diately the sound of the pulmonary texture, and even its consistence.

If we are aware of the above-mentioned circumstances, by and by, with patience, careful exercise, and intelligent combination of all that we see and hear, and of all that we feel with our percussing fingers, we cannot fail to arrive at a high degree of certainty in this sort of diagnosis. A new practitioner must proceed in a very simple way. He must not attempt to discover scattered lobular pneumonia, or single tubercles; this is, in general, a matter of approximative induction or conclusion. The pathological knowledge of the respiratory organs is carried to-day to a certain minuteness, which makes the subject rather difficult to the understanding. My anatomical line and gradation is the following:—

Simple bronchitis.—Inflammation of the bronchial tubes of large and middle size.

Capillary bronchitis.—An extension of the former into the fine bronchial ramifications. The highest degree is—

Broncho-pneumonia—by some authors termed catarrhal pneumonia, by others vesicular bronchitis, which, taken anatomically, is all the same; and it is even difficult to draw a line of separation between capillary bronchitis and broncho-pneumonia, only we may apply this latter name, or its mentioned synonymes, to the highest degree of capillary bronchitis. As merely an appendix, or a somewhat higher degree, or neglected state of broncho-pneumonia, may be considered the—

Lobular pneumonia.—This consists in the hyperæmic, indurated, or suppurated state of either single scattered lobuli, in which case we say *scattered lobular pneumonia*, or there are a great many of them present in one part of the lung, and then we say *generalized lobular pneumonia*, and hence, then, the gradual transition to lobar pneumonia. The expression “*mammellous lobular pneumonia*,” signifies a circumscribed indurated state of single lobuli; and with the term “*partial lobular pneumonia*,” French authors understand a lobular inflammation whose centre presents much hardness, but gradually less towards the periphery. These are pathological subtleties important in science, but less available in practice. Then we have—

Lobar pneumonia.—This is the phlegmon of the lungs; it takes a whole part of one or both lungs, with all its constituent elements, and begins in general in the finest parenchyma of the lungs, without, or at least frequently without, bronchitis. In all these forms of broncho-pneumonia and pneumonia, there can be a complication of tubercles, either scattered, or extensive infiltration. We can only conjecture at their presence. Tuberculous caverns are seldom found in little children.

Pleurodynia.—Pain in the pleura, without fever or inflammation.

Pleuritis.—I term the first stage of acute pleuritis *pleuritic transudation*; there cannot be any mistake in this term.

Carnification has just the same value as in adults, but is less frequent in children.

Now, I am sure, that for practical purposes we

can limit our diagnosis upon the following points:—*Simple bronchitis*—numerous large râles, clear sound of percussion, much cough, free inspiration, free movement of the chest. Or, *broncho-pneumonia*—very much diffused large and fine râles, the vesicular murmur not always, nor everywhere, audible, the inspiration imperfect, the movement of the chest lessened, the sound of percussion less clear, in some cases even partially a degree of dulness. In this latter case, and by the more pertinacious course of the malady, we may suspect lobular pneumonia complicated with it; and if these fine râles and some dulness are perceived between the scapule, and the habit of the child scrofulous, we suspect tuberculosis. Or, there is a high degree of dyspnoea, the movement of the chest much impeded, no vesicular murmur in a large part of the chest, but around it some fine râles, or crepitation and respiration present, we are induced to suppose *lobar pneumonia*. Lastly, with regard to pleuritic affections. Impeded inspiration, with evident expression of pain in the countenance, without fever, denotes *pleurodynia* on that side where the chest moves less freely, and where we perceive, by auscultation, less distinctly the respiratory murmur. If, under these very phenomena, fever be present, we regard the affection as the *first stage of pleuritis*. If over the lower part of the lung, much dulness is present, no respiratory murmur, no râles nor crepitation, no bronchial respiration, this denotes a large *pleuritic transudation*. If the transudation is less, or begins to be absorbed, then râles appear, and bronchial respiration.

Gentlemen, these are the most important significations of physical symptoms of the respiratory organs important for practice, and attainable by the well-informed practitioner even in a tender child.

On the next occasion we shall speak on the symptoms of the heart, and proceed to those of the abdomen.

CASE OF POPLITEAL ANEURISM,

CURED BY PRESSURE ON THE FEMORAL ARTERY.

By W. WARD, M.D., HUNTINGDON.

Read at the Cambridge and Huntingdon Branch Meeting of the Association, held at Ely, June 17th, 1851.

THOMAS BAKER, of Spaldwick, aged 36, admitted into the Huntingdonshire Infirmary, March 13th, 1847. Has been for the last ten years of his life an ostler at an inn, and previously to that time a post-boy, and in the habit of drinking much beer, but has always had good health; is a stout muscular man, of sanguine temperament. In August last he first felt pain in the popliteal space and about the knee, which made him lame, but did not observe any swelling or pulsation. The pain and lameness then disappeared, but came on again three months ago. His wife then observed a pulsation under the knee, which had escaped his own observation; since that time it has gradually increased.

For the last month or five weeks the pain has much increased, especially at night, not being much complained of in the day time; but there has been much difficulty in moving the limb from a state of rest. When admitted the limb presented the following appearance:—In the popliteal space of left leg there is a somewhat diffused swelling, which has a distinct pulsation through its whole extent, especially on the outside. Upon compressing the femoral artery the pulsation ceases, and the tumour diminishes in size; the stethoscope gives a distinct bruit de soufflet; the tumour appears about the size of a small egg; there is great pain felt in the tumour, which prevents his sleeping at night; the general health is good; the heart's sounds are normal; the posterior tibial can be distinctly felt, although pulsating feebly; the anterior tibial more feeble, and not so distinct.

19th.—For the last day or two there has been increased pain and swelling in the integuments and cellular tissue over the inner hamstrings, but apparently not connected with the aneurismal tumour. In consequence of the success which has attended the treatment by pressure of late, especially in two cases by Mr. Storks (*vide Lancet*, May, 1846), and this case appearing favourable, from the small size of the tumour and general good health and age of the patient, this treatment was adopted. Signorini's tourniquet was applied over the superficial femoral, at the upper-third of the thigh, not to completely stop the circulation, but only to impede it, the intention being not to apply pressure too forcibly at first. It was borne very well for a few hours, when the tourniquet was slightly slackened by the patient. Before the application of the tourniquet the temperature of the affected limb below the knee was lower than the sound one; three or four hours afterwards the temperature increased, and became higher than the other, and a slight swelling of the foot and leg appeared.

20th.—Had no sleep; at intervals has tightened and slackened the tourniquet; the posterior tibial can be felt beating distinctly; there is slight oedema of the limb. The circumference of the sound limb is thirteen inches and a half, that of the affected seventeen inches, measured round the knee. Ordered an aperient. Pulse 80; tongue clean; slight thirst.

21st.—Slept tolerably well; there is considerable swelling of the leg; bowels open from an aperient.

22nd.—Slept but little; obliged to slacken the tourniquet, or could not sleep; pulse 84; slight thirst; the temperature of the leg higher than the sound one; felt much ease from the application of Goulard lotion to the foot and leg. Size of the limb seventeen inches. On removing the pressure, pulsation of the tumour more feeble than before it was applied. The posterior tibial artery cannot be felt, probably owing, in part, to the swelling of the foot.

This treatment was continued, with variation of the pressure according to circumstances.

April 22nd.—For the last three weeks he has had no pain under the ham, and the aneurismal tumour has considerably diminished, and so altered in its character as to leave little doubt that the aneurism is becoming

obliterated. Pulsation in the posterior and anterior tibial cannot be felt. During the whole of this month slight pulsation could occasionally be felt, and pressure was continued, with occasional intermission.

In the middle of June, some slight pulsation with bruit still continuing, the pressure, which had been left off, was reapplied. This was continued for three weeks, when no further pulsation could be felt.

August 28th.—There is now little or no swelling to be perceived in the ham; no pain upon walking; no pulsation. There is a slight bruit to be heard when the leg is flexed, and the stethoscope pressed deeply into the popliteal space; but this is probably produced by the compact coagulum around the artery.—Discharged.

June, 1851.—Up to the present time continues perfectly well.

Hospital Reports.

BIRMINGHAM GENERAL HOSPITAL.

CASE ADMITTED UNDER THE CARE OF J. HODGSON, ESQ.

(Reported by ALEX. H. PATERSON, Esq., Altricham)

Gun-shot Wound of Thigh, with injury of the Neck of the Femur.

EDWARD MILLER, aged 18, glass-maker, admitted into the Birmingham General Hospital, November 2nd, 1845. On examination, a wound about two inches in diameter was found in his glutei, behind and a little external to the hip-joint. It was bleeding freely, appeared about three inches deep, and on being probed by the finger was found to contain a great number of shot, some wadding, and so many splinters of bone, that the surgeon who first examined it considered the trochanter and neck of the femur to be blown to pieces. The boy said that, being out shooting, he had, when clambering through the gap of the hedge, held his gun behind him by the upper part of the barrel, and that the piece had gone off, the whole of the charge being lodged in his right thigh.

Ordered a yeast poultice to the wound, and to lie on his chest. The bleeding soon ceased, most of the shot, the wadding, and some of the splinters, were removed by the finger.

3rd.—Passed a bad night; bowels confined; face rather flushed; tongue moist and white; wound very painful, filled with dark blood, some of which has discharged into the poultice.

4th.—Passed a bad night, general symptoms much as yesterday. No tenderness in the abdomen; pulse 106, not hard; bowels open. Ordered a glass of wine daily, and three grains of carbonate of ammonia every four hours in an ounce of camphor mixture.

5th.—Passed a bad night and otherwise much the same. Ordered half an ounce of castor oil, and an enema. This acted freely in the evening.