that the patient should not take much nourishment, but as the disease advances, the food should be more and more sustaining. In cases in which the stomach fails to retain the food, nutritious enemata should be employed. You will remember that the disease which produces the diarrhoea, is in the small intestine, not in the large.

The other essential of which I wish to speak is fresh air, but I will reserve that for the opening of the next lecture.

PLEURISY WITH EFFUSION IN AN INFANT FOUR MONTHS OLD; PARACENTESIS; RECOVERY.

Under the care of Dr. Cayley.

George W—, aged four months was taken as an out-patient to the hospital on October 22nd, 1878. He was a well-nourished, well-grown infant, fed entirely at the breast. His mother stated that he had always been healthy till the present attack. A week before, the child began to suffer from cough and difficulty of breathing, which soon became very great. Medical advice was obtained, and the mother was told that he was suffering from congestion of the lungs. She could assign no exciting cause for the attack, but said that immediately before, a scabby eruption, which had covered the child's head for some time, disappeared. The child continuing to get worse in spite of treatment, she took him to the hospital. He was then suffering extreme dyspnoea. The respirations were excessively rapid. He kept tossing his arms about and throwing his head back. The extraneous muscles of respiration were brought into active play; but there was no laryngeal stridor, or inspiratory retraction of the ribs, and the face was not cyanosed. There was a frequent short abortive cough. On examining the chest, absolute dullness was found over the whole of the left lung, with absence of breath-sounds. The heart was displaced, and the apex could be felt beating to the right of the sternum. The breath-sounds on the right were much exaggerated. Dr. Cayley at once performed paracentesis. The trocar and canula were introduced in a line with the angle of the scapula, and eight fluid ounces of very turbid serum, which solidified on boiling, were drawn off by a bell-jar aspirator. The mother then took the child home.

On Oct. 25th the child was brought again. The dyspnoea had been at once relieved by the operation, and had not returned. The breath-sounds were audible quite down to the base of the left

lung, but the percussion-note over the back was deficient. On Oct. 29th the child appeared quite well, with the exception of a slight cough; the physical signs remained unaltered. On Nov. 5th, the child still had a cough, but was otherwise quite well. The scalp was again covered with a scabby eczematous eruption. The percussion resonance at the left base was much impaired, and the breathing somewhat tubular.

Remarks by Dr. Cayley.—I believe this to be youngest case of pleural effusion on record. Several cases of empyema and simple effusion in children between the ages of twelve months and two years have been published, and I now have in the hospital a case of empyema, which is being treated with a drainage-tube, in a child one year and ten months old. It is of course possible that cases may sometimes occur without being recognized. At the North-Eastern Hospital, however, where it is the practice to auscultate all infants, suffering from dyspnoea, no other case under the age of twelve months has yet been met with.—*The Lancet.*

VARIETIES OF PULMONARY PHTHISIS.

EXTRACTS FROM A LECTURE DELIVERED IN BELLEVUE HOSPITAL MEDICAL COLLEGE.

BY ANDREW CLARK, F. R. C. P., LONDON.

(Continued from page 142.)

Now, in the second classification, we have a caseous pneumonic phthisis. The history of this form of phthisis is almost the reverse of that of tubercular phthisis. In tubercular phthisis the constitutional symptoms are profound, while the local symptoms are comparatively few. In the cases I am now describing we have an abundance of local symptoms. By physical examination perhaps one-quarter, one-third or one-half of an upper lobe of a lung may be found to be uniformly solid. You will have dullness and tubular breathing, which may be accompanied or not by crackling. You may have bronchophony, but the constitutional symptoms are often few. The patient looks fair, has a bright eye, is well nourished, and perhaps slaps his chest and says, "But for this cough I would be quite well." Perhaps the disease has come on insidiously. Perhaps by inflammation not so severe as croupous pneumonia, and the case itself runs for an indefinite time until a certain change takes place which brings it within the pale of serious cases of phthisis.

Suppose, then, we have a case of pneumonic phthisis with unbroken consolidation of the lung or only a few small cavities. The patient is tolerably well, engages in his work, complains comparatively little of constitutional symptoms. By and by the caseous pneumonia breaks up into large