wards. The left arm is drawn close to the side; and the fingers of the left hand are flexed on the palm, the thumb being flexed on the fingers, and the index finger slightly projected beyond the others. Her ordinary attitude is that of sitting in a chair with her left hand flexed on the forearm, the right hand more or less supporting it. When the right hand is withdrawn and her attention is distracted, the fingers of the left hand are seen to move irregularly and more or less constantly. The movements are principally these; viz., a slow extension of the fingers, the three inner fingers being moved together, and the index one later; then the thumb is extended; and then the fingers are flexed on the palm, the index projecting, and the thumb being flexed over the fingers and under the index. These movements are repeated pretty constantly through the day, but they appear to be arrested during sleep.

The mental condition of the patient is one of imbecility, with occasional attacks of excitement, about three or four times a year, lasting a few days. She is always very touchy and ill-tempered, and requires some tact in management. She has epileptic fits nearly every week, never passing over two weeks without an attack; and at such times is very excitable. Sometimes, during these paroxysms of excitement, she has had convulsive movements of the left (paralysed) arm, and has had the idea that a miracle had been worked, and that she had suddenly regained the use of her limbs. By practice, she has been able to do some coarse sort of knitting, the right hand doing most of the work, and the left supporting the other needle.

A FEW REMARKS UPON THE USE OF TURPENTINE IN DISEASED STATES OF THE SYSTEM OF AN ACUTE CHARACTER.

By R. PERSSE WHITE, L.K.Q.C.P., F.R.C.S.I.,

Surgeon to the Meath Hospital, Dublin.

So long ago as 1860, I was led to try the use of turpentine in a case of typhoid fever in a young lady, which had run a course of twenty-eight days without extreme severity. The diarrhoea was not severe, and was kept in check by acetate of lead, with small doses of opium.

On the twenty-ninth day of the patient's illness, in fact on the first of her convalescence, the symptoms had all abated, and she seemed to have overcome her illness. On the thirtieth day, on visiting her, I found her in a state of terrible excitement. There was some cause, but not enough, to account for her state. Fearing mischief, I at once sent for a leading physician from Dublin. He advised the use of turpentine, but his advice was based on the view that there was uræmic poisoning; for, during his visit, she had severe convulsive movements of her face. The urine was scanty; it was tested, but did not show any morbid condition. On the thirty-first day, her night was terrible, with violent raving and restlessness; no sleep. On the thirty-second day, she was in a worse state and almost collapsed. The sphincters were failing. The turpentine mixture had been continued since the consultation, but there was no benefit from it. She died that night.

In this case, the turpentine was given for the head-symptoms. The next cases in which I used turpentine were various, and at different stages of the disease. In my earlier practice, and in hospital practice, in 1873, when I acted as physician to the Meath Hospital in the absence of my colleague Dr. Stokes, and of his colleague in the medical wards, I had at least one great case which showed the value of turpentine in typhoid fever. Here the chest was, in the latter stage of the fever, attacked with severe bronchitis, the bowels being much too free at the same time. The attack of bronchitis was intense, of the form common at that time; but after the second day she rallied, and passed on to complete recovery. I saw her in health long afterwards. Bronchitis was for some years an almost constant attendant on typhoid, and often the cause of death.

My mode of giving the turpentine was as follows. If bronchitis were present, and even if diarrhoea complicated the case, I gave what was known as my turpentine mixture. $\mathcal{R}$ Terebinthinæ olei, $\mathfrak{z}$ ii; liquoris potassæ $\mathfrak{z}$ ii; mucilaginis acaciæ $\mathfrak{z}$ iv; syrupi papaveris albi, syrupi floris aurantii, $\mathfrak{aa}$ $\mathfrak{z}$ viii; aquæ camphoræ q. s. ad $\mathfrak{z}$ viii. Fiat mistura. A tablespoonful to be taken every fourth hour, the bottle being first shaken.

Since I commenced that treatment, I never lost any case of typhoid from either bronchitis or diarrhoea, or from its sequelæ of ulceration or hæmorrhage. Each epidemic of typhoid (and at present there is a wide-spread and severe one passing over the country) is marked by its peculiar characters. In the present time, most of the cases of typhoid are characterised by intense pain in the abdomen, with enormous flatu-

lent distension. Constipation exists before the illness is developed, and at times during its progress; and when it is removed by purgatives, diarrhoea sets in. I give a short sketch of some cases recently under my care.

I was called to visit a boy residing several miles from the city. The child sickened slightly about September 30th, but nothing was suspected for some days. On Monday, October 4th, I found him very ill, and I at once suspected typhoid fever. He had on Sunday some vomiting and slight diarrhoea, which was, on the 7th, followed by constipation. I found it necessary to give an enema, with turpentine. This brought away a quantity of scybala of a light colour, and gave some relief. The abdomen was at this time tumid, with some pain on pressure. I gave a small dose of castor-oil and turpentine on the succeeding day. It gave much relief, with a similar character of discharge. Between the 9th and 10th, his bowels became a little too free, but the distension of the abdomen had become so great that it pressed up on the heart and lungs, so as to give much distress. I at once ordered about ten minims of turpentine every third or fourth hour in mixture. On the 11th, there was some improvement; the pain was much less. On the 12th, he allowed me to press my hand on his abdomen, which hitherto he could not bear, and expressed himself much better. I need not detail the case. I continued the turpentine for nearly a fortnight, toward the end lessening the dose to twice each day. No diarrhoea returned, but the bowels were slightly free twice most days. After this, slight pain and diarrhoea came on, and a few doses of the turpentine were given with perfect success. This child is now quite well, running about; he convalesced in the sixth week.

The next case is that of a lady, aged 73, without any previous history of illness. On Sunday last, November 18th, she vomited, and diarrhoea quickly set in, severe in its character; blood was mixed with the stools, but in small quantity. When I first saw her next day (Monday), I put her on aromatic sulphuric acid, with small doses of Batley's liquor sedatives. This gave much relief for two days, and at my visit on Wednesday all was well; she had had only two slight motions, with no blood. In the afternoon, profuse diarrhoea occurred four times before 9 P.M.; nine times to 7 A.M. on Thursday; and five times more up to my visit, blood coming in all the later motions. I at once ordered the turpentine mixture, two tablespoonfuls every fourth hour. On Friday morning, she was going on well. The diarrhoea had ceased. There had been only two small motions since the turpentine was commenced. I saw her at night. She still continued in comfort; no more motions since morning. On Monday, November 26th, she continued in comfort; no pain and no diarrhoea; only two small motions in the twenty-four hours. On December 5th, after four days of complete constipation, she had the following draught at bedtime: $\mathcal{R}$ Olei ricini $\mathfrak{z}$ vj; tincturæ sennæ comp. $\mathfrak{z}$ i; syrupi zingiberis $\mathfrak{z}$ ij; mucilaginis acaciæ $\mathfrak{z}$ ij; spiritus terebinthinæ $\mathfrak{m}$ xxv; aquæ cinnamomi $\mathfrak{z}$ ij. This case is not concluded, but all goes on most favourably.

I have several other cases of typhoid on hand at present; but none of them of any peculiar type, except one, who developed jaundice. About the twelfth day it quickly yielded, and the child (five years old) now progresses favourably.

FOREIGN BODIES IN THE EAR.

By W. B. DALBY, F.R.C.S.,

Aural Surgeon to St. George's Hospital.

I AM sorry to say that I read with little surprise in the BRITISH MEDICAL JOURNAL of December 8th, that a child had died whilst attempts were being made to extract a bead from its ear; and with, if possible, less surprise that a *post mortem* examination showed there was no bead or other foreign body in the ear.

Instances of the destruction of the tympanic membranes and injuries to the tympana occurring in a manner similar to what was described are too familiar in my experience; and, if surprise be an element in any emotions I may have on the subject, it is that death is not more frequently the termination of these operations, if such a term be applicable to them.

It cannot be too often repeated (evidently it has not yet been often enough repeated) that, with the exception of a vegetable substance which swells rapidly as it absorbs water, or a living insect, no foreign body in the ear *left alone* can possibly be injurious, and that any subsequent injury is the result of manipulation by inexperienced hands.

In the course of two separate days, I have had brought to my notice four tympanic membranes ruptured in this way; the monotony of one day being relieved by seeing a small stone in the meatus, and behind it

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

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

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".