forty miles from the Riviera, the weather must be very severe in winter; and even at such a place as Grasse, one thousand feet above the sea, and at rather less than an hour from Cannes by rail, the winds must be very cold and trying in the winter months. Such is not the case, however, on the hills and high ground in the immediate neighbourhood of the Mediterranean coast. I do not recollect, this last winter, except once, seeing any snow upon the slopes, which rise to a height of about seven hundred and seventy feet, near Cannes. That exceptional occasion was on the night of February 17th, when people at Cannes could witness the remarkable phenomenon of a snowstorm accompanied by lightning and thunder. I have gone all over the hills to which I am referring, and observed a number of spots sheltered in a great measure from the easterly and north-westerly winds, and well adapted for a winter residence.

While wintering at Nice, I placed on January 5th, 1873, a minimum thermometer (by Casella) in a small cairn on the northern side of a pile of stones erected on the summit of Mont Pacanaglia, a hill rising to a height of 1,890 feet above the bay of Villefranche. The cairn was not fully open, but air reached the instrument freely through a few loose stones which were placed at its entrance in order to conceal the thermometer. I examined the instrument on the 25th of March following, when it registered 0.7 deg. C. (30.8 F.). During that same lapse of time, the lowest reading of the minimum thermometer at Nice was 0.5 deg. C. (32.8 deg. F.) on the 13th and 14th February. It therefore appears that at 1,890 feet high, on a spot nearly towering over the Mediterranean, the temperature had been but very little colder than at the seaside. One observation, however, is not enough to settle the question. I should consider the radiation of heat to be decidedly greater at that height than at the sea-level, as I remember seeing ice one afternoon about a quarter or a third of an inch in thickness in a small pool sheltered from the sun on the slopes of that mountain, while what little ice had formed at Nice during the night had disappeared long before noon. It may be added, that on two or three occasions in winter I have observed snow to fall on the summit of Mont Pacanaglia, but do not recollect seeing it at a lower level than two or three hundred feet from the highest point, and after a very few hours it melted away entirely. I have also made a few comparative observations as to the temperature at the top of the Cimîès hill and in the town of Nice below. The minimum at Cimîès (300 feet above the sea) was placed against the trunk of a tree, and was consequently exposed to radiation in a greater degree than the minimum at Nice. The latter was hung up outside the wall of a house, against the shutter of one of the windows, on the north side of a high second floor.

	Cimîès (300 feet high).	Nice (sea-level).
February 19th.....	34.9 deg. Fahr.	40.1 deg. Fahr.
„ 20th.....	35.6 „	37.4 „
„ 22nd.....	38.3 „	40.1 „
„ 23rd.....	37.4 „	40.1 „
„ 27th.....	37.4 „	42.8 „
March 3rd.....	38.3 „	40.1 „
4th.....	34.9 „	39.2 „

If we allow a correction of about 3 deg. Fahr. for the difference in the exposure, the readings of the two instruments will not differ much.

I do not wish it to be understood that the climate of the hills is not at all colder than that of the seaside; but it should only be considered as a trifle colder, which is certainly not sufficient to detract from the usefulness of the light, fresh, and invigorating air of these charming resorts. Their great drawback is the want of accommodation. At Cimîès, there are two hotels, or one hotel and one pension or boarding house. These, however, can only afford room for a very limited number of invalids. At Cannes, there are most admirable sites, between one hundred and five or six hundred feet high, for large hotels or a number of villas, where shelter from the winds, a southern aspect with exquisite views, and a pure bracing air, could be enjoyed. The hills are skirted with beautiful woods, through which delightful walks might be made. Moreover, a canal, with a full supply of pure water destined to the use of the town, makes its way along the slope near the top of the hill, and would, I believe, afford means of erecting a bathing establishment, where the water might be turned to great advantage. It is true that there is still a want of carriage-roads, by means of which the various parts of the hills could be reached; but one excellent road has already been made, and others will undoubtedly be opened later.

I have attempted, in my three communications, to establish rules, founded on physiological data, calculated to act as a guide when medical advice has to be given with reference to the advisability of wintering on the Mediterranean coast. These may be summarised in a few words as follows.

1. The state of the vital power left in the patient is to be carefully ascertained.

a. If the vital power, although at a low standard, do not appear to be declining, and if the case be decidedly chronic, benefit may be expected from a winter's residence near the Mediterranean coast, on the sea-level, in a warm sheltered spot.

b. If the vital power be declining rapidly, although perhaps the affection may not be of long standing, it is questionable whether the South will arrest this downward progress. The air of the hills near the Mediterranean may check the evil for a time—say, perhaps, for half or two-thirds of the winter season; but the disease is not unlikely after that period to resume its ascendancy.

c. If the vital power should keep up well, although the disease be attended with a quick pulse and high temperature, together with progressing pulmonary mischief, a decided benefit is to be expected to result from one or more winter seasons spent on the Mediterranean coast, the hilly country, or high ground, near the sea being selected for the first period of the residence in the South.

2. The condition of the lungs of the patient, as determined by the physical signs of the chest, should be taken into consideration.

a. Patients with consolidation at one apex, although unattended with apparent ill-health, do well to winter in the South as a means of precaution; but such persons should be very careful to regulate strictly their mode of living abroad.

b. Patients with a hæmorrhagic tendency, and exhibiting little more than harsh respiratory murmur and debility, usually progress favourably on the hills near the Mediterranean coast. They should be careful not to take up their residence near the sea or at the sea-level, and to leave the South early in the spring, before the warm weather sets in.

c. Patients, with softening and cavities, sometimes derive much benefit from wintering in the South. The state of their vital powers should be considered as a guide towards a decision being taken with respect to autumnal movements.

3. Patients should make up their minds beforehand, in accordance with medical advice, as to whether their case is likely to do best on the hills and high ground, or near the Mediterranean sea-side; as, when they have selected their residence and settled down for the winter, they find it often very difficult and inconvenient to make a fresh move.

THORACIC ANEURISM: LARYNGEAL SYMPTOMS: GREAT RELIEF FROM THE HYPODERMIC INJECTION OF MORPHIA.

By W. E. PARKES, M.D., etc., Birmingham.

MRS. A. B., aged 50, married, with no family, had good health until the last five years, when she became subject to severe attacks of neuralgia, affecting the back, arms, and legs. In the summer of 1872, she commenced to suffer from a cough, which gradually became worse; and, on April 14th, 1873, she had a violent attack of dyspnoea, which lasted about fifteen minutes. The face became purple, and the breathing stridulous. These attacks occurred since at irregular intervals; sometimes there were two in one day, and at other times there were ten or fourteen days between each. After each attack, the cough was very troublesome, and from one-half to three-fourths of a pint of frothy mucus was expectorated.

In May 1873, on inspection, the chest was seen to be broad and well formed. There were slight flattening of the infraclavicular region of the left side, and a slight fullness of the superior sternal region. On close inspection, pulsation about the left clavicular region was observed. There were no enlarged veins. The pupil of the left eye was usually dilated, but this dilatation was variable. A very distinct pulsation was felt on pressing the finger over the sternal notch towards the aorta, and also when the fingers were placed on the left clavicle, near its sternal end. Firm pressure about this part caused pain. She also complained of pain down the left arm, and at times she had a feeling as if a cord were tied around her waist. She had dyspnoea on exertion. There were no boring pains about the chest or back. She had no actual difficulty in swallowing; but she was always conscious of the passage of food down the œsophagus. She could lie on either side; but the breathing was most comfortable when lying on the back. There was no alteration of voice. The radial pulses were equal to the touch and the sphygmograph. On percussion, there was dulness over the manubrium sterni and the left clavicular region as low down as the lower border of the second rib; the other parts of the chest were normal. On auscultation, when the cough was absent, the sounds of the heart and lung were

heard to be normal; but, when the cough and dyspnoea were present, bronchial *râles* were heard at all parts of the chest, and the expiratory sound was prolonged. No murmur was heard over the aneurism. She was ordered twelve grains of iodide of potassium and six grains of bromide of potassium three times a day.

On August 4th, 1873, the aneurism had steadily increased in size, the pulsations being much more marked. The attacks of dyspnoea and coughing occurred more frequently, large quantities of frothy mucus being daily expectorated. The treatment consisted of rest by remaining in one room, and the hypodermic injection of one-sixth of a grain of acetate of morphia each night. About ten minutes after the injection of the morphia, the cough and mucous *râles* entirely disappeared, the patient being able to move about and converse freely without the occurrence of the slightest dyspnoea. The action of the morphia lasted from eighteen to twenty hours, when the cough and dyspnoea gradually returned, to be again controlled by the morphia. Under this treatment, the patient steadily improved; the aneurism became smaller, the attacks of dyspnoea less frequent, and the neuralgia of the back, arms, and other parts, considerably relieved.

On January 17th, 1874, the improvement still continued. The pulsation in the clavicular region had disappeared; at the sternal notch, it was still felt, but much diminished in force. The quantity of morphia given each night was now a quarter of a grain.

On April 17th, the controlling action of the morphia lasted only thirteen hours. In order to keep down the cough, it had to be given night and morning.

July 6th. The condition of the patient was much about the same.

September 28th. The patient died suddenly this morning.

Post mortem examination, thirty hours after death. On opening the chest, the pericardium was seen to be greatly distended with fluid, and, when opened, was found to contain twelve ounces of bloody serum and clots. On removing these, the heart was found to be rather smaller in size, and more friable than usual; its cavities were empty, and its valves normal. The aneurism involved the whole length of the lower part of the transverse portion of the arch of the aorta. Its length was four inches and a half, and its circumference seven inches and a half. The innominate, left common carotid, and left subclavian arteries were normal in size and position. The sac of the aneurism was lined with a layer of laminated fibrine three-fourths of an inch thick at its lowest part, which gradually became thinner as it extended upwards, until it entirely disappeared at that part where the three great vessels are given off. Large patches of atheromatous degeneration were found in the aorta. The lungs were emphysematous at their edges, in other respects healthy; the bronchial tubes were slightly reddened in patches. The trachea was healthy, with the exception of a reddened patch corresponding to the part pressed upon by the aneurism. There was no erosion of the ribs or of the vertebrae.

CLINICAL MEMORANDA.

CROUP AND DIPHTHERIA.

I HAVE perused with interest and attention the correspondence which has for some time been carried on in the pages of our JOURNAL, on the *identical* and *differential* characters of those two most important diseases, croup and diphtheria. I cannot find any practical difference between the principles of differential diagnosis, in which as a student I was instructed a quarter of a century since, and those now enumerated and maintained by some of the highest authorities who have communicated their views on this subject. There are some few who appear to class croup and diphtheria as almost convertible terms. I have had a large practical experience of croup in its different characters and stages, and also of diphtheria; and I firmly believe that if anything is certain in medical science, it is that there is a practical and pathological difference between these two diseases. I also believe that a confusion of these terms would inevitably lead to a lamentable and fatal confusion in therapeutical treatment. I am rather surprised to notice the omission of the names of Stokes and Porter of Dublin from the list of authorities to whom reference has been made, and yet, in Dr. Stokes's work on *Diseases of the Chest*, published many years ago, will be found a graphic comparative differential diagnosis between "primary and secondary croup"—the latter being synonymous with diphtheria. In making these remarks, I refer to inflammatory or acute croup, or the "cynanche trachealis" of children", say under twelve, from which false, spurious, or spasmodic croup is easily distinguished, both by the general symptoms, and by the causes which provoke the attack.

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CASE OF PLEURISY WITH EFFUSION TREATED BY PARACENTESIS: VERY RAPID RECOVERY.

FROM my recollection of the tedious course of bad cases of pleurisy with effusion in England, whether treated by paracentesis or not, I think the following notes may not be uninteresting to some of my brethren at home. On March 13th, 1875, a Kaffir applied to me for advice: he was evidently suffering from a severe attack of pleurisy with effusion; there was dulness on the right side of the chest, both back and front, as high as the third rib; the breathing, which was tubular at the apex, was almost inaudible at the base. The heart's action was very irregular. The left lung was healthy. The patient had of course no idea of his age, and could give but little account of his illness; the attack seemed to have come on rapidly but insidiously, and with little febrile disturbance. As he could get no lodging, I was obliged to treat him for a week in a small ill-sheltered waggon. During this time the fluid increased considerably. On the 22nd, there was absolute dulness over the whole of the right side, except at the extreme apex; the intercostal spaces were bulged, the liver was depressed. The man's pulse was very irregular, weak, and fluttering, and there was distinct lividity of face; in fact, he appeared to be sinking. I determined, therefore, to perform paracentesis at once as a last chance, and, having obtained an amateur assistant (there being no other medical man within thirty miles), I drew off with one of Meyer and Meltzer's small aspirators five pints of turbid fluid. After the operation, I had the satisfaction of hearing the air freely entering the previously compressed lung, and of finding that that side of the chest was quite resonant except at the extreme base. Next day, the patient was breathing quietly, and seemed quite comfortable; friction could be heard over the base below the seat of puncture. By the 27th this had disappeared, and, on the 31st, that is, nine days after the tapping, he left the village quite convalescent. The whole of the lung was then clear on percussion, and the respiration normal.

I may add, now I am writing, that there are plenty of good openings in this colony for men who can withstand the temptation of drink. Here, in the Colesberg district, 4,800 feet above the sea, we have a dry bracing climate admirably suited for most phthisical subjects, and plenty of game, springboks, etc., to be had for the shooting.

E. KNOX DAVIS, M.R.C.S., etc., Hanover, Cape of Good Hope.

OBSTETRIC MEMORANDA.

CASE OF EXTRAUTERINE FETATION.*

ABOUT 5 A.M. on September 9th last, I was sent for to see M. A. F., aged 22, who was said to be dying. I knew the girl, and had indeed seen her at my surgery on the previous afternoon, when she came for her father's medicine. She then appeared to be in robust health. When I arrived at the house, I found her dead. She lived with her father, who is a widower, and attended to his household. He gave me the following account of the circumstances immediately preceding her death. She had gone to a dancing-party on the previous night, and, after dancing a short time, complained to her partner that she was in pain. He procured her a small quantity of brandy, which relieved her, and she resumed the dance. She was, however, obliged to desist, and sought her home at about 11, or near midnight. She then suffered from severe pain in the abdomen. Her father, who alone was present during the night, told me that the symptoms were violent retching and vomiting at intervals, with severe abdominal pain. About 4 A.M., she expressed a desire to have her bowels relieved, and rose for that purpose. After sitting a short time, she fainted, and being removed to bed, died shortly afterwards. I was told by a neighbour, that she had not been regular for three months, and had been taking medicines with the object of re-establishing the catamenial functions. The case was so peculiar and suspicious, that I thought it advisable that an inquest should be held. This was done; and I made a *post mortem* examination on the evening of the same day, assisted by Dr. Huntley of Jarrow.

As the possibility of poisoning was not overlooked, care was taken to have suitable vessels to contain the necessary viscera. There were no external features deserving of remark. To all outward appearance, the body was that of a well-nourished healthy girl. The os uteri indicated that the uterus was unimpregnated. The abdomen was considerably distended, and, at the lower part, emitted a dull sound on percussion. We examined the contents of the cavities of the head and chest, and found all the organs in a perfectly sound and healthy state.

* Read before the Northern Branch.