OBSERVATIONS ON CERTAIN FORMS OF DISEASE OF THE LUNGS.

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II.—PNEUMONIA. VARIABLE AMOUNT OF SYMPTOMS IN DIFFERENT CASES; CHRONIC PNEUMONIA (?); PNEUMONIA OBSCURED BY THE SUPPRESSION OR EXAGGERATION OF PARTICULAR SYMPTOMS; UTILITY OF FREE PURGING; PAIN IN THE ABDOMEN AS A SYMPTOM OF PNEUMONIA; EPIGASTRIC PULSATION; DELIRIUM; COMA; PNEUMONIA COMPLICATING OTHER DISEASES; PNEUMONIA OF FEVER, OF RHEUMATISM; ACCESSORY PNEUMONIA; CONNEXION BETWEEN PNEUMONIA AND JAUNDICE; CRITICAL PNEUMONIA.

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THUS far we have been considering pneumonia as the chief, if not the only disease, under which the patient is labouring; but a very large and most interesting portion of the clinical history of pneumonia relates to it less as a primary disease than as a complication of other pathological conditions; for most acute diseases, specific or otherwise, claim pneumonia as one of the most important secondary affections by which their course is liable to be complicated. But not all in the same degree; for, while in some the occurrence might seem the result of an accident, others have pneumonia connected with them as a probable complication, which we must be on the look out for and guard against. Its occurrence in these diseases is not by chance, as far as it is allowable to use this expression, but from a specific connexion with the constitutional affection. At a stated period in the course of the primary disease, there is a likelihood of pneumonia making its appearance. Of this kind is the connexion of pneumonia with the two diseases of which my opportunities of observation allow me to speak more freely; namely, continued fever and acute rheumatism.

The pneumonia of fever deserves careful attention. Its anatomical characters after death are indeed involved in all the perplexities which the subject of hypostatic pneumonia and pulmonary collapse involves; and the condition of the posterior portion of the lungs is sometimes not less difficult of interpretation by the ear during life, than by the eye of the anatomist after death. Yet it has often a very definite history and very characteristic symptoms; and its clinical distinctions from bronchitis or collapse of the lung are often readily appreciable, and, in the latter case at least, directly applicable to practice.

Pneumonia is a late complication of fever, rarely coming on before the second or third week, and connected rather with convalescence than with the downward progress of the disease. This fact favours, to a certain degree, the opinion that pneumonia is an accident, under the circumstances, and depending on some incautious exposure to cold. And, in further confirmation of this opinion, I may observe, that this complication is most frequent in the spring and autumn months, which are precisely the periods when, on general grounds, such an occurrence would be most probable. But, on the other hand, the liability to pulmonary complication will be found, I believe, to vary inversely as the liability to cerebral or intestinal affections during the same period; as if there were really a type of fever characterised by this undue prominence of one set of symptoms. And, on an impartial review of the evidence, this conclusion seems the most probable.

But, apart from these abstract questions, clinically speaking, the pneumonia of fever deserves all the attention which its symptoms will be pretty certain to attract. The circumstances attending the intercurrent pneumonia in fever are often very striking. The story is told in a few words. We may have been sustaining life with difficulty by the constant exhibition of stimulants; but this is all changed with the accession of pneumonia. The pulse rises, and local depletion even is often required, and borne very well; and, as this change in the general symptoms appears, the feeble respiration and equivocal moist sounds in the depending portion of the lung, are replaced by the characteristic physical signs of pneumonia.

Our means of treatment are, under the circumstances, very much limited. Depletion can be employed only very sparingly, and with the aid of general stimulants. Mercury and antimony are scarcely admissible; at least, my own experience has not impressed me favourably as to the results of their employment. However, local depletion and counterirritation are generally adequate, if not for the complete and immediate removal of the disease, at least to reduce it within certain safe

limits; which is perhaps as much as may reasonably be attempted in the treatment of any of the complications of fever. And the result is generally favourable; both immediately, as to the issue of the more threatening symptoms; and ultimately, as to the complete repair of the local disease.

The pneumonia of acute rheumatism, like the corresponding secondary affection in fever, usually supervenes at a comparatively late period; but these two forms of the disease have not much else in common. I have already observed how, in fever, when pneumonia comes on, with the new disease comes strength to allow us to treat it in the way which experience shows to be mostly successful. But it is otherwise in rheumatic pneumonia. The general symptoms on its accession are changed, not in kind, but in degree; and for the worse. It comes on when the constitution is already suffering most severely from inflammation of one of the most important organs. Just when we might doubt whether our poor patient could suffer more pain and distress, and yet life go on, this further complication usually arises. Just when all our resources have been exhausted, we may have to watch, without means of interference, the progress of the most acute pleuropneumonia.

Secondary pneumonia is, on these accounts, much more to be dreaded in acute rheumatism than in continued fever. Few cases of acute rheumatism terminate fatally without this complication; and, in bringing about the fatal issue, the pulmonary affection generally takes an active part. It would be impossible to recall, in any general description, the clinical interest which attaches to a case of this kind, where all the dangers and difficulties are successively developed and accumulated; and the long daily records of such a case forcibly remind one of Gooch's remarks on notes too lengthy ever to be read after they have been written. (*On Diseases of Women*, 2nd edit., Preface, p. viii.) I would, however, try, in the following abridged details, to sketch the history of such a chapter of accidents as rheumatic pneumonia involves. The very tediousness of the case is characteristic.

CASE IV. *Acute Rheumatism, with Pericarditis, Endocarditis, and Pleuropneumonia*, James Baker, a delicate looking boy, 14 years old, was admitted into St. Bartholomew's Hospital in November 1844, still suffering from articular rheumatism, which had begun a month before. It was his second attack of rheumatism. The first came on six months before, with pain in the chest, palpitation of the heart, and dyspnoea on exertion. These never quite left him; but the chest symptoms did not set in with their present severity till a fortnight ago, on the subsidence of the articular affection.

Pain in the region of the heart, extending through to the back, with cough, constituted the most prominent symptoms on his admission. The fourth left costal cartilage was slightly prominent. There was dulness on percussion up to the second rib. The impulse of the heart was preternaturally increased. There was a harsh systolic murmur at the apex; but, about the base, all other sounds were masked by a churning friction sound, extending also for a short distance along the course of the aorta.

The daily notes of the next week narrate the gradual disappearance of the pericardial friction sound, and some changes in the tone of the systolic endocardial murmur at the apex. He bore well the use of calomel and opium in small frequently repeated doses. The pain in his chest had yielded to a slight cupping and subsequent blistering. His pulse was less frequent, and he seemed to gain strength. It was singular to observe how any pressure on the epigastrium was resented, as causing pain in the chest.

On November 28th, the previous day having been marked by a slight return of the articular affection, the pericardial friction sound grew a little more distinct; and, with acute pain of the right side of the chest, a pleural friction sound also became audible all over the right axillary region, while over the lower part of the left side there were dulness on percussion, increased vocal resonance, and transmission of the heart's sounds with impaired respiratory murmur.

A blister was applied over the right side of the chest, with relief to the pain; but the signs of pneumonia of the left lung became more distinct and more widely diffused; and, the next day, the general evidences of pulmonary obstruction displayed themselves in the restless dyspnoea which harassed the poor sufferer; though no further change had taken place in the physical signs, beyond the pleural friction sound having assumed a louder and rougher character.

The affection of his gums having quite disappeared since the discontinuance of the mercury on November 25th, this was now

resumed. For the next three days, an improvement was noticed: his breathing became easier; he slept well, and was free from pain; but his profuse perspirations and his rapid jerking pulse showed that the slight amount of antiphlogistic treatment employed was quite as much as he could bear. The condition of the heart and of the right pleura remained the same during this period. The left lung had become more pervious in the upper half; but below, the respiration was still purely bronchial, with bronchophony, small crepitation, and dulness on percussion. He was in this condition when, on December 3rd, the calomel was reduced to one grain nightly; as his mouth was again just touched, and his pulse had risen to 130.

December 4th. He slept well much of the night, but had pain in the region of the heart, which still continued. The face was pale; the tongue furred; pulse 128, small, and rather sharp; the skin was perspiring; the bowels were open. On auscultation, the pericardial friction sound was audible only behind the sternum, and less distinctly. The physical signs of disease of the left side of the chest had again become more marked, and extended higher up.

A large blister was applied over the left side of the chest; and five grains of Dover's powder were ordered twice a day, omitting the calomel. The next day found both the local and the general distress much relieved. The physical signs on the left side remained unchanged. Abundant small crepitation and dulness on percussion showed, however, the extension of pneumonia to the lower third of the right lung, where the evidences of pleurisy only had hitherto been discoverable.

For the few next following days, there was little to do but support the poor child with small doses of opium, and watch the progress of the diseases in his chest, without having any means of directly interfering with them. The note of December 9th indicates the material results of the changes during this period. On the left side, there was more extended resonance on percussion; the bronchial breathing and bronchophony generally were less marked; indeed, there was good vesicular breathing, with only scanty small crepitation in the upper third. In the lower third, there still was abundant small crepitation. On the right side, there was a clear vesicular murmur at the apex; below, some small crepitation, more abundant towards the base of the lung. The lower third was quite dull to percussion; still the pleural friction sound was audible. The pericardial friction sound continued audible behind the sternum, but was softer; the systolic murmur at the apex of the heart was musical.

The treatment during the next three weeks consisted of a succession of blisters, the constant use of Dover's powder to calm the still excited nervous system, and the occasional cautious use of mercury. At the end of this time, the right lung had completely recovered; but on the left side there was crepitation on deep inspiration about the scapular region; and the resonance on percussion over the base was still impaired. The pericardial friction sound, too, still continued. There was heaving impulse, and extended dulness on percussion, over the region of the heart.

Still, after another fortnight, the repair was far from complete. There was then abundant small crepitation over the lower third of the left lung, and to this extent almost no respiratory murmur. Some crepitation was audible about the base of the right lung. The heart's impulse was still heaving, and the organ evidently enlarged; and still, from time to time, a pericardial friction sound could be recognised.

It was nearly two months more before he had recovered sufficiently to leave the hospital; and then his face was as pale as if he had recently suffered from the most profuse hæmorrhage. The signs of cardiac disease were manifestly on the increase. Percussion over the lungs gave normal results everywhere; but still, from time to time, there was some crepitation audible in the left lung, with an occasional pleural friction sound in the right scapular region.

I feel how very imperfectly this dry bare narrative conveys all the dangers and perplexities which beset this case from beginning to end. These are but faintly expressed by saying that the poor child had double pleuropneumonia and pericarditis, the severity of any one of which, in the exhausted state in which he lay, would have been accepted as quite a sufficient explanation of an unfavourable result. But, instead of endeavouring to give interest to these clinical details, my object is rather to justify the application of the definite name of pneumonia to the disease. There are conditions occurring during acute rheumatism, aptly enough expressed by the names of pleurodynia and rheumatism of the respiratory

muscles; and the alternation of bronchitis with the articular affection in gout is familiar to all. But such conditions are not to be confounded with real definite pleurisy and pneumonia, such as complicated acute articular rheumatism in this poor child.

Without any over refinement, this subject may be pursued farther. There are specific characters observable in rheumatic pneumonia, distinguishing it from the ordinary form of the disease. One is the mode in which it originates, namely, in bronchitis. The bronchitis, however, does not long continue as such. I cannot, indeed, recall the observation of a single severe case of rheumatic pulmonary affection where bronchitis has continued as such throughout, without running into pneumonia. As traced by auscultation, the bronchitis displays specific characters of its own, in its tendency to attack the minuter ramifications of the bronchi, instead of the larger tubes, in the first instance; and the peculiarities of the disease are not wholly lost among the various changes which dissection displays in fatal cases: for, on carefully looking over the records of dissection, the descriptions of the morbid appearances do not seem, on the whole, to represent the same results of pneumonia as would probably have been found in as many simple cases of this nature. The terms congestion and softening, and the equivocal expression splenisation,* occur more frequently than the explicit mention of red or grey hepatisation. And the bronchial origin of the pneumonia shows itself further in a tendency to lobular, rather than lobar diffusion.

We must, however, in these rheumatic cases, allow largely for the period at which the disease proves fatal. At a very early period, the characteristics of early pneumonia would naturally predominate. At a later period, we must not overlook the possible effect of growing valvular disease of the heart in modifying the changes going on in the lungs. And I must add, that the ordinary anatomical characters of pneumonia are of more frequent recurrence in M. Bouilland's recorded cases than in those which my own note-books furnish.

On another point I can speak less confidently; but I do not think that the tendency to plastic fibrinous exudation is as strong in rheumatic as in ordinary pleurisy. Still, there are other circumstances, and more particularly the late period at which pleurisy supervenes in rheumatism, to be taken into account, before assigning to rheumatic pleurisy a specific character so unlike what the general pathology of rheumatism might have led us to anticipate.

There is little more to add on this subject. The clinical history of rheumatic pneumonia has been drawn by Dr. Latham (*On Diseases of the Heart*, Lect. ix) with even more than the usual elegance and truthfulness of his descriptions; and all that I have observed myself of the statistics of the disease may be comprised in a few words.

In sixty-one rheumatic cases analysed for this purpose, pulmonary inflammation was found to have occurred twenty-four times. Of these cases, four were of simple pleurisy, of which two were fatal; seventeen were of pneumonia, of which four were fatal; three were of pleuropneumonia, none of which were fatal. Thus much for its frequency. Of its importance, it may fairly be said, that the question of life or death in rheumatic pericarditis turns more often on the affection of the lungs than on that of the heart; and, though pulmonary inflammation may arise during acute rheumatism without the occurrence of any cardiac affection, yet it seems as if the pericardial complication were necessary to the manifestation of the pulmonary inflammation in all its severity. (*Medico-Chirurgical Transactions*, vol. xxxvi, p. 11.)

It is not the essential nature of rheumatic pneumonia which renders ordinary remedies inapplicable, so much as the circumstances under which it occurs. Indeed, all that general experience approves in ordinary pneumonia is available here under the same general limitations. It is only the collateral circumstances which forbid the employment of active depletion, and confine us so closely to the use of counterirritation. If I were to name any single specific indication of treatment which the rheumatic origin of pneumonia suggests, it would be, I think, the preference of opium and ammonia to wine for the support of the exhausted nervous system, when this, as is so commonly the case, demands especial attention.

This general exhaustion accompanying rheumatic pneumonia, of which I have been speaking, as contraindicating the employment of active antiphlogistic treatment, has been regarded in quite another point of view by some physicians. It has been regarded, namely, as an effect of too active treat-

* Probably, had I to observe these cases over again, the term "collapse" would supersede that of "splenisation".

ment; and further, as itself a cause of the secondary complications. The subject would not be complete without some inquiry into the merits of this question.

The evidence on which this opinion rests seems to me partial and insufficient. Facts have been collected mainly on one side, the positive evidence quite eclipsing the negative. We have abundant records of the results of active treatment, both for good and for ill; but comparatively few records of what happens when the efforts of Nature are not interfered with. And what perhaps has done most to condemn the system of active treatment is the fact that its most untoward consequences have been observed in his own practice, and recorded, by one of its most enthusiastic advocates.

It were well to preserve a question of such vital interest as the treatment of acute rheumatism free from all prejudice or party feeling. There can be no doubt that what has been so inappropriately called the heroic plan is productive of great mischief; but the unfavourable results of this plan, of doing everything by one remedy pushed to extremes, must not be urged as an argument for the entire rejection of this remedy. General experience, overlooking abstract difficulties, seems to be pretty well agreed that there is no reason for assigning to acute rheumatism a pathology altogether different from that of all other acute disease. It is no more than what the experience of nearly all physicians will confirm, to say that we have the same evidence in acute rheumatism as in other acute diseases, of the beneficial effects of active antiphlogistic treatment, when employed on its familiar indications. And this holds not only as to the prevention of secondary complications, but as to their cure, should they arise. Further, we have the same evidence in all alike (though the principle has, unfortunately, been pressed here beyond its legitimate application) that depletion employed wrongly, or too freely, will actually tend to produce the secondary inflammations it was designed to prevent.

Yet, again, general experience dissents from the universal adoption of one arbitrary plan, whatever that plan may be, in the treatment of acute rheumatism, bleeding as well as the rest. But we must not, because blood-letting can be made so very mischievous, forget how much good it is capable of effecting, if only it be used in its proper place, like all other remedies for acute rheumatism. It would be beside my present purpose to speak at any length of these. I would only add one remark. Each claims the first place for his favourite remedy, be it purging, bleeding, nitre, lemon-juice, or whatever else; in my own opinion, the alkaline carbonates. How many concur in assigning the second place, should their favourite specific fail, to calomel, opium, purgatives, and depletion, as ordinary indications may suggest!

We may regard pneumonia as constituting a regular part of these two diseases, rheumatism and continued fever. It is not indeed essential to them; for they are often transacted without its occurrence, and we know of no phase during their progress which requires the development of pneumonia, or something instead of it. But in both diseases there is a certain stage at which we must be prepared for the occurrence of pneumonia, as if its connexion with the original disease were more than merely accidental. The absence, however, of any specific effects of the secondary on the further course of the original disease leads us to infer that this is a complication only, not an opposite action; that it is accessory merely, not critical.

Accessory pneumonia finds some of its most apposite illustrations in cases of phthisis or valvular disease of the heart, or of granular disease of the kidney; the pulmonary inflammation being simply an addition, however serious, to the original disease, and its pathology being in great part external to the lungs. Pneumonia arising under these three different conditions preserves certain characters common to them all alike, which may be very briefly summed up thus. Its progress is rapid, more so, perhaps, in appearance than in reality, from the slight general symptoms under cover of which the disease may advance before it is discovered. It is easily removable under appropriate treatment, but is singularly apt to recur; and in its treatment there is the greatest reward for discrimination. A large blister, a slight cupping, or watery evacuations from the bowels and kidneys, will respectively sometimes produce the most striking effects for good, according as the pneumonia may be connected with phthisis, or with disease of the heart or of the kidneys; and I think that I have seen untoward results equally striking ensue, when these collateral indications have been disregarded.

The coincidence between inflammation of the lungs and biliary derangement of all degrees; up to complete jaundice, or

to what Stoll has distinguished as bilious pneumonia, is so very frequent, and of such pathological importance, that it should not be passed over wholly without remark; and, as I cannot define the connexion to be either accessory or critical, in the absence of any rule of classification, the subject may most conveniently be introduced here, between the notice of these two forms of disease. In assigning to this coincidence a deeper cause than the mere juxtaposition of the lungs and liver suggests, I am claiming no more than the facts of the case warrant; for jaundice is not particularly connected with inflammation of the base of the right lung. But, even were it so, had the opinion of the connexion of pneumonia and jaundice by extension of inflammation in so far a plausible foundation, yet the explanation would be insufficient; for partial inflammation of the substance of the liver is by no means necessarily followed by jaundice.

I cannot, from my own experience, confirm Grisolle's observation, that cases of bilious pneumonia are singularly amenable to active treatment, of which bleeding and free purging should constitute an essential part. I do not, indeed, feel sure that a case of Stoll's bilious pneumonia has ever come under my observation; and would leave it for more extended experience to say, whether this nosological distinction has any practical value as regards the question of treatment. (Grisolle, *ouv. cit.*, p. 405.)

The pathological interest of the problem is, however, very great, and stretches so far beyond the question of the connection between jaundice and pneumonia, that it were ill to rest content with an insufficient explanation which looks no further than this. It is another point of view from which to study the functions of the liver. And the pathology of this organ, just as that of the heart has done, may help to clear up some points in its physiology. We need something more intelligible than the phrase of an interchange of functions or a sympathy between the lungs and the liver; something more than mere contiguity to express the relation of pneumonia to jaundice, of inflammation of the parenchyma of the lungs to excessive biliary secretion. There is certainly some specific connection, independent of the amount of pulmonary obstruction.

Critical pneumonia is most familiarly known in connection with measles and small-pox, where the stress of the disease is suddenly transferred from the surface of the body to the substance of the lungs. My own very limited and favourable experience of pneumonia in this form, indeed, would lead me to consider it as accessory rather than critical; and to regard its occurrence under these circumstances as the effect of some extraneous cause, having no specific connection with the original disease. The change of symptoms, however great, has always seemed reconcilable with this supposition. The larger experience of Grisolle (*ouv. cit.*, p. 353), however, has detected in the rapid progress of such cases of pneumonia apparent evidences of their specific nature and origin.

It is superfluous to stop here to inquire whether the term retrocession or repulsion be more correctly applicable to these cases. The question is not unimportant in a prophylactic point of view; but it has little or nothing to do with treatment. For from whatever cause, internal or extraneous, the pulmonary affection may arise, once set up, it asserts its own independent importance, and demands its own remedies.

In employing terms of this kind, we must bear in mind that they are useful and necessary only in their legitimate sphere: that is, so long as we regard them only as convenient formulæ for investigation, not as expressing ascertained truths. With this understanding, I would venture to apply to the following cases terms expressive of a more intimate acquaintance with the operations and intentions of Nature in disease, than the facts might otherwise strictly justify me in employing.

I have spoken thus far, under whatever names, of secondary pneumonia constituting a part of some other disease and often adding much to its danger. But we may regard it in yet another point of view, under a form to which, if to any other, the term *critical* is most happily appropriate.

The general history of this class of cases may be sketched in a very few words. Cases occur now and then, where, after a more or less protracted obscure ailment, something directs attention to the chest. And there we find pneumonia, and, under the more definite treatment which this more positive knowledge suggests, the patient rapidly recovers; the pneumonia passes away; and with it all the obscure ailments, on which the pulmonary inflammation had engrafted itself, subside. The following case is one of many illustrations of the class which my note-books supply. As the patient had been

watched for some time before most closely by my friend Mr. Scott, I can speak very confidently on the improbability of any thing having been overlooked.

CASE V. *Manifestation of Pneumonia coinciding with Relief of the General Symptoms.* A delicate girl, aged 15 years, had been for some weeks ailing, a slight cough being the most prominent complaint. Two days before I saw her, general fever set in, with pain in the left side of the chest. The existence of pleuropneumonia was strongly suspected at this time; but it was not for nearly two days that its physical signs could be discovered. Meanwhile, she was put on the cautious use of calomel and antimony, with the best result; her pulse falling from 160 to 120, and her respirations from 60 to 24. At length, a little small crepitation below the left scapula with some coarse breathing and slight dullness on percussion was recognised. Still the changes were so slight, that it required the knowledge of all that had happened previously to satisfy oneself that they were the physical signs of important disease. Such, just so slight, were they then.

The daily notes henceforth record a steady improvement in her general symptoms; and, singularly enough, as steady an extension of the physical signs of pneumonia. For, on the fifth day from their first appearance, as above recorded, the bronchial breathing was found to extend from the apex to the base of the left lung, with very decided dullness on percussion about the base. And over the lower third of the right side too, behind, there were bronchial breathing and dullness on percussion; but less marked than on the previous day.

I would merely add that this was the turning point of the local manifestations of the disease, which subsided steadily from this time forwards. The constitutional symptoms, as already noticed, had been relieved in great measure on the first appearance of the pulmonary affection. Now, after more than four years, the child is alive and well.

I cannot allow this case to stand thus without a few remarks. We may often observe in cases of pneumonia a great improvement in the general symptoms, while the disease is still extending in the lungs. In explanation of this, it may be properly urged that auscultation takes cognizance of the condition of the superficial parts of the lungs only: so that, notwithstanding the evidence of the extension of the disease on the surface, this may yet really be subsiding within, *pari passu* with the decline of the general symptoms. But this supposition, which, in the absence of means available to disprove it, must sometimes perforce be tolerated, was to my mind quite inadequate to explain the anomalies of the preceding case. The great extension of the disease from the date of the first recognition of its physical signs to the period when it began to recede, and the length of time which these progressive changes occupied, seem to me strong arguments against this hypothesis. The most reasonable explanation is that which would connect the sensible feverish symptoms and the organic pulmonary affection, not as cause and effect respectively, but as conjoined effects of some further cause. The inflammatory fever was relieved by the treatment employed; while the pneumonia still for a while pursued its course.

I am afraid, however, of spoiling the narrative of a very interesting case by any loose speculations on a matter of which we know so little as final pathological causes. Let this case stand as an instance, the simplest I can find, of a disease going on independently of its own general symptoms. The next case, advancing a step beyond this, seems to supply, by a more complex process, a fair illustration of critical pneumonia.

CASE VI. *Pneumonia terminating a long Series of Ailments.* A delicate, unhealthy girl had an attack of peritonitis in May, 1854. It came on slowly, and subsided as gradually under the use of ordinary antiphlogistic treatment. Next she had mumps severely, going through a most unusual course to suppuration. But the general symptoms on this occasion, compared with those of the only other case of the kind that I have seen, were singularly slight. The next that I heard of her was, that she had suffered inflammation of the left posterior tibial vein, but that this too had quietly subsided. It was about a month after the appearance of peritonitis that pneumonia set in, commencing with slight fever and a trifling cough. The symptoms were indeed quite trivial, and would hardly have aroused suspicion in another case. But the previous experience of this patient showed what extensive disease might be going on with scarcely a symptom to betray it. And her chest, being examined on these slight indications, was found already to present the signs of extensive structural changes. My notes record that the right side of the chest was dull on percussion from top to bottom, with general bronchophony, and, about the base, some large

crepitation. About the left base also some mixed moist sounds were audible, with dullness on percussion. With the manifestation of these signs of pulmonary disease the pulse fell immediately from 120 to 96; and the general symptoms of irritative fever began to yield quite independently of any change of treatment. This was the last of her ailments; she now at once and permanently recovered.

To enlarge upon this particular case would only weaken the impression of the above few and simple details. It is only one illustration of what I believe most would assent to, if expressed more generally thus:—That sometimes pneumonia supervenes on and concludes a long series of ailments of the most various kinds, in such a manner that we might almost say that its occurrence eliminates something which has been keeping up irritation. I would only observe, that the successive inflammatory attacks of different parts were not to be attributed to active antiphlogistic treatment; for, as each new affection arose, the fear that it was based on tubercular disease of that organ forbade the employment of any measures more active than were absolutely required. I would leave the case as it stands, doubting only lest it be my preconceived notions, rather than the facts themselves, which make the illustration which it supplies seem so very pointed.

Reviews and Notices.

GUY'S HOSPITAL REPORTS. Edited by SAMUEL WILKS, M.D., and ALFRED POLAND. Third Series, vol. iv. pp. 372. London: John Churchill. 1858.

[Concluded from page 1008.]

MR. S. J. A. SALTER furnishes Contributions to Dental Pathology, consisting of articles, 1. On the Shedding of Teeth and Exfoliation of the Alveolar Process, consequent upon the Eruptive Fevers; 2. On Warty Teeth; and 3. On Polypus of the Tooth-Pulp. The author, in the first of these articles, mentions that he has, in performing his duties as surgeon-dentist to Guy's Hospital, met with a number of cases in which necrosis and exfoliation of the alveolar processes of the maxilla, accompanied by shedding of the contained teeth, has been one of the secondary results of attacks of scarlet fever, measles, and small-pox. The proportion in which the cases occur after the previous fevers varies much: thus, after scarlatina, Mr. Salter has met with eight or ten cases; after measles, three or four; and after small-pox, only one. As the number of children who have measles much exceeds that of those who have scarlet fever, it would appear that the cause of the morbid change is less extensive in measles than in scarlatina. The following are the general characters of the cases which Mr. Salter has noticed:

"The first evidence of exfoliation has always been apparent within eight or nine weeks after recovery from the eruptive fever, usually within four or five. It has never been preceded by swelling or pain, or accompanied by periosteal abscess; the suppuration always occurring at the part where the gum peels from the alveolus, which appears to be the simple method of exposing the dead bone. It has happened more frequently in the lower jaw than the upper; and when in both, first in the lower. Whichever jaw has been the subject of the exfoliation, it usually occurs on both sides, either coincidentally, or in rapid succession; its tendency is to be symmetrical. The severity of the previous attack of fever seems to have no relation to the subsequent exfoliation—a very light attack of eruptive fever may be followed by a considerable exfoliation, or the reverse: sometimes it is associated with other secondary symptoms, more often not; indeed, it has seemed to me to have generally occurred in very healthy children. The age at which these exfoliations have occurred is worthy of especial note. It occurs during the time that the most active tooth-development is going on in the jaws, and when all those parts are undergoing the most rapid nutritional changes—about five or six years of age. From four to eight years are the extreme limits I have seen. It is not a little remarkable, that in every instance that has come under my observation, the temporary molar or molars, and the corresponding bicuspid or bicuspids, with their containing alveoli and loculi, have been the parts to suffer. In no one case has the shedding of teeth been confined to the temporary set; the successional (bicuspids) have always been in-