CASE OF PHTHISIS TREATED BY THE OPEN-AIR METHOD.

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MR. W., aged 32, whom I saw on August 19th, 1883, gave a history of acute lung illness dating from about March of that year. Since that date he had suffered from progressive emaciation, cough, expectoration, evening pyrexia frequently of 102°, and night sweats. There had been no diarrhoea or hæmoptysis. His family and personal history were unimportant.

On examination I found his pulse 120 and his temperature 101°. The left lung showed signs of extensive and progressive disease. Gurgling sounds and other signs of a cavity were present in the upper lobe at its antero-lateral part, marked dulness back and front extended over more than the upper half of the left chest, and moist *râles* showed that extensive breaking down was in progress. Feeble bronchial breathing existed at the base. On the right side beyond a raised pitch in the subclavicular percussion note and a slightly "blowing" respiration, I found nothing abnormal. Cough was very troublesome and muco-purulent expectoration profuse. The urine was slightly alkaline, but it did not contain albumen or sugar. The heart and abdominal organs appeared normal and the digestive system in fair order.

The house occupied by the patient was situated in its own grounds, in an elevated locality about a mile and a half from the town and sea, and having a southern aspect. A verandah entirely surrounded the house on a level with the first floor and opening thereon was the patient's bedroom. Upon this balcony, shaded from the direct rays of the sun, reclining on a comfortable couch, he was directed to spend the entire day, moving round the house to avoid wind or dust as occasion required. His bedroom was stripped of all superfluous hangings, curtains, and carpet, and was thoroughly cleansed by damp cloths impregnated with Sanitas, while all dusting and sweeping were forbidden. The window was kept open night and day. During the continuance of pyrexia absolute rest was insisted on, and all excitement forbidden. He was, fortunately, able to take the large amount of nourishment that was pressed upon him, but he required very little medicinal treatment. I noted on September 29th following that the temperature had fallen to 99° for the previous 7 evenings, that the pulse was 76, and that there had been only one slight night sweat during the same period. He was sleeping fairly well and felt much better with the exception of some dyspepsia.

The cough was less troublesome and the sputum was diminished in amount. There was a decided diminution in the number of moist *râles* in the left lung below the vomicæ. A few days after this, slight hæmoptysis occurred, and the temperature for three or four evenings reached 100°, but he again began to improve, and the pyrexia disappeared. He was then allowed to take exercise in the grounds in gradually increasing amount. A month later he had considerably increased in strength; he was able to walk moderately well, and had a very fair appetite. He was not weighed, but had manifestly gained considerably in flesh. The area of dulness extended down to the third rib in front, with dry cavernous respirations. Below this the absence of resonance was certainly less marked, as was also the case below the scapular spine. Crepitus was still evident, mingled with dry creaking towards the axilla. After this he went to Mentone, and I saw nothing more of him till July, 1885, when he reported himself much improved in every respect. He had regained his normal weight, and was able to walk several miles without difficulty. Cough and expectoration had practically ceased, and he no longer regarded himself as an invalid. The vomicæ at the left apex appeared to have diminished to the extent perhaps of half its former area; some retraction of the lung had taken place, uncovering the heart; impaired percussive resonance existed to the third cartilage in front and slightly below the scapular spine posteriorly, where feeble cavernous breathing was audible. A little crepitus on full inspiration could be detected below the excavation and in the axilla, but the signs were plainly those of a lung in process of healing.

Owing to circumstances, I had no further opportunity of examining the patient, but I afterwards heard that he was still progressing favourably.

It is supposed by many that the modern plan of treating phthisis by exposure to the open air is a novelty, but it is at least forty years old, for it was practised by Brehmer at Goerbersdorf in 1859, while, about 1874, Dettweiler established his well-known sanatorium in the Taunus Mountains. Broadbent also, many years ago, tried the method at St. Mary's and published his results. His plan, which he termed "hyperventilation," consisted in keeping patients in bed in an upper ward, lying between an open window and an open door continuously in a current of air. The case I have recorded occurred nearly sixteen years ago, so that even in England the treatment is not quite new, while it was "made in Germany" forty years since.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

A USEFUL MANŒUVRE IN SOME CASES OF RUPTURED URETHRA.

THE difficulty of the perineal operation for traumatic rupture of the urethra consists in finding the proximal end of the ruptured urethra, and any means by which this difficulty may be lessened is worthy of consideration.

The manœuvre practised in the following case I have used on the living subject in two cases previously.

M.K., aged 18, was admitted to the General Hospital, Singapore, on December 7th, 1896, with a history of having fallen astride of a wooden rail. He complained of being unable to pass water; his bladder was distended to within 1 inch of the umbilicus, and blood was escaping in drops from his meatus. There was very little pain, and his temperature was 99.2°. At 11 P.M. his bladder was tapped above the pubes, and an elastic catheter was tied in through the wound. On December 9th, under chloroform, perineal section was done, but the proximal end of the urethra was not found.

I saw him in consultation on December 13th; no further attempt at completing the perineal operation had been made; the wound was still open, and the urine was coming away by the suprapubic catheter. Under chloroform I withdrew the catheter from the suprapubic opening, and passed in one rather smaller, mounted on a slightly curved stilette. The end of the catheter was passed down the anterior wall of the bladder, and, by means of a finger in the rectum, was easily guided into the vesical end of the urethra. The stilette was then withdrawn, and the catheter passed on, easily felt and helped on a little by the finger in the rectum, until the end appeared in the wound and showed the proximal end of the ruptured urethra. A large catheter was then passed through the penis and into the bladder, guided into the proximal urethra by the suprapubic catheter, which was then withdrawn altogether. The large catheter was tied in. Recovery took place in the usual way. The catheter was left in for some days, then withdrawn, and passed daily for a time without difficulty. The patient was discharged cured on January 15th, 1897.

I regretted that I did not suture the wound in the urethra. If this were done the urethra ought, I think, to unite with the least possible chance of a bad stricture eventuating. At the end of a week or ten days a cautious attempt to pass a catheter may be made, and, if successful, the suprapubic catheter may be withdrawn, and the patient left, a catheter being used as occasion may require.

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POISONING BY THE APPLICATION OF BELLADONNA PLASTER.

THE recent prosecutions for the sale of belladonna plasters of uncertain strength were, in my opinion, well deserved, as I think the following cases will prove.

A few weeks ago a man came to me complaining of pain in the side. I prescribed, among other things, a belladonna