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A CLINIC ON INTERCOSTAL NEURALGIA; ACUTE PLEURISY WITH EFFUSION; MITRAL INSUFFICIENCY; CROUPOUS BRONCHITIS.

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Thus far we have occupied ourselves in formulating the methods employed for physical examination and mapping out the chest-wall into regions, which, though artificial, are none the less convenient. We have also defined the various tissues and organs that lie either wholly or in part in these regions. The various aids to examination have been enumerated; percussion notes and the various auscultatory signs described both those that are normally found in the chest and those that are adventitious. We have also defined their positions when normal, and their significance when found out of place, and have furnished interpretations for the various adventitious signs. We shall now make a practical application of the facts that I have described. Our first patient is a man who complains of pain in the left side of his chest. Now, what causes this pain? Remember to consider the subjective, as well as the objective symptoms. The history discloses that he had a sharp pain in the left side of the chest, and that no chill accompanied it; it was also paroxysmal and of several days duration; he has had no cough and no dyspnœa. We find him anæmic and poorly nourished; pulse and temperature normal. Inspection shows that the left side of the chest does not fully expand. Palpation reveals a point of tenderness in the sixth intercostal space. There is no dulness on percussion. Auscultation reveals some restriction of respiration more marked on the left side, and no friction sound. The absence of fever and pleuritic friction are objective signs that enable us to exclude the first stage of pleurisy. From pleurodynia or intercostal rheumatism we may distinguish this condition by the presence of a localized spot of tenderness, while an extensive area of tenderness exists in the former, and increased pain on the slightest muscular movement. Pain is augmented by pressure in rheumatism, and often relieved in intercostal neuralgia.

Angina pectoris presents a very different and characteristic history; the pain extends from the chest to the left shoulder and down the arm, and is usually of short duration. Also upon examination a cardiac lesion is frequently found accompanying this condition. For this case of intercostal neuralgia we will apply counter-irritation, and administer opiates. A combination of morphia and atropia given hypodermically is usually most efficacious. Five to ten minims of the following solution:—

℞ Morphia sulphatis..... 1. gram.
Atropia..... .03 "
Acidi salicylici..... .03 "
Aquæ distillatæ .....30.

Sig. To be used hypodermically, as directed.

Such cases of neuralgia are also benefited by cod-liver oil and quinine.

Our next patient is a man who also complains of pain in his chest. When seen by me about a week ago the pain was much more severe than now. The temperature and pulse were slightly elevated, and upon auscultation a pleuritic friction sound was heard in the right side of the chest, a diagnostic sign that might have been overlooked from the fact that there was a disinclination to take deep inspirations, had I not required him to do so. These two cases are instructive, the chief subjective symptoms being pain, while the objective symptoms are quite different. In the last instance, which is one of pleuritis, the pain has declined, dyspnœa and a slight cough remain. Let us make further examination. Inspection shows that the respiratory movement of the chest wall is nearly absent on the right side, but is increased on the left; there is no marked prominence of the intercostal spaces. Mensuration gives negative results. Palpation shows an absence of fremitus on the right side. Percussion discloses flatness in