paracentesis must necessarily affect the physical conditions of the lung. It seems as if the danger lay in the too free use of aspiration—in the attempt, futile though it must be, to exhaust more or less the pleural cavity of its fluid contents. The pressure, in such circumstances, upon the lung is very likely to lead, in a certain number of cases, to perforation into the lung, and passage of some of the remaining pleural fluid. Albuminous expectoration ought to occur much more frequently if it were due to the ordinary cause of pulmonary oedema. Why is it so rarely seen in cases of pulmonary oedema apart from thoracentesis?

Some of the difficulties surrounding this question will be cleared up as the operation of thoracentesis becomes more common. Meanwhile, I instance my case as one where albuminous expectoration occurred immediately after the operation of paracentesis, and under such circumstances as make it clear that it was not due to oedema of the lung. I have no doubt that many of the recorded cases can be explained in the same way.

[June 12th, 1876. Since the above was written, my patient has enjoyed excellent health, and has suffered from no chest-symptoms whatever.]

FREE INCISION, *VERSUS* THE ASPIRATOR IN EMPYEMA.

BY ANTHONY BELL, L.R.C.P.,

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HAVING always held a strong opinion regarding the vast importance of a free incision in empyema, and having treated several cases successfully by this line of treatment, perhaps a brief history of my last three cases may not prove uninteresting. I have never lost sight of my patients, and, upon inspection last October, found them in perfect good health.

CASE I. M. A., aged 19. On February 15th, 1869, I met his medical adviser in consultation. The patient had suffered from an attack of pleurisy of the left side. He was propped up in bed and gasping for breath. His pulse was 144; he was much emaciated, and troubled with a short dry cough. The left side was dull on percussion; the heart pushed to the right side. An exploring needle revealed pus. A free incision was made into the pleural cavity. No drainage-tube was required. The cavity was not syringed. The wound was poulticed; and it closed in about two months. The weight of the lad when he first went out was 7 stones. In October, 1874, his weight was 11 stones 11 pounds.

CASE II. Mr. W., aged 34, stated that he had been under treatment for a period of six months, and that his illness commenced with a severe pain in the left side, accompanied by cough and difficulty in breathing. He was emaciated and extremely weak. His weight was 8 stone. The whole of the left side of the chest was dull on percussion, and the heart was pushed to the right of the sternum. An exploring needle revealed pus. A free incision was made into the pleural cavity, and over 40 ounces of pus were evacuated. The cavity was daily syringed with warm carbolic lotion; no drainage-tube was required. The wound was poulticed, and the opening closed three months afterwards. In October 1874, his weight was 10 stones.

CASE III. On May 18th, 1874, I visited Mr. O., aged 36, and found him suffering from a smart attack of pleurisy of the right side. He was being treated by his medical adviser by hot applications, which were continued by myself. With my utmost efforts I failed to arrest effusion and produce absorption. On July 15th, he complained of shortness of breath and troublesome cough, with profuse expectoration. He was much emaciated, and suffered from night-sweats; pulse 104; temperature 98.3 degs. On inspection, I found the right side almost stationary. The intercostal spaces were flattened and somewhat widened; but there was no perceptible enlargement of the right half of the chest. Upon percussion, there was dullness in front from the liver to a little above the nipple, and behind from the liver to within an inch from the spine of the scapula. There was absence of respiratory murmur, vocal resonance, and vibration. The infraclavicular space of the same side was resonant, and there the respiratory murmur was harsh. The left side was normal. The aspirator-needle was inserted between the seventh and eighth ribs, and over 30 ounces of thick laudable pus were withdrawn. Great relief was afforded by this operation. A dose of chlorodyne was then given.

On July 16th, the pulse was 100; temperature 102.2 degs. He stated he could breathe with his right lung.

On July 17th, chloroform was administered, and a free incision made at the site of the puncture into the pleural cavity. More than 20 ounces of pus without odour were evacuated. A pad of tenax was applied. The chlorodyne was repeated.

On July 18th, the pulse was 100; temperature 98 degs. There had been no cough nor difficulty of breathing since the first operation. The cavity was syringed night and morning with warm carbolic lotion.

On July 20th, the opening seemed to be closing too quickly, consequently, a drainage-tube was inserted. Tenax was substituted for the poultices, as it was found lighter and cleaner.

On July 21st, there was a free discharge from the tube.

On August 7th, the patient was up. His weight was 8 stones 5 pounds.

On August 28th, only a little serum exuded from the tube in the morning.

On September 18th, he went down to the home.

On September 28th, the tube was removed. The wound then closed, and healed in three days. In October 1874 his weight was 10 stones 11 pounds. His weight in March 1875 was 12½ stones.

[Mr. Bell forwarded with his paper photographs of all three patients, taken in October 1874. The men were evidently at that time in good condition. In each case, the skin was puckered in at the site of the healed opening into the pleura; which, in every instance, was just below the anterior margin of the axilla, between the seventh and eighth ribs; and so situated, that the nipple of the same side lay about midway between the cicatrix and the middle line of the sternum. In Cases I and II, the puncture was made into the left pleura; in the third case, the opening was on the right side of the chest. The side which had been diseased seems at that date to have been no smaller than the opposite healthy side; and, altogether, upon paper, the results appear highly satisfactory.]

CLINICAL MEMORANDA.

EAR-DISEASE AND LIFE-ASSURANCE.

ERE the interest on the above subject, which was called forth by a communication in the JOURNAL on June 17th, by Dr. Thomas, passes away, and as he, as well as many others, may be under the impression that this subject has hitherto escaped notice, I ask the favour of space in order to say that this impression, if made, is erroneous. So long ago as 1860, Toynbee, in his work (p. 344), drew attention to it, but in the briefest possible manner; while, in January last, I read a paper On Unrecognised Ear-Disease in relation to Life-Assurance, at a meeting of the Medico-Chirurgical Society in this city, an abstract of which paper and the discussion that it elicited may be seen in the report of the meeting in the *Glasgow Medical Journal* for April. I cannot lay claim to priority in bringing this matter before the profession, but I do claim to be the first aural surgeon who has gone fully into the subject, more fully than any foreign writer, so far as I know; certainly more fully than either Toynbee or Dr. Thomas, who are the only English writers on the subject; whilst, in point of time, I have forestalled the last-named gentleman. Besides suggesting to the assurance-offices the pressing need of a direct question in their proposal-forms as to the past and present history of the organs of hearing, I have laid down principles to guide their referees in regard to cases of ear-disease; in fact, in that paper I endeavoured to exhaust the subject of "ear-disease in relation to life-assurance", and I believe I have done so. The paper, I may add, is based upon a wide and what, I think, is an unique experience of life-assurance ear-cases.

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THERAPEUTIC MEMORANDA.

C U C A.

I HAVE recently made several trials of this drug; and, although circumstances have prevented my undertaking such a crucial test as that detailed by Sir R. Christison, I am convinced that it greatly relieves muscular fatigue, though only for a limited time (between two and three hours). The first specimen I procured, although from one of the foremost metropolitan chemists, was absolutely inert; and I am afraid that most of the cuca at present sold in the shops is in like condition. Messrs. J. Bell and Co. of Oxford Street have lately furnished me with a much better sample; and, by comparing this with others, I conclude that good leaves have three distinguishing characteristics: a tea-like odour, a warm pleasantly pungent taste, and a dark green colour. In bad specimens, the odour is camphoraceous, the colour brownish grey, and the pungent taste wanting.

The bulk of the dried leaves is a great hindrance to a more general use of cuca, the ordinary dose of a drachm and a half being equivalent