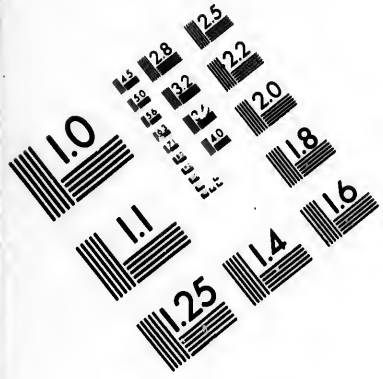

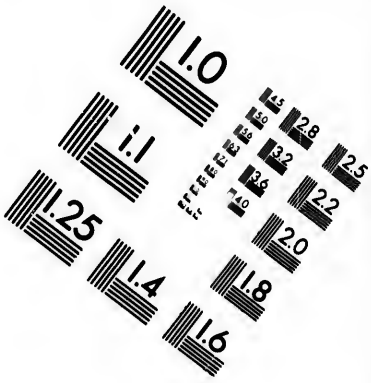

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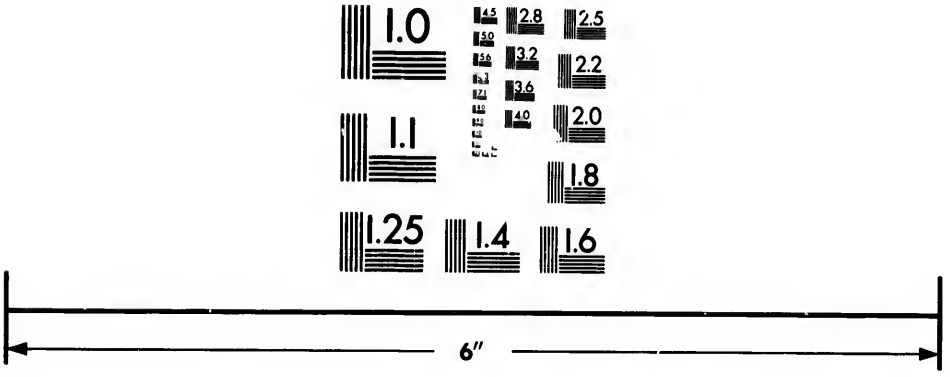

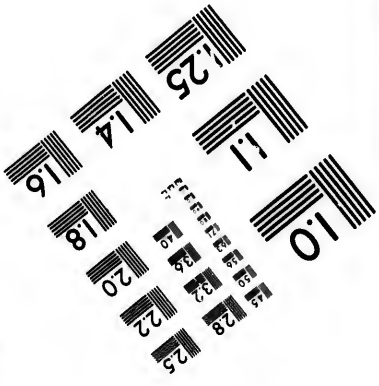

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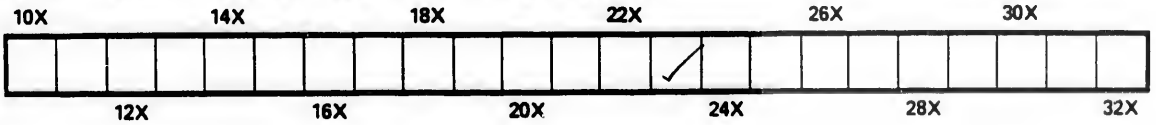

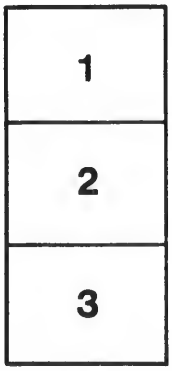

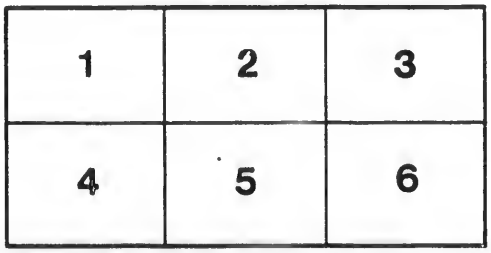

"OBITER SCRIPTA" I.

(Casual notes from the Medical Clinic of the Royal Victoria Hospital.)

BY

C. F. MARTIN, M.D.

Lecturer in Medicine, McGill University; Assistant Physician to the Royal Victoria Hospital.

(In the ensuing casual notes are embodied a few observations on cases which are of interest either in reference to diagnosis or treatment, or as presenting some instructive variations from the commoner so-called text-book types. It is hoped that while they offer no features of startling importance, there may at least be a few facts of interest to some readers of the JOURNAL.)

SOME FORMS OF NEPHRITIS.

CASE I.

Uræmia affecting a boy in previously good health—General and special diagnosis of the renal condition—Treatment.

A boy, æt. 12, had been complaining for several weeks of intermittent headaches, occasionally quite intense, sometimes persisting throughout an entire day, at other times being quite absent for several days together. With this there was vomiting, usually at the time of the headache, and at all events quite independent of the ingestion of food. The vomitus had no special characters. Careful enquiry failed to elicit any other symptoms or complaints up to the day of his entering the hospital. There was no history of scarlatina or other infective disease since infancy, nor could exposure to cold or any other etiological factor be discerned to account for the condition present.

On admission he was very restless, held his hands to his head with the intense pains, and vomited several times on the first day. The temperature was normal, the pulse 104 and of very slightly increased tension, and the respirations were 24 per minute. There was a coated tongue, anorexia, marked thirst and constipation.

Œdema and anæmia were conspicuous by their entire absence.

By a curious coincidence there lay in the adjoining bed a boy with cerebral tumour, in whom likewise the main symptoms had been merely headache and vomiting and the eye ground on examination had shown marked papillitis. The similitude of symptoms in the present case led at once to a retinal examination to complete the

classical trio of sym
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nephritis, being diminished
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gravity of 1012. There were numerou
thelial casts. The heart was slightly enlarged
apex there was a soft systolic murmur. The aorti
was accentuated ; the arteries showed no sclerosis. On the
ing day he developed unilateral convulsions and coma, and during the
first 24 hours, only 11 ounces of urine were passed.

Treatment.—At the outset, saline purgatives and hypodermic injections of pilocarpine were freely administered, though with practically no effect, and on the next day he was given croton oil, which was speedily followed by satisfactory purgation. His restless, convulsed condition made it impossible to give vapour baths properly, so that hot wet packs (for 20 minutes at a time, and at intervals of from four to six hours) were employed, producing within 12 hours a remarkable relief, the patient being quieter, partly conscious, and showing distinct improvement in the pulse. During the first 24 hours, the packs were given five times, and from that on with diminishing frequency till after four days the patient was practically out of danger, perfectly conscious, with no convulsions, or even restlessness. The urine steadily increased in quantity, and three days later he passed a normal amount. Nine days after admission, merely a trace of albumen was left, the quantity being no longer estimable by Esbach's method. Throughout the rest of his stay in the hospital his condition progressively improved, and six weeks later he was discharged, the parents being given due precautions as to the treatment and diet, inasmuch as a trace of albumen or occasional casts were still present. It was also noteworthy that during this time the urine was much increased in quantity, being frequently over 50 or 60 ounces per diem.

Remarks.—The case presents several features of no little interest. While probably two-thirds or more of all cases of nephritis in childhood are associated with infectious diseases, and especially scarlatina, yet, as in the present instance, a small proportion have a distinctly obscure etiology. The question of diagnosis, so far as the general disease is concerned, presents in reality very little difficulty, and the similarity of symptoms to those in cerebral tumour is perhaps more striking in the present instance from the coincidence above referred to. Yet the complete absence of either œdema, dyspnœa or pallor, as well as the lack of any specific antecedent cause might all very

...ache and vomiting

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...han in adults, one is never
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tend t... ...mular kidney is extremely rare
in children. ...ed very much to that diagnosis.
More especially ... urine of low specific gravity
persisting throughout the ... disease, the markedly increased
quantity when once recovery ... established, the advanced albuminuric retinitis, which even under any condition is extremely rare in children, and lastly, the persistent thirst. In the light of such a diagnosis the ultimate outlook would be proportionately serious, these cases reaching a lethal termination in a much shorter period.

CASE II.

Acute nephritis ushered in with symptoms simul...ting appendicitis

The victim of this affection was a young man aged 26 years, whose illness was preceded by distinct exposure to cold. Following upon this was general malaise and a vague feeling of abdominal discomfort, nausea and vomiting. The bowels were constipated. On the next day the abdominal discomfort was more marked, and tenderness in the right iliac fossa pronounced.

An enema was administered, and after three hours the pain on pressure immediately outside McBurney's point was even more distinct. Palpation in this area revealed a finger-like body which was painful to pressure, and, so far as could be estimated, was the swollen appendix. The temperature was 100·5°. The pulse 96. On the next day, however, examination of the patient revealed but little tenderness in the affected area, even on deep pressure, while on the other hand the lumbar region became markedly painful. The temperature now reached 101·5°, but the general symptoms were no longer those of appendicitis, whereas the urine on examination revealed all the characters of an acute hemorrhagic nephritis. Repeated tests of

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the kind. In tw e patients the int
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e days the signs of enteric fever. The present
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bacute nephri s two years previously, and had not been
l February of 98, when she requested admission to the
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the existence of some new form of life . Within a very short period recently in numerous examples of the various forms aps, rather unusual and worthy of more hese Dr. James Stewart has already made barking girl, whose intermittent uproars he hospital phonograph. So also of the arm and leg permanently, so far as we are pnotism. Others admitted quite recently f the characteristic varieties of motor and hich are always of interest and which at s in diagnosis to those not much engaged ses. This applies naturally rather to the anifestations, inasmuch as the irregular s localisation to areas not corresponding f nerve supply makes the diagnosis in either case, moreover, it is as a rule not nata diaboli" which help to elucidate the .

examples are here noted, not because of t as illustrating in a group some of the

CASE I.

lower extremities with foot drop.

red the hospital complaining of weak- in walking. He was a Canadian by employed as a machinist, baker and ways been moderate, and apart from , he had had no maladies of import- pecific history nor evidence of heredi- amily. Some three years before admis- ad somewhat severely ; as a result he ot lose consciousness for a moment. of a " pins and needles" feeling in the isted for months, and was soon fol- k, which he described as intermittent Two months after the accident, he f the difficulty in walking, due, as iption, to marked " foot-drop." On le difficulty in walking, while under ily, and in order to lift his leg he s hands. Ever since that time, now

more than three years ago, the patient has been more or less thus afflicted.

On entering the hospital he was seen to be in every way well nourished and apparently healthy, apart from the conditions of which he complained. His gait was the most characteristic feature ; the feet, during walking, were lifted high in the air, the toes pointing to the ground. On returning them to the ground when raised, the toes first came into contact with the floor, the heels later, and with a sharp thud. There was a most obvious effort in walking to lift the toes well above the ground, though at times the patient utterly failed, leaving them meanwhile to drag, with inversion of the feet. This condition was marked in both legs, though much more so in the left. A slight ataxia was likewise prominent.

Examination of the nervous system revealed good voluntary power in the muscles of the upper extremities, as also in those of the right thigh ; the muscles of the left thigh, however, were distinctly weakened, as well as those of both lower legs. The condition was briefly as follows : Right leg, complete inability to flex the ankles, slight power to flex the toes ; extension fair but distinctly weakened. Left leg, absolute paralysis for extension and flexion.

The reflexes were throughout normal, except for some slight exaggeration of the plantar and patellar reflexes on the right side, and marked diminution of the patellar reflex on the left. *Electrical reactions* were normal. Romberg's symptom was slightly present. *Co-ordination* and muscular sense were otherwise normal ; there was no disturbance of *sensation*. The *tâches cerebrales* were well marked.

After a short stay in the hospital of three weeks, the patient was discharged, being slightly improved. Six weeks later he returned practically in the same condition. An effort had been made by Dr. Stewart to hypnotise him but with only moderate success. Complete paralysis was now evident in the flexor muscles of the left foot. There was no evidence of atrophy nor of advance in the condition in any other way whatsoever.

The treatment employed throughout was unsatisfactory, inasmuch as after his second sojourn he was again discharged unimproved.

The question of diagnosis in such a case is not a difficult one, resting as it does mainly between three conditions, peripheral neuritis, anterior poliomyelitis, and functional or hysterical paraplegia. The condition having lasted for so great a length of time without atrophy and with but slightly altered reflexes and a total absence of progressive changes, as well as the healthy condition of the muscles in their

reaction to electrical tests, would be quite sufficient to exclude the anterior poliomyelitis, or any changes whatsoever in the condition of the ganglion cells in the anterior horns of the spinal cord. Multiple neuritis, too, is readily excluded from the absence of all sensory symptoms in the lower extremities, both subjective and objective; well preserved muscles, no atrophy, normal electrical reaction, the absence of any known cause, etc. The course and symptoms of the malady, moreover, would also render a transverse myelitis quite improbable. The mere fact that such a condition had gone on for three years or more without appreciable change in the nutrition of the parts, makes the diagnosis of hysteria absolute, and the prognosis could not be considered serious.

CASE II.

Hysterical paralysis of the lower extremities following each effort to walk a short distance.

The victim of this malady was, as might be expected! a girl of about 30 years of age, who was admitted to Dr. Stewart's clinic because of inability to walk.

The first manifestations appeared some 7 years ago with dragging of the left leg, from which, however, she partially recovered for two years or more. The recurrence ensued, and in a graver form of the disease, the patient being quite unable to walk for one year. Partial recovery again took place, and the patient was in the habit of taking fairly long walks every week for several years.

The condition persisted thus till the middle of 1895, when she again became worse and remained almost constantly in bed from July, 1895, to February, 1896. At this time marked weakness developed in the right leg, and the left became quite useless. Crutches were now employed till November, 1896, and since that period she had been fairly well till last year.

Her gait, as observed on admittance, was quite remarkable. Being held up by the nurse at first she would exhibit obvious efforts in beginning to walk, and progression was characterized by distinct shuffling and dragging of the dorsum of the toes over the ground with inversion of the feet: this was far more marked on the right side.

Although the first few steps were taken fairly well, until obvious weakness developed, each step was then succeeded by a weaker, till the patient fell into the attendant's arms. After a prolonged sojourn in the hospital the condition became gradually improved till by February, 1898, the patient left the hospital with complete use of her limbs.

The treatment was in the main directed on general principles, without the application of local remedies of any kind whatsoever.

CASE III.

Hysteria following operation for appendicitis; geometrical (glove and stocking) anæsthesia.

Among the less common forms of functional anæsthesia, though by no means a rare variety, is that affecting one or two extremities completely up to a certain well defined limit—such for example as the areas included in the whole forearm to the elbow—or the lower leg to above the knee—in other words, the condition described so aptly by French writers as glove or gauntlet anæsthesia and stocking anæsthesia.

A young girl who had successfully passed through an operation for appendicitis, complained two and a half weeks later of soreness in the right arm and leg, more particularly in the region of the elbow and knee. With this, there was numbness and weakness of the affected limbs. Examination revealed distinct paresis of both leg and arm, though without evidence of atrophy, or joint disturbance. Sensation, however, was quite absent over the whole forarm to a zone immediately above the elbow, while the same was found in the leg to just above the knee joint. In each case the limiting line was astonishingly well defined, and the anæsthesia of a general nature, *i.e.*, touch, pain and temperature. Furthermore, the skin was absolutely insensible to the faradic brush (electro-anæsthesia) and pin pricks would scarcely bleed at all, evidencing marked disturbance of the vasomotor system as well.

Examination elsewhere revealed no other evidences of hysteria except anæsthesia of the pharynx.

There was no history of lead intoxication.

The treatment now being adopted is directed to general improvement of her moral, mental and physical condition, with local application of the faradic wire brush.

CASE IV.

Hysterical tremor with marked affection of special senses.

In this instance there was no etiological factor discernible, there being no history of trauma or intoxications. The patient had suffered from several hysterical convulsions since three or four months, and later on developed a marked and coarse tremor, chiefly of the arms and hands—less so of the lower extremities. Even while lying quietly in her bed the arms and legs could be seen to tremble, often violently

the oscillations always being coarse and rapid. At times there were distinct contractures of the arms and legs with variable degrees of paralysis.

The gait is uncertain—at times markedly ataxic and at others undertaken with comparative ease.

With this are other stigmata, such as defective color vision, lost taste and smell and distinct alteration in hearing. The pharyngeal reflex is absent. Sensation to pain is variable from time to time, though the tactile and thermic sense seem present normally.

"OBITER SCRIPTA" III.

Some Interesting Cases Affecting the Respiratory System.

CASE I.

Serous membrane tuberculosis, involving pleura and peritoneum, with chronic non-tuberculous muco-purulent bronchitis. Terminal disseminated miliary tuberculosis.

Cases of this kind are always of very great interest and belong really to the more uncommon manifestations of tuberculosis. The victim of this disease was a young man, who, had according to his account been in good health up to the onset of his present illness.

History.—He entered the hospital on the last day of December, 1897, complaining of dyspnœa, cough, general malaise and an acute pain in the left side which had come on *suddenly* two weeks previously. All these symptoms had followed exposure to cold and wet and in a very short time copious expectoration and prostration supervened. There was a family history of tuberculosis.

On admission, his temperature was 100½°, his pulse 106, and the respirations 28 per minute. He was markedly anæmic and the skin was moist. Apart from some irregularity in the pulse, the circulatory system showed no other evidence of disease.

His *chest* was of a tuberculous conformation being long with an acute angle at the ensiform cartilage, widened intercostal spaces and generally flattened. Examination showed a left sided pleural effusion of moderate degree, while on auscultation a few moist râles were heard over the left apex; the breathing on the right side was harsh. The sputum was copious, muco-purulent in character, and repeated examination *failed to give evidence of either tubercle bacilli or elastic tissue.* The *digestive system* showed in the main, a full and tense abdomen with no spontaneous pain, and palpation revealed neither tenderness, tumour, nor evidences of fluid. The spleen and liver were of normal size. The urine gave no evidence of disease.

Course.—Throughout the course of the malady the temperature assumed the daily intermittent type; there was copious sweating and rapid emaciation, while the cough and expectoration persisted. Puncture of the pleural cavity revealed the presence of slight hæmorrhagic effusion, which on microscopical examination showed mainly a few blood cells and very few leucocytes which had undergone marked fatty degeneration. Death followed in less than three months after the onset of symptoms.

Autopsy.—The autopsy showed *bilateral hæmorrhagic pleurisy*, more advanced on the left side; tuberculosis of the peribronchial glands; a subacute more or less *dry chronic tuberculous peritonitis* which was obviously of longer standing than the pleural affection. The *mesenteric glands* were caseous and the *ileum* presented one small shallow ulcer evidently tuberculous in nature; the pericardium was free from disease. In the *lungs* there was a chronic simple mucopurulent bronchitis, but no evidences of chronic tuberculosis. The only other condition of interest at the autopsy was the generalised miliary tuberculosis which evidently had induced the lethal termination.

Remarks.—The special features of interest in this case are as follows:—A chronic peritonitis which had been completely masked through the acute symptoms in the pleural cavity; the course of the malady throughout; the presence of a simple muco-purulent expectoration with many râles in one lung, naturally arousing the suspicion of chronic pulmonary tuberculosis, though oft repeated examination for bacilli had been quite negative.

Infection had occurred here no doubt from the alimentary tract as seen by the condition of the ileum and mesenteric glands, the peritoneum being thereby secondarily involved. The pleura was infected through the diaphragm as is usual in cases of this kind where the peritoneum is the primary seat of disease. In many cases recorded by Vierordt, the pleura was first involved and the peritoneum secondarily, and not infrequently the pericardium was likewise secondarily affected. That authority has never seen a primary pericardial tuberculosis under such conditions.

Clinically, cases of serous membrane tuberculosis vary considerably, being often extremely insidious in the onset, at other times, as in our present case, very acute. It is unusual to find other organs of the body affected. Frequently a pleurisy, evidently tuberculous in nature becomes "healed" and then within some months after the pleural symptoms have disappeared, the peritoneum shows evidence of acute inflammation, and later on again the pleura becomes involved for the

second time. This feature in the course of the disease is often of aid in the diagnosis. It would appear that, from various observations made, fever is not a necessary accompaniment of the disease, though usually present. Dropsy is often a very marked symptom, and then the differential diagnosis between cirrhosis of the liver and serous membrane tuberculosis becomes extremely difficult, more especially where fever is absent. The difficulties are all the more striking when the spleen is palpable, for in many cases of this form of tuberculosis, that organ is distinctly enlarged. Indeed, observations have shown that not uncommonly cirrhosis of the liver occurs with serous membrane tuberculosis, usually as a result of an old standing peritoneal involvement and capsular fibrosis. When the double affection occurs the actual condition must present great difficulties of diagnosis though doubtless *one* of the two processes would readily be assumed. The *treatment* is on the whole unsatisfactory, puncture of the pleural cavity being recommended for effusions in that region, and laparotomy for the peritoneal affection.

CASE II.

Latent pyo-pneumothorax.—Signs of extreme pleural effusion; normal temperature, pulse and respirations.

(The notes of this case are in part abstracted from the careful report of Dr. McCallum, one of the Resident Physicians).

A young woman who had cough, expectoration and dyspnœa, entered the medical clinic last April under Dr. James Stewart. She had been ill for nearly a year from influenza, so she stated, upon which a pneumonia had supervened. She was confined to her bed almost constantly from July to October with cough and frothy expectoration and slight intermittent attacks of dyspnœa. She never had had any hæmoptysis, nor were there sweatings, chills nor other evidences of pulmonary tuberculosis. The dyspnœa had at no time been very marked till two weeks before admission, which in this connection is a point of distinct interest, all the more so, inasmuch as she stated, that in December, of the past year she noticed splashing sounds in the chest on any rapid movement; this only persisted for a few weeks, and the onset had never been attended with any acute symptoms or pain. Ever since the splashing had been observed however, she had also noticed palpitation of the heart on the *right* side of the chest.

There could be no doubt from the history given that the patient had been suffering from a pneumothorax contracted in the course of a more or less chronic pulmonary disturbance. In the absence of further history however, it was impossible to state more definitely the actual course of the malady.

Her condition on admission was very briefly as follows:—

She was distinctly anæmic, preferred the left lateral decubitus, other positions causing marked dyspnœa and distress. The temperature was 98°, the pulse 96 and the respirations 20 per minute. Examination of the chest showed a condition typical of that induced by *extreme left pleural effusion;* viz., fulness of the left side and obliteration of the intercostal spaces; diminished expansion; absence of vocal fremitus; a flat note on percussion from the extreme apex to the base; absence of breath sounds and of vocal resonance on auscultation. There was dulness too on the right side in front, close to the sternum, up to the 2nd rib, and at the level of the 3rd rib this dulness extended outwards for three inches and was continuous below with the hepatic dulness. In the 4th interspace three inches to the right of the sternum, was seen the diffuse apex beat of the heart and the dulness extended slightly beyond. Both basal sounds were markedly accentuated, but there were no murmurs. The spleen was distinctly palpable, being pushed down evidently by the superjacent fluid. The urine was normal. The sputum contained no bacilli of tuberculosis, and there were no signs at this time of pneumothorax.

On the day after admission 30 oz. of creamy pus was removed, though without altering to any marked degree the physical signs in the chest. Cultures made of the fluid remained sterile. Three days later she was again aspirated, and 15 ozs., removed. This time the heart receded slightly towards the normal position; there was a tympanitic note over the upper third of the left lung, and the Hippocratic sucussion was readily obtained, and quite audible to those standing some distance from the bed. Beyond this feature, however, there were no definite evidences of pneumothorax, the coin sound and metallic tinkling not being elicited. Operation was urged but the patient refused, and nine days later she was aspirated again, this time 40 ozs., of creamy pus and lymph being removed. Great relief followed and the physical signs altered to a marked degree. There was a tympanitic note on percussion as far as the 4th rib, and from there down to the base the note was flat, the sucussion splash, coin sounds and metallic tinkling being all readily obtained. Respirations were performed with greater ease, and the patient felt in every way so comfortable that she insisted on leaving the hospital the same day.

Throughout the course of her stay, with one day's exception, her temperature remained normal. The tuberculin test was not employed.

The case is of particular interest as illustrating how insidiously pneumothorax may sometimes develop and quite in the absence of the usual acute symptoms which call for urgent treatment.

Cases of this kind have been recorded by others, particularly by S. West of London, who mentions instances where in the so called apparently healthy, pneumothorax has been found from time to time, and in many instances associated with strain. Probably in 90 per cent. of cases tuberculosis . . the main etiological factor though numerous instances exist showing other causes to be at work, and in not a few the antecedent condition has been, as in our own case, quite obscure.

OBITER SCRIPTA IV.

Casual notes from the Medical Clinic of the Royal Victoria Hospital.)

BY

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AND

HARVEY SMITH, M.D.,

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SOME ATYPICAL FORMS OF PNEUMONIA.

Year after year, diseases which are epidemic present variations not only in the individual cases but likewise in the disease as a class, and it is by no means easy to detect the reasons for these general departures from the usual types. Five or six years ago, for example, it was a common experience to find in the epidemics of typhoid fever, that diarrhœa was one of the most constant of the earlier symptoms, while on the other hand, more recently constipation has been present in probably 90 per cent. of the cases. In many of the epidemics too, in present years, the vast majority of the cases have been of the mildest type, while previously even with very much similar treatment, the number of fatalities was certainly greater.

So far as the incidence of pneumonia is concerned, the epidemics of influenza have had an undoubted influence on the statistics of the disease, as has already been noted by several authors. Rankin of Glasgow, for example, described some three years ago a series of cases following influenza where the features were distinctly unusual, there being a very insidious onset without rigor, pain or cough, and where nausea and gastro-intestinal symptoms were the prominent conditions. In these cases too, the temperature was markedly irregular and the pulse slow. Rendu, of Paris, and Gmeiner, have noted somewhat similar facts though in less detail, referring more especially to the gradual onset, the irregular temperature, and the termination by lysis rather than by crisis.

During the past season, it has been our experience at the Royal Victoria Hospital in meeting with an unusual number of cases of pneumonia, to find comparatively few typical so-called text-book types. Only two or three at the most, out of fifteen or twenty cases, have presented a frank pneumonia where the temperature has run from five to ten days a high continued course followed by a crisis. In many of the cases indeed, the onset has been most insidious, the initial symptoms continuing over several days, and being those rather of a mild form of influenza with slight malaise and perhaps chilliness, headache and gastro-intestinal symptoms, all of which are superseded after some days by the initial pleural pains of pneumonia. In several of the cases too, the gastric symptoms were so marked as to completely mask in the earlier stages, the true nature of the disease.

One case is peculiarly interesting as showing precisely the reverse of this mode of onset, the patient presenting the initial rigor within 12 hours of the time of exposure, his condition previously being that of perfect health. True rigors at the onset of the disease have been comparatively few, *i. e.*, in less than one-third of all the cases. So far as the children are concerned of which there have been 7 ill with pneumonia, the onset was likewise gradual and was in no instance demonstrated by convulsions which under ordinary conditions is apparently fairly common.

So insidious has the onset been in certain cases that it has only been through the ordinary routine examination of the lungs that the signs of consolidation were manifested, as in the case of one child who entered the hospital because of some pain in the neck, while in another instance, a child who was originally brought to the Outdoor Department on account of general malaise, was found to have the apex of one lung consolidated without there being any other subjective or objective signs of the affection. This same child who had for some five weeks a markedly high temperature accompanying the pneumonic process, was never at any time in any obvious distress, and insisted throughout the course of his malady on sitting up in bed.

Histories such as the following have been quite common in the present epidemic. The patient entered the hospital complaining that early in the malady for six days he had had coryza, neuralgic pains in the legs and sore throat followed by nausea and occasional vomiting. At no time did he have any chill. One week later, pain in the side developed and the patient, though endeavouring to keep on with his employment, was obliged to take to his bed, and a few days later came to the hospital, one lung being found in a state of partial consolidation. During the next week that he was under observation

there, his temperature assumed a distinct intermittent type as the chart will show, (Chart No. I) and although a complicating pleurisy with effusion was suspected on account of this irregularity in the fever we were never at any time able to obtain proof of its presence.

This question of temperature has been throughout the series of cases one of the most interesting features. In two patients where the ordinary basal consolidation was present without complications, the temperature assumed a markedly intermittent type for at least one week. Pseudo-crises have been the rule rather than the exception, there being often several in the same patient. Remittent temperatures and termination of the fever by lysis has likewise been among the commoner manifestations as will be seen from the accompanying chart No. II.

One of the patients in whom this was manifest was a young married woman in whose family during the same week there had already been two other cases of the same disease. Five days after the initial rigor, she took the cars for some distance towards the hospital and then walked a quarter of a mile in order to gain admission. She was practically moribund on being placed in bed and the heart itself was showing signs of failure, the second pulmonary sound being distinctly weakened. However, the condition fortunately subsided, and though no complications could be detected, the temperature ended in much the same manner as do ordinary cases of enteric fever.

Among other interesting features which have been noticed in the present epidemic has been the insidious manner in which pleurisy with effusion may complicate the disease, and in several cases where the temperature was either on the descent, or had already attained normal, fluid either serous or sero-purulent had collected without manifesting any appreciable alterations in the temperature. In one case indeed, the fluid collected within 24 hours, filling half the chest without there being any evidence to indicate it on the chart. Aspiration of this patient's pleural cavity, showed the presence of sero-pus which disappeared without further operation.

That pus may be present in the pleural cavity without appreciable chart alterations is of course a well recognised fact, but to have it completely fill the pleural cavity as in another instance, where the pulse, temperature and respirations were normal, is certainly among the very atypical forms of disease. In yet another of our cases delirium tremens was present and the pneumonia occupied but a very secondary part of the symptomatology. It is perhaps less uncommon to find in patients with delirium tremens a great elevation of temperature, and the condition may go on insidiously though much of the lung be involved.

Such was the condition in our case referred to where, though there was but slight rise of temperature, the rusty sputum and evidences of consolidation in a portion of one lung, were quite sufficient to make the diagnosis of pneumonia undoubted.

Examination of the blood showed that in most of the cases, leucocytosis was present, and it has been our experience to find that in the non-fatal cases, a good prognosis is certainly associated with its presence. To this, however, we have perhaps a slight exception, in a young child whose condition was so severe as to be considered practically beyond hope, and only 8000 leucocytes were present. The disease became bilateral, the pulse reached 175 per minute, and the respirations 72; for a time likewise there was Cheyne-Stokes respiration. A few days ago, however, a crisis appeared and the patient is now convalescing. It should be stated, however, that the day after the crisis the leucocytes reached 16,000 to the cubic millimetre. The most marked leucocytosis present in any case was 44,000 to the c.mm.

Delayed resolution had not been uncommon, the signs of consolidation persisting often for many days after a crisis would have been expected. In two instances occurring some months ago, delayed resolution was of such a nature as to arouse the suspicion of a tuberculous pneumonia although the temperature had attained the normal for some days. Tuberculin was injected without a definite reaction, and a correspondingly good prognosis was given to the friends, a proceeding which was finally found to be quite justifiable, the patients both ultimately making a good recovery.

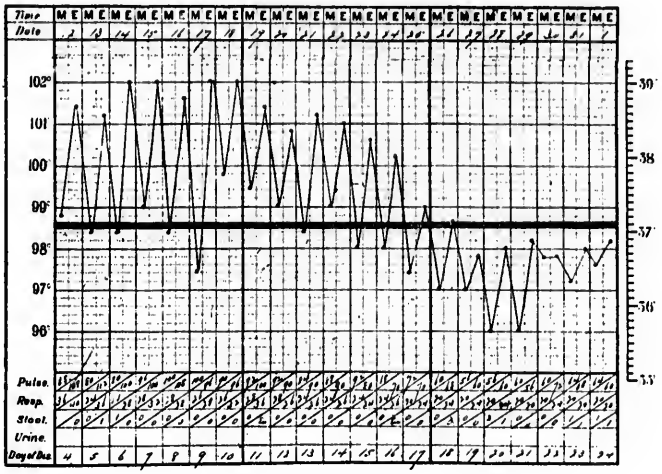

CHART I.

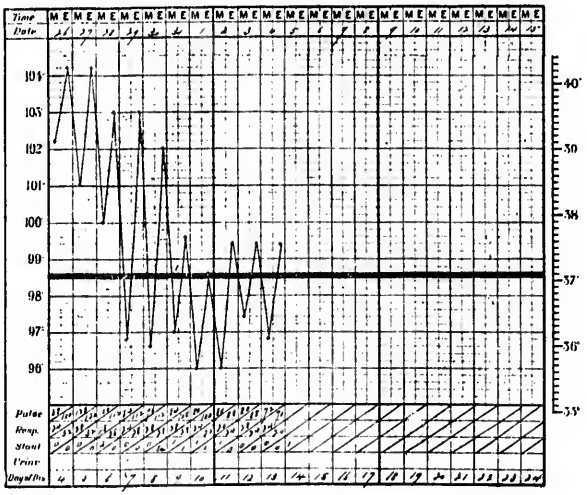

CHART II.