unfortunately the veterinary surgeon who was in attendance was unable to give any accurate information on this point.

Still it appears almost certain that the man derived the infection directly from the "ulcers" in the horse's mouth, so that the case resembles the one investigated by Bouley in 1863, and reported by him at the time to the French Academy of Medicine. Bouley was then engaged in experimenting on the possibility of transmitting diseases of the horse to other animals by inoculation. His horse had pustules in the mouth but no eruption elsewhere, and at first he described the condition as an "aphthous stomatitis." By inoculation of the matter from the pustules he produced "true pustules of cow-pox," from which he subsequently inoculated an infant of 11 months. Bouley afterwards recognized that the condition in his horse was not an aphthous stomatitis, but that it was one of the possible local manifestations of the same horse disease as was dealt with by Jenner and Loy, and shown by the latter to be a constitutional disease.

I am indebted to Dr. W. M. C. Wanklyn for permission to publish the notes of F. K.

PRIMARY PNEUMOCOCCIC PERITONITIS.

By ANDREW SMITH, M.D. EDIN.,
WHICKHAM, DURHAM.

I WISH to thank Dr. Archibald Cuff for his excellent paper on Primary Pneumococcal Peritonitis in the JOURNAL of April 18th, and to supplement it by two cases that have come under my own observation.

CASE I.—A girl, aged 8 years, was suddenly taken ill during the night with severe abdominal pain, prostration, and restlessness. When I saw her next morning she looked flushed, had somewhat hurried breathing, and looked ill. Abdominal pain was evidently severe and definitely located in the right inguinal region, there was marked tenderness and rigidity, and she lay with the thigh flexed. The temperature was 103° and pulse quick. The general aspect was, however, most suggestive of pneumonia, and the chest was carefully examined without result. Next day the condition was much the same and I felt very anxious, still suspecting pneumonia, but fearing to allow an acute appendicitis, which it entirely resembled, to go wrong without the chance of operation. Early next morning, still finding no physical signs of pneumonia and the patient obviously getting worse, I sent her to hospital with a diagnosis of acute appendicitis, stating in my letter that I had endeavoured to eliminate all other possible conditions, including pneumonia. Two days later I received a note from the hospital surgeon, stating that his diagnosis was pneumonia, though even then the physical signs were very indefinite; two days later they became more pronounced and the patient was removed to the medical wards. The following week I saw the patient in hospital and was surprised to find her still very ill, with high temperature, and still almost wholly complaining of abdominal symptoms; the abdomen was now somewhat distended. There had been something of a crisis, but the temperature speedily rose again and continued high but very irregular. An extension of pneumonia to the left lung was suspected, but there were no physical signs, and the temperature was essentially a pus temperature. Empyema was negatived after use of the exploring needle. Things went on much in the same way for several days more, the abdomen increasing in size, when the surgeon under whose care I originally sent her was asked to see her again. By abdominal incision he evacuated, as he described it, "not pints, but gallons of pus pneumococcal in origin." Recovery was speedy and complete.

I do not doubt that a true pneumonia did exist in this case, but I feel equally certain that the peritoneum was also attacked from the very beginning of the illness, and in any case there was a genuine pneumococcal peritonitis.

CASE II.—Not long afterwards a child 4 years old, a relative of my own, was taken ill during the night with severe abdominal pain, again definitely located in the right inguinal region. When the doctor saw her next day he recognized the seriousness of the attack, and from the situation of the pain with tenderness and rigidity he suspected acute appendicitis, and called in a surgeon, who reserved his judgement, and advised against operation. Two days later I was asked to see her, and on entering the room I was struck by her appearance; it seemed so typical of pneumonia—flushed cheeks, hurried breathing, and herpetic eruption on the lips; there was an occasional short cough. The pain complained of was entirely abdominal in the right inguinal region, where there was marked tenderness and resistance and sense of fullness.

Thorough examination of the chest failed to discover definite signs of pneumonia, though I satisfied myself that over a small area near the base the respiratory sounds were not quite pure. The temperature was high and the pulse quick. I saw her again on the eighth day of illness, when she looked much better, and the temperature was 99°. This certainly looked like a definite pneumonic crisis, but there were no further physical signs of pneumonia to be elicited on examination of the chest and the abdominal symptoms and signs persisted. The temperature rose again the same night; it continued to be irregular and the abdomen increased in size and fluid formed. We again had a surgeon to see her, some of the abdominal fluid was removed by an exploring needle and found to be a pure culture of the pneumococcus. The abdomen was incised and drained and the patient made a speedy and complete recovery.

Here, again, I think there can be no doubt that the peritoneum was attacked from the very beginning; I think the right lung was also invaded, but that view was not supported by the other doctors who examined her and not by the doctor under whose care she was throughout and who gave her the most devoted and anxious attention. In both these cases the general aspect was most striking, being so characteristic of ordinary pneumonia, including the herpetic rash in one case. The imperfect crisis is also worth noting, especially in the second case, if the peritoneum was alone attacked.

I am rather surprised at the bad prognosis which Dr. Cuff gives in these cases. Both my cases did very well, though they looked very ill before operation. Simple incision and drainage relieved them at once, and they recovered without untoward symptoms, just as does empyema when it follows pneumonia. I can scarcely believe that they are nearly as dangerous as septic peritonitis.

The great point, however, is that cases of primary pneumococcal peritonitis occur, and that we cannot afford to ignore them. Though in all cases of peritonitis one must still make every effort to discover a probable local origin—a centre of infection—it is well to keep this possible origin in mind.

I do not know what significance is to be placed on the fact that in both my cases the symptoms were located in the right inguinal region long before the peritonitis became generalized.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL.

CASE OF CHLORODYNE POISONING.

I WAS called to Mrs. T. B., aged 50, wife of a coal-heaver, at 7.30 a.m. on April 25th. She was said to have been found lying on the floor of the day room "stiff and cold." There was a bottle in the room containing 3ss of liquid having the odour and appearance of chlorodyne; there was also a diluted mixture of the same in a teacup. The patient's breath smelt of chloroform, the skin was of an ashy grey tint, the pupils were equal, moderately contracted, and did not react to light. She answered questions when spoken to loudly. The pulse was regular and of fair volume. Zinc sulphate ℥j was given without result, ol. ricini 3j, and also a teacupful of strong coffee and liq. strych. m℥ by mouth. At 9.30 the patient could not be roused, and the tint of the skin was greyer. There had been no emesis nor any action of bowels. A pint of urine was drawn off by catheter to prevent involuntary micturition. The pulse was regular and of good volume; there was slight conjunctival reflex, but she was quite unconscious except for an occasional opening of eyes. Liq. strych. m℥ was injected under the skin, and the stomach washed out. At 11.30 solution of potassium permanganate (gr. v in 3iv of water) was poured into the stomach and retained there for half an hour, when it was removed by a second washing out, and half a pint of strong coffee was given through tube. An enema of brandy (3ss in water 3iv) was given and retained. The pulse at 12.30 was still good, 128. About 3 p.m. the patient recovered consciousness sufficiently to recognize her daughter and to drink some tea.

She stated that she had been taking chlorodyne "for years" for sleeplessness. She is in the habit of drinking strong tea without milk at all three meals, and eats little.

Farningham.

T. F. HUGH SMITH.