was no doubt produced by the clot acting as a foreign body. There was not a trace of tubercular or other deposit to be found in either lung. There was general anasarca.

On February 15th, 1872, I attended a young woman aged 23, who had suffered, when about fifteen years of age, from a severe attack of rheumatic fever with endocarditis. This had left behind chronic mitral regurgitant disease, in consequence of which she had also suffered ever since from chronic bronchitis, which was always worse in winter. She now had a serious attack of hæmoptysis, brought on by nursing a baby. The cough was severe. The quantity of blood brought up was great. The pulse was exceedingly weak, about 95 per minute. There was a loud systolic mitral murmur to be heard, and the lower part of the left lung was dull. The cough, difficulty of breathing, and expectoration of blood continued, and on the nineteenth day the patient died.

On examining the heart, both tongues of the mitral valve were thickened and irregular. The left heart was dilated and hypertrophied. Both lungs were dark and slightly oedematous; the left lower lobe was solid, in some parts almost black; the tubes were filled with blood, and pieces of the lung sank in water. The other organs were healthy.

The first patient suffered from bronchitis; but this was aggravated by the much dilated, flabby, and degenerated heart, which could not with sufficient force pump the blood onward from the left ventricle, and thereby produced engorgement of both lungs, the blood-vessels of which had no doubt undergone fatty changes, and were ready at any time, if the patient underwent severe exertion, to give way. Again, in the lower part of the right lung, a clot acted as a foreign body, and set up inflammation all around. The commencement of inflammatory action was no doubt coincident with the sudden increase of the heat and rising of the pulse. Here we see the necessity there is for us, after lung-hæmorrhage, carefully to watch the pulse and temperature daily, which will surely indicate the setting up of inflammatory action, the products of which, combined with the clot, are apt, by mutual pressure, ultimately to end in destructive caseation and formation of a cavity.

In the second case, the hæmorrhage was no doubt predisposed to, not by a weakened state of the heart, but by the leakage through the mitral opening. The sudden hæmorrhage was immediately produced by severe exertion; but the tendency thereto was present before. The pulmonary, unlike other veins, being destitute of valves, readily permit of regurgitation into the lung in cases of mitral-valve disease; hence the engorgement is chronic; and the walls of the blood-vessels, owing to the pressure upon them produced by the within contained blood, become weak and more apt to give way when there is the slightest exertion undergone by the patient.

THERAPEUTIC NOTES, WITH ESPECIAL REFERENCE TO THE TREATMENT OF PHTHISIS BY CHLORIDE OF CALCIUM.*

By JAMES SAWYER, M.D.Lond., M.R.C.P.,

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A GREAT deal of the art of therapeutics as it is practised amongst us is unwritten. We are sometimes shy about telling what we do for our patients, because we have not courage to brave the risk of being thought common-place. Useful as are our meetings, I believe their profit would be much increased if members would more frequently bring forward and compare their therapeutic experiences. Those of us who are in earnest and who believe that therapeutic art—an art which includes, but is much more than, the administration of combinations of the materia medica—can powerfully modify morbid processes and can powerfully aid the *vis medicatrix natura*, and who think of what we do, have done, have not done, and shall do for our patients, must be constantly arriving at conclusions, as the result of observation in our own practices, which modify, confirm, correct, extend or suggest extensions of what I may call our therapeutic conduct. These conclusions may not be able to bear the test of an exhaustive logical scrutiny; perhaps they are no less true, perhaps they are not more true, than John Wesley's belief that sulphur did his rheumatism good (Wesley was probably right in his opinion, notwithstanding the ridicule of Mill, and that grand logician's brilliant exposition of the strict logical limitations of a therapeutic inference); but if these conclusions, which we must be constantly forming for ourselves, are accepted by each of us as reasonable

and responsible men as guides to our therapeutic action, they are as worthy of communication to our brethren, and I believe they are as interesting to them as the inspection of a rare case with striking objective manifestations, the demonstration of a pathological specimen, the description of a new operation, the exhibition of an ingenious instrument, or an elaboration of surgical statistics.

Have we a remedy for phthisis? We now know that the term chronic pulmonary phthisis includes a variety of pathological conditions and a variety of textural lesions in the lungs which have long been recognised as distinct, which recent research has done much to unravel, and about which we may still expect to learn more. We know the differing clinical and pathological courses of tubercular phthisis, unresolved lobar pneumonia, chronic catarrhal lobular pneumonia, and pulmonary cirrhosis. All these are included in the generic name phthisis. When I say have we a remedy for phthisis? I mean, have we a remedy for this allied group of conditions, due to varying pathological changes, but marked in common by progressive wasting of the body, by progressing asthenia, by progressing diminution of respiratory capacity, and by fever of a hectic type. Every case of phthisis requires special study, and can be treated by no rule-of-thumb practice because it is phthisis. In one case anæmia is prominent and calls for iron, perhaps for arsenic; in another, continued but small hæmoptysis calls for ergot or hamamelis; in another, a racking and frequent cough calls for opium, morphia, or codeia; in another, dyspepsia calls for alkalies or acids, or bitters, or pepsine; in another, nervous unrest calls for bromides; in another, laryngeal troubles call for special local medication; in another, we have to aim at controlling excessive sweating or checking an exhausting diarrhoea. Apart from these and other particulars, I suppose we are all agreed that cod-liver oil, given alone, or variously combined with other agents which tend to promote its assimilation, as with ether, as suggested by Dr. Foster, stands at the head of remedies calculated to promote the general nutrition of the phthisical. Have we any other general remedy? For a long time I trusted to syrup of the iodide of iron. This I gave up for a mixture of hypophosphites and iron—five grains of hypophosphite of lime, ten grains of hypophosphite of soda, and fifteen minims of syrup of the phosphate of iron, for a dose. This is a good combination, and I still use it. But chloride of calcium is my favourite drug. I have used it for some years in hospital and private practice, and I believe with great advantage. Perhaps you will say, Do you give it alone? I do not. I give it with cod-liver oil, or with cod-liver oil emulsion, or with morphia, or with ergot; but my general impression is, *quantum valet*, that I get better results with chloride of calcium with these combinations than I do with anything else in the same combinations. My attention was called to the value of chloride of calcium in phthisis by a paper in one of our medical journals, wherein it was stated that the drug was much used by the late Dr. Warburton Begbie. Scarcely mentioned, if noticed at all, in books on drugs, chloride of calcium has an old repute for the cure of strumous glandular swellings. In phthisis, I give ten grains dissolved in a drachm of water and mixed with a drachm of glycerine, in a wine-glassful of milk twice daily, immediately after meals. I think it tends to check night-sweats, to cause increase of weight, and to dry up pulmonary lesions. Of course I do not maintain it does these things in all cases. What I have stated are general conclusions, open, I am aware, to objection on the ground of their insufficient logical basis, but conclusions which have been and are for me grounds of therapeutic conduct. In prescribing chloride of calcium, we must be careful to write the name of the drug distinctly and in full, in order to avoid an error from which one of my patients suffered, namely, the substitution of "chloride of lime".

ON CHAIR-SUPPORTS IN SPINAL CURVATURES.*

By CHARLES STEELE, F.R.C.S.,

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WHEN Dr. Sayre brought before the profession in England his method of treating spinal curvatures, I was strongly impressed with the value of the principles which he enunciated. My appreciation of the sound and practical character of the system has been deepened by a careful study of his valuable works, and also by the success which, in several cases in my practice, has attended the adoption of his plan of first setting (if I may use the term) the diseased or displaced bones, and then keeping them in place with closely fitting and firm splints, which secures to the invalid the power of maintaining the erect position, and the remedial benefits of exercise and fresh air.

The plaster-of-Paris bandages, which alone were available for this

* Abstract of a paper read before the Birmingham and Midland Counties Branch.

* Read in the Section of Surgery at the Annual Meeting of the British Medical Association in Cork, August 1879.