a tympanic membrane intact. In two of these instances, rupture of the membrane had been effected, although there was no foreign body in either ear.

With such experiences, in which I am probably not singular, it will not be thought presumptuous in me to urge that all students at hospitals be taught that, so long as they live, they are to abstain from any attempts whatever to remove a foreign body from the ear unless they have learned to use their hands at the same time that the external auditory canal is thoroughly illuminated from a mirror worn on the forehead. So long as this rule is obeyed, no injury will be done. Whenever this rule is broken, the tympanic membrane will be ruptured, and the life of the patient placed in imminent peril.

As this subject has been discussed by me in *Lectures on Diseases and Injuries of the Ear*, I abstain from further remarks, excepting to add that occasionally syringing will increase the difficulty attending the removal of foreign bodies from the ear, inasmuch as this proceeding often has the effect of pushing deeper into the canal an object which, previous to the syringing, was more easily capable of removal by other means.

NOTE ON THE DIAGNOSIS OF THE NATURE OF PLEURITIC EFFUSIONS.

By LAUCHLAN AITKEN, M.D., Rome.

AT the Manchester meeting, various able papers were read on the treatment of pleurisy by paracentesis, and on the mortality arising therefrom; but neither in the papers nor in the discussion which followed was any allusion made to the possibility of diagnosing by physical signs the nature of the effusion. As the President of the Section very properly restricted the discussion to the treatment by puncture, the attention of the meeting was scarcely directed to the diagnosis of the nature of the fluid by any means, although, as all the speakers admitted, this question has most important bearings both on the treatment by puncture and on the method of its performance. The publication of several of the papers induces me to forward a brief note on diagnosis.

Dr. Barlow and Mr. Parker admit that there is no certainty in the diagnosis of the nature of the pleuritic effusion. In children, they say that "the aspect of the patient—a peculiar anæmia, with an earthy complexion—and, above all, clubbing of the finger-ends, have been the most characteristic features, suggesting empyema rather than serous effusion"; and they allow that by physical signs "they know no means of discriminating serous from purulent effusion, except when the latter has led to localised swelling, which we believe the former never does". Dr. Clifford Allbutt says nearly the same thing: "The presence of œdema in the wall of the thorax, however, will generally tell us when the contents are purulent"; and Dr. Henry Barnes alludes to the absence of œdema of the chest-wall in one case as probably indicating a sero-fibrinous effusion. In the most recent text-book, too—Ziemssen's *Handbuch*, vol. iv, *Krankheiten des Respirations-Apparates*—where Fraentzel treats of the physical signs of pleurisy in a perfect deluge of words, there occurs the assertion "that œdema of the diseased side of the chest, whether over the whole half of the thorax or only at isolated points, almost always justifies a diagnosis that the effusion is purulent".

In 1875, however, Dr. Baccelli, the Professor of Clinical Medicine at Rome, published some papers* on the Transmission of Sounds through Endopleural Fluids, in which he maintains that there is a physical sign by which we can distinguish the character of the fluid. The slight vocal vibrations produced by a whisper, he asserts, are differently transmitted to the ear according to the nature of the fluid; through purely serous effusions much more intensely than through sero-fibrinous; while in thick purulent fluids they are entirely, or almost entirely, lost. He formulates the results of his observations thus.

1. The whispered voice-sound is transmitted most clearly through a serous effusion.
2. Through sero-fibrinous effusions the same sound is transmitted more or less clearly according to the point at which we listen; clearly at the upper part, where the fluid is lightest; less clearly lower down, where the fluid is denser; and probably lost altogether at the base.
3. In empyema, the transmission of the whispered voice-sound is reduced to a minimum or altogether lost.

Baccelli draws those conclusions not only from the numerous cases he publishes, in which the character of the fluid had been diagnosed by

this sign previous to paracentesis, but also from the results of some physical experiments which prove, he says, that "the denser and more heterogeneous a fluid is, the more quickly and the less intensely does it transmit sound; and the lighter and more homogeneous the fluid, the more intensely and the less quickly does it transmit sound".

I am in no position to judge the truth of this physical law, and I have not had the necessary time to attend the *clinique* with sufficient regularity to confirm the observations except in a single case. In private practice, I have found in several cases variations in the intensity of transmission of the whispered voice-sound at different levels of the fluid and at various stages of the complaint; but none of my cases have required puncture since I became acquainted with the sign in 1875. It would be a waste of time to give extracts from Baccelli's cases published then, or from the more recent ones which have just appeared in the *Gazzetta Medica di Roma* for October and November of this year. My object has been to draw the attention of hospital physicians to the point, as they alone have the necessary material for its confirmation or rejection.

There are some precautions which ought to be taken in listening to this sound. The patient should be sitting, with the face directed away from the side affected; to the left, for instance, if the auscultator be listening at the right posterior base. One ear should be applied direct to the chest-wall, and the other should be thoroughly closed by the finger.

HÆMORRHAGE FROM THE BOWELS, DURING ENTERIC FEVER, FOUND TO BE DUE TO POLYPUS OF THE RECTUM.

By ALEXANDER R. COLDSTREAM, M.B., L.R.C.S.Ed., Leith.

IN September this year, I was called to attend a boy, nine years of age. The patient, a blanched delicate-looking lad, I found to be suffering from the symptoms of the initial stage of enteric fever; but was somewhat surprised to learn from the mother of the patient that, every time the bowels acted, a small quantity of bright red blood appeared in the motion. From the history of the present illness, I concluded that the fever was only of twenty-four hours' duration, rigors on the previous day having been preceded by a fortnight's *malaise*, and succeeded by the feverish condition which induced the mother to obtain medical advice. The hæmorrhage, therefore, could not be attributed to the specific typhoid lesion. Further, the general condition of the patient was good; and, granting that my calculation as to the invasion of the fever had been incorrect, there was nothing to indicate the probability of intestinal hæmorrhage. On questioning the mother closely, I ascertained that for three years previously she had occasionally noticed stains of blood on the boy's shirts; and, on still more closely questioning the boy, he allowed that for long some drops of blood had been daily lost at stool. A rectal examination revealed the presence of a polypus, which, on being drawn beyond the grasp of the sphincter, was found to be of the size and colour of a cherry, and attached to a well-defined pedicle. The fever ran the ordinary course, the temperature curve and the appearance of rose-coloured spots confirming the diagnosis. On the occurrence of every motion, the polypus was found to protrude, but was at once and easily replaced in the rectum by the boy himself. After convalescence had been fairly established, I proceeded to remove the polypus, intending to ligature and then snip the pedicle; no cutting, however, was necessary, as during slight traction on the growth, so as to allow the application of the ligature to the pedicle, the latter gave way at its point of insertion on the polypus. A perfect recovery ensued, no pain or hæmorrhage occurred, and the ligature separated the sixth day after the operation. The boy immediately began to improve in colour and to put on flesh. His weakly and anæmic appearance, for some time previous to the attack of fever, had been noticed by his parents; no alarm, however, being raised in their minds, as no complaint was made, and no symptom of disease evident beyond the stains of blood occasionally seen on the clothes, which were supposed by the mother to be due to piles.

The case seems worthy of record, as an example of the accidental discovery of a serious and uncomplained of condition. But for the occurrence of the enteric fever, the loss of blood might have gone on for an indefinitely long time.

MEDICAL students have already enough to answer for without being called upon to bear by imputation the blame of any offence which may be committed by young men such as Edward Lee, who was described by the reporter at Bow Street Police-court recently as being "something like a medical student".

* *Archivio di Medicina, Chirurgia, ed Igiene*, 1875, Disp. vii e viii; also as a pamphlet.