in contact with the heart, "in which", says Dr. Balfour, "the pulsation, though expansile from being communicated through fluid, is less forcible than that of the heart." In this particular case, the pulsation was fully as forcible as the apex-beat; but the apex-pulsation was feeble. Dr. Balfour's proposition is not, therefore, invalidated, provided that the cardiac pulsation is of normal force.

In spite of the great similarity to aneurism, the diagnosis of intrathoracic tumour was arrived at for the following reasons.

1. *The extensive nature of the dulness.* An aneurism sufficiently large to cause such dulness would have produced more active pressure-symptoms—notably pain. There had been slight pain in this case at the commencement of the illness.

2. *The great emaciation.* There was no obstruction of the oesophagus, no prolonged suffering—conditions which cause emaciation in aneurism.

3. *The associated paralysis and its very gradual commencement* favoured the idea of a secondary deposit in the brain.

4. *The position of the pulsating tumour.* It is rare for an aneurism to point an inch and a half above the left nipple.

I was aided, too, in the diagnosis, by the experience gained in the case published in the JOURNAL of January 6th, 1877. The first attack of paralysis was obviously caused by the cerebral abscess; the second by the embolism. The origin of the cerebral abscess is not quite clear. There was no purulent discharge from the ear, nose, or other portion of the skull. It may have been a secondary deposit in the brain which had softened and liquefied, or it may have been the result of a previous embolism. The former view is probably correct, because, first, only one embolism, and that a recent one, was found; second, the gradual way in which the lesion produced mental changes, then aphasia, then paralysis of the arm, then of the leg. The first attack of hemiplegia was probably due to pressure, and not to direct lesion. Had all the conducting fibres from the centres for the arm and leg been destroyed, it is difficult to suppose that the recovery could have been so rapid and complete. This view is quite in accord with the localisation of Ferrier and Broca. The fact that the temperature did not exceed 100 deg. during the attack of pericarditis, is perhaps worthy of remark. The large nodule in the lower part of the ileum was pathologically interesting. The enlargement of the mesenteric and postperitoneal glands in the neighbourhood of the capsules and of Peyer's patches is frequently seen in Addison's disease.

CASE OF POISONING BY A LARGE DOSE OF TINCTURE OF ACONITE: REMARKABLE SYMPTOMS: RECOVERY.

By L. HERBERT JONES, M.R.C.S., Harrow Road.

A GENTLEMAN, staying at my house on a visit, on the morning of January 16th, went down to my surgery at eleven o'clock, and there, mistaking a small bottle of tincture of aconite for one of succus limonis, drank off two ounces. A few minutes afterwards, I met him in the hall, and, to my hurried glance, he appeared strange. In answer to a passing question, he said he should not be back to luncheon, as he was going to call upon a friend two miles and a half off. I saw no more of him until he was admitted by the servant at 2.30; he went straight to his room, and, as he did not soon put in an appearance, I went up and found him in bed, and, by his appearance, thought he was under the influence of drink; happily, I was wrong in my conclusion. He was semidelirious, very flushed in the face, suffering intense dyspnoea, bathed in an icy-cold perspiration, with pupils widely dilated. I could at first get nothing out of him, but finally ascertained that he had walked to the friend's house, had partaken of a glass of wine and some biscuits, and, feeling faint, he returned home, walking. On his way, he felt "as if his legs would give way under him", and within about half a mile of my house he vomited freely. I ordered hot bricks to be put into the bed, gave him a strong glass of brandy-and-water, put extra blankets on, and ordered strong coffee to be got ready. The pulse was not perceptible at the wrist, and the heart-sounds could faintly be heard. At 3.30, violent vomiting came on; and, acting upon the dictates of nature, I gave him half a drachm of sulphate of zinc, which had the effect of bringing away a large quantity of dark grumous fluid. He at this time casually mentioned that he hoped he had not mistaken one bottle for another in the surgery. I knew he was fond of the succus limonis, and, in going down to my room, I found, to my horror, that he had mistaken one bottle for the other.—At 4 o'clock, the delirium still continued. There was great muscular prostration; no pulse at the wrist. Temperature 89 deg.—At 4.30, I gave him two ounces of castor-oil, which soon had the desired effect.

The pupils were widely dilated, but there was great dyspnoea, which almost suffocated him. I became somewhat alarmed. By applying mustard sinapisms to the calves of his legs, hot bricks to his feet, and rubbing him over with rough towels, and sedulously giving him brandy and water (six ounces to the half pint), he partially rallied.—At 5.30, tonic spasms occurred, lasting a considerable time. Temperature 84 deg.; pulse at wrist imperceptible. The hands, including the nails, were in appearance slate-blue. Hot coffee (strong) and brandy-and-water were given every half hour up to twelve.—At 12 o'clock, the heart-sounds were more distinctly heard. There were marked diplopia, and intense thirst. Temperature 89 deg. He had no power over the lower extremities. There were great tingling and numbness in the arms, and he said he felt inclined to sleep.

January 17th, 4 o'clock. I saw him again. The pulse was perceptible at the wrist; the dyspnoea was disappearing. He had great palpitation; temperature 95.4 deg. He took a boiled egg and a strong cup of coffee.—At 9 o'clock, he had had some refreshing sleep. He was quite conscious, and complained of seeing double; the pupils were widely dilated. He ate an egg and a little toast. I kept him in bed for two days, by which time he had quite recovered, with the exception of great muscular weakness and occasionally severe attacks of palpitation.

My first impression was that the drug I had was innocuous; but I had the positive assertion of the wholesale chemist who supplies me, that the drug was prepared according to the *British Pharmacopoeia*, from the root. My late lamented tutor, Dr. Fleming of Birmingham, ascribed great powers to aconite, and was often in the habit of remarking the lowering of the temperature of the body by aconite. Among recent writers, Kinger predicts a great future for aconite. I did not notice any vesicular rash, which, he says, sometimes occurs during the administration of this drug.

I think I am not wrong in stating, that this is the largest dose of the tincture that has been taken without causing death. Quoting from Taylor's *Medical Jurisprudence*, I find "considerable uncertainty appears in the operation of this poison under the form of tincture". Again, "a man recovered in three days after having taken upwards of ten drachms of the tincture". It is interesting to observe that the effect of this drug differs. It has been known to contract the pupil. In my case, the pupils remained widely dilated for nearly three days, showing that its power over the nervous system varies.

My apology for sending this interesting case is, that it may be of some use in a medico-legal point of view.

SURGICAL MEMORANDA.

ABSCCESS IN THE KNEE-JOINT.

TOWARDS the middle of last January, I saw, with Mr. Wigmore of Inverness Terrace, a married woman, 39 years of age, of a decidedly phlegmatic temperament, who had been confined to bed for some time past with rheumatic fever. All her joints had been attacked in turn, and the effusion in her left knee, though lingering for a time, had at last become absorbed under the administration of quinine and iron and the application of blisters. To this treatment, however, the right knee would not yield; it persistently increased in size.

When I first saw her, she was lying supine, with the right leg slightly flexed and abducted, the knee, well wrapped in flannel, being supported on the outer side by a pillow. The synovial membrane bulged up under the quadriceps extensor and on either side of the patella and its ligament. The slightest shake or movement gave rise to intense pain in the joint. The surrounding skin was red and hot. The pulse was extremely weak and frequent, and the appetite and power of sleep were well-nigh gone. Although she sweated profusely, she had had no shiverings. Next day, however, she had a severe rigor, and her physical condition was worse in every respect. Further temporising being out of the question, a free incision was made along the prominent and fluctuating swelling on the outer or dependent side of the joint. Several ounces of a thin and streaked synovia at once escaped, and with it a considerable quantity of pus. Then, by gentle pressure with the hands, the joint was as completely emptied as possible, and some tenax was loosely bound over the wound. Two days afterwards, when this dressing was removed, it was found that there had been no subsequent discharge, and that the edges of the incision were completely and soundly united. Moreover, all pain had left the joint, and anxiety and distress had given place to tranquillity and repose. The appetite returned, and with it the power of movement at the knee. The last report of Mr. Wigmore (February 18th) says: "The patient is now