

when an autopsy has shown that diagnosis was possible, it has not always been made; nevertheless, cases comparatively frequent appear where a consideration of the possibility of an earlier infection (heredity, measles, etc.), combined with the rational and physical signs, makes their presence more or less probable. Especial weight is to be laid on the presence of a peculiar cough resembling pertussis in its paroxysmal character, and the presence of a very loud, indeterminate, though usually bronchial, respiratory murmur in the neighborhood of the upper thoracic vertebrae. The difficulty in diagnosis is well illustrated by a case reported by Stoll, occurring in a girl ten years old, in which the symptoms were so obscure that it was impossible to determine the seat of the disease until the autopsy, which showed a perforation of the trachea on a level with its bifurcation, through which a gland about the size of a walnut emptied itself. Beneath this large one were several others with softened centres. The trachea itself was obstructed by a plug of pus, situated above the perforation, which filled up the whole lumen and was probably the immediate cause of death.

BRADYCARDIA DURING CONVALESCENCE.

In speaking of the slow pulse (60 or less) which is sometimes met with during convalescence from acute diseases, Dehio says that we have little positive knowledge of the cause of its appearance or the anatomical changes which accompany it. With the establishment of convalescence the pulse falls with the temperature, but the fall continues below the normal rate until its beats number only sixty a minute or even decidedly less. This condition in mild cases lasts but a few days to a week, and, with this exception, the patient presents no noteworthy symptoms. The heart seems normal though the apex beat is weak, the pulse is easily compressed and often dicrotic, at times, also, slightly irregular. In the severe forms, however, the patient shows signs of great prostration, the lateral area of the heart's dullness is increased, its action is irregular and intermittent, and a systolic murmur is heard over the left ventricle. In order to determine whether this resulted from some change in the heart itself or was of central origin, Dehio injected hypodermically one-sixtieth to one-thirtieth of a grain of atropine, which has the power of paralyzing the cardiac terminations of the vagus nerve. In a mild case he found that the number of beats was increased to the same degree as under normal circumstances, while in the more severe forms this increase was much less marked. He therefore concludes that the cause is to be found in the heart itself, and not in some change in the nervous mechanism, such as an increased irritability of the vagus or an atonic condition of the medullary centre of the acceler-

ator sympathetic fibres, and is, therefore, an evidence of cardiac weakness, and of the same import as other symptoms (intercurrent attacks of rapid pulse, irregularity, palpitation) of this condition, many of which were present in his cases. The occurrence of this symptom is comparatively rare as he only met with eight cases in his hospital clinic during the past semester. He suggests the probability of its being due to the toxic action of some specific material produced in the organism during the course of an infectious disease which causes no anatomical change in the heart, but considers it probable that an individual predisposition also exists, otherwise it would be difficult to explain why it was not present in all convalescent patients and why it was not more common after severe infectious cases than after mild ones.

CURE OF EMPYEMA.

Aufrecht describes his progress through the various methods which have been devised for the treatment of empyema. After an experience with four cases he discarded aspiration as a means of cure, and practised incision and drainage, but has now reached the conclusion that resection of a rib is by far the most satisfactory proceeding, as it obviates the danger of hæmorrhage, allows free exit for masses of fibrin and prevents the too rapid closure of the opening, which by the simpler method could sometimes be kept open only by a silver tube. He selects a rib near the angle of the scapula, unless contraindicated by pleural adhesions or by the very weak condition of the patient. In the latter case he chooses the axillary line, as there is much less chance of death during the operation if the dorsal position be maintained. Beside the preliminary puncture to ascertain the presence of pus, he is accustomed to make a second after resection through the free pleura. He recommends at first daily irrigation. Cure results from the fact that with each inspiration the lung collapsed by the operation must dilate if the size of the opening in the chest-wall is smaller than that of the primary bronchus leading to the part. In addition, however, it is necessary that the pleura itself should be in a condition to allow adhesions to form between its two surfaces. The slow subsidence of the pleural inflammation in some cases to the point where this is possible, explains their occasional protracted convalescence.—George G. Sears, M.D., in *Boston Med. and Surg. Jour.*

Prof. Hare says that there is no drug in medicine that will give as much relief as the *Spirits of Chloroform*, in the dose of from twenty to thirty drops, to a patient suffering from abdominal pain; and it possesses also the advantage over opium that it does not constipate.