

RECENT PROGRESS IN THORACIC DISEASE.

TUBERCULOSIS AS A CAUSE OF PLEURITIC ADHESIONS.

Schleuber gives the results obtained from 106 autopsies, but 21 of which showed no pleural adhesions. Among the remaining 85 the adhesions could be attributed in a number of cases to affections of the lungs other than tuberculosis, or to cardiac disease. Leaving these cases out of consideration, there remained 57, in 33, or 57.9 per cent., of which the adhesions, from the microscopic examination, could be referred in all probability to a tuberculous cause. Schleuber is of the opinion that these figures would have been increased rather than diminished by the use of the microscope.

PECULIAR ODOR OF THE BREATH OF TUBERCULOUS PATIENTS.

Rosenbach calls attention to a peculiarity of the breath of tuberculous patients, slightly resembling that of mild cases of putrid bronchitis, but differing from it in having a disagreeably sweet quality. It may become apparent in the neighborhood of the patient even in the absence of expectoration. It adheres to expectorated matter but feebly, being probably dependent on some volatile substances. It is only present in the exhaled air, and thus becomes most evident when the patient coughs or breathes with open mouth. It is a sign of unfavorable prognostic significance, even though the other manifestations in the case appear favorable. It is often present when the destructive process is not marked, and is most noticeable when the physical signs are unobtrusive. It is almost always an associated manifestation of disseminated broncho-pneumonic consolidation. It is wanting in cases of extensive infiltration, when cavities have formed and also when the sputum is copious. In a large number of cases in which this symptom was observed hæmoptysis occurred. Night-sweats, anorexia and febrile exacerbations were also frequently noted. The phenomenon is of diagnostic significance, as it early indicates the occurrence of a morbid process in the lungs, and should therefore be sought for in all doubtful cases. To insure against a possible source of error, the mouth and teeth of the patient should be first thoroughly cleansed.

THE DISINFECTION OF TUBERCULOUSLY-INFECTED HOUSES.

Delepine and Ransome give the result of their efforts to disinfect rooms in which a phthisical patient has lived by chlorine or more correctly

euchlorine. Pieces of paper were perfectly sterilized in glass capsules, and then infected with tuberculous material, either sputum or pure cultivations of the bacillus (human in most cases, avian in a few). The capsules were sealed, the sputum or cultivation being allowed to dry on the paper, and were not opened until just before the acid was poured on the chlorate of potash, and were again sealed when the room was re-opened. Rabbits and guinea-pigs were then inoculated with small pieces of infected paper or superficial scrapings mixed with sterilized bouillon. In nine experiments made with three different kinds of sputum the results were unsatisfactory; in some cases complete disinfection seems to have been obtained, but the control experiments showed that some sputa were not as virulent as others. In six experiments made with pure cultures of the bacilli of human tuberculosis, distinct evidences of the disease were observed within three or four weeks after inoculation. They therefore conclude that this method of disinfection, as well as that with sulphurous acid, which they have also investigated, is ineffectual. From some laboratory experiments with an old method of disinfection (not given) they hope before long to give practical means of effectually disinfecting places that have been contaminated with tuberculous products.

TUBERCULOSIS OF THE BRONCHIAL GLANDS AND ITS RELATION TO THE TUBERCULOSIS OF CHILDHOOD.

Neumann sums up an interesting paper on this subject as follows:

Tuberculous infection in children is usually at first localized in the bronchial lymph glands. It is very common in the first years of life, and results from inhalation of the infectious material. This method of infection may be prevented by proper hygienic regulations, which, though at times difficult to obtain in private practice, should be demanded in all public institutions. From the bronchial glands infection either rapidly spreads through well-known anatomical paths or it remains latent for an indefinite period, until its activity is finally excited by some condition (catarrh or inflammation of the respiratory tract) in which the glands are secondarily affected. At times, however, it may remain permanently latent or cure result from calcification. Diagnosis is only possible in advanced cases, and only then when the condition of the gland is not masked by affections of other organs. So long as they are simply tuberculous, but not enlarged or adherent to neighboring organs, they give rise to no signs or symptoms, while, on the other hand, the process which started from them may have produced such marked pathological changes in their neighborhood as to conceal the original trouble. Even