taken ill and died. The symptoms observed were wasting, loss of appetite, inability to swallow, cough, and expectoration. They were ill some days before the children, and when ill were carried about and nursed by them. The children's illnesses were attributed to this cause by the household. The dates of the illnesses and deaths, as nearly as could be ascertained, were as follows:

First cat: taken ill November 18th and died December 1st.
Second cat (yellow Persian): taken ill November 18th and died December 4th.

Third cat: taken ill November 25th and died December 7th.

Mr. B.'s two children were taken ill on November 26th and 27th respectively, and the one taken ill on November 27th died on December 9th, so that the illness and deaths of the cats preceded those of the children, and it appeared as if they had been connected. This was the opinion of the parents and people of the house. Mr. B.'s house was quite a mile from the village, and strict inquiry from the nurse and parents failed to elicit at first any connection. The nurse, however, was sister to Mrs. R., where the third case had occurred. She had visited her sister with Mr. B.'s children, but does not appear to have suffered from sore throat. Although at first sight the disease would appear to have originated with the cats, and the symptoms during life (above described) were such as would be anticipated if diphtheria affected the throats of the animals, this piece of evidence, showing a possible source of personal infection, renders it impossible to say whether the disease in the cats was any more than a coincidence. The first cat to die was examined by the medical attendant, who did not examine further than the throat, where he found no signs of inflammation, but a round worm of large size, which had choked the animal by blocking up the larynx.

Dr. Thursfield was of opinion that this was merely a symptomatic incident, and could be explained by the fact he had observed that during a febrile attack in human subjects the *ascarides lumbricoides*, doubtless rendered uncomfortable by the abnormal heat of the intestines, seek an exit by the bowel or the mouth. It is, moreover, possible that the violent efforts at coughing, obviously to clear the throat (described as a marked symptom in the cats) may have been chiefly, if not entirely, observed in this one cat. Another cat was unfortunately buried so as to be useless. The cat which died on December 7th was secured, the symptoms of which were described as "coughing and something wrong in the throat." It was sent for examination to Dr. Klein, who reported that there was extensive disease of the lung not uncommon amongst cats.

Whether or not the illness of the children can be attributed to the cats or was merely coincident cannot be ascertained, but I consider that the incidents above related clearly show the desirability of examining the household cat or cats in every family infected with sore throat or diphtheria, and ever since it has been my custom to make careful inquiries after the cats.

The connection between infectious sore throat and diphtheria is well illustrated in the incidents of this epidemic, and I have often noticed that virulent diphtheria is very apt to occur shortly after the appearance of these ill-defined sore throats, and I am of the opinion that they are closely allied.

NOTES OF A CASE OF SEROUS EFFUSION INTO THE PLEURA TREATED BY FREE INCISION AND DRAINAGE AFTER THE FAILURE OF REPEATED TAPPINGS.

By RUTHERFORD MORISON, M.B., F.R.C.S.,
Senior Assistant Surgeon, Royal Infirmary, Newcastle-on-Tyne.

DR. SAMUEL WEST's report, in the *BRITISH MEDICAL JOURNAL* of April 27th, 1895, of a case of serous effusion into the pleura treated successfully by free incision after the failure of repeated tapping, and the interest his paper excited when read at the Medical Society of London, induce me to send the notes of a case very similar to his. My case occurred in 1882, and was recorded in a thesis presented by me to the University of Edinburgh, from which I have made the following extract.

E. A. L., aged 23, residing at West Hartlepool, was first seen on February 7th, 1882. The patient, a thin, pale, delicate-looking little woman, was unable to lie down because of difficulty in breathing. Her feet were swollen. The temperature was 100.6° F.; the pulse was 96, when she was lying quiet, but ran up to 120 when she was disturbed. In the abdomen a large apparently multilocular ovarian tumour was discovered; and the right chest was found to be dull all over on percussion. Breath sounds, vocal resonance, and vocal fremitus were absent.

The abdominal swelling had commenced with what, from her description, was an attack of peritonitis seven months earlier, and three months afterwards her abdomen was tapped by her medical attendant to relieve difficulty in breathing. A large but unknown quantity of clear fluid was removed by the tapping with some relief, but the abdomen rapidly refilled.

On February 9th, 1882, I tapped her abdomen and obtained 4 gallons of the glairy fluid commonly found in ovarian cysts. The tapping relieved her, but dyspnoea at night was still troublesome.

On February 11th I aspirated the right pleura and withdrew the needle when 25 ounces of clear fluid had escaped. For two nights she was relieved; then the dyspnoea returned. On February 14th I aspirated again, slowly withdrawing through a small needle $4\frac{1}{2}$ pints of fluid. The chest rapidly refilled, and by February 28th the dyspnoea had returned and the right chest appeared to be full again. I then decided to try if I could gain on the fluid by repeated small aspirations, and removed 1 pint of fluid. On March 2nd a second pint was aspirated; on March 6th a third pint; and on March 10th a fourth pint. On March 12th the chest seemed to be as full as ever, and the patient was steadily losing ground from fever, night sweats, the frequent tapplings, and inability to eat.

On March 14th, 1882, with the antiseptic precautions practised at that time, under the carbolic spray, and without any anæsthetic, I made a free incision into the pleural cavity in the middle axillary line, and inserted 3 inches of large-bored india-rubber drainage tube. Fluid rushed from the tube during its escape. On several occasions, fearing that so sudden an emptying of the cavity might cause serious disturbance, I restrained the flow. The patient, however, only felt relief, and made no complaint of pain or discomfort, except a weak sensation. Large antiseptic dressings (carbolic gauze) were applied, but in spite of frequent change and liberal use of gauze the dressings were continually soaked during the first five days. For the first two days the tongue was dry and the temperature 100° at night, otherwise there was no constitutional disturbance. On the sixth day after drainage the discharge suddenly ceased, and the dressing was for the first time found to be almost dry. From the sudden cessation of discharge I feared the tube might be blocked, but, on removing it, I found its lumen patent. A director passed into the pleural cavity also showed that it was empty. The percussion note at this time was tympanitic all over; there was a complete pneumothorax. The tube was introduced and retained for two days longer, when it was finally removed, as there was no discharge from it. The patient steadily gained ground for a fortnight, at the end of which there were no physical signs of any chest derangement, except slight impairment of the percussion note and some weakness of the breath sounds.

The abdominal swelling now began to be troublesome again, and a week later I performed ovariectomy. The operation was a difficult and severe one from dense adhesions to the parietes in the left lumbar region and the patient died half an hour after being put into bed. No *post-mortem* examination could be obtained.

REMARKS.—Before performing this operation I had seen Sir Joseph Lister open and drain knee-joints distended by fluid with success. This experience gave me confidence, and the result justified the means, for I have as little doubt as it is possible to have in the absence of a *post-mortem* examination that my patient's chest was well when she died. I have since always thought that an aseptic opening into the pleura was free from danger, that the proper surgical treatment of pleural effusions which resisted a moderate amount of tapping was to have them incised, drained, and dressed by a

careful surgeon; and my strong impression is that no present-day surgeon would be found unwilling to do as was done in Dr. West's case or my own.

CASES OF BILIARY COLIC CURED BY THE ADMINISTRATION OF OLIVE OIL.

BY J. MICHELL CLARKE, M.A., M.D. CANTAB.,
M.R.C.P. LOND.,

Physician to the Bristol General Hospital.

THE case of hepatic colic cured by ingestion of olive oil, recorded by Dr. A. S. Gubb,¹ has led me to report very briefly three cases under my own observation, in which this treatment was followed by satisfactory results. The patients took the oil after meals with less difficulty than one would imagine. They began with a dose of $\frac{3}{4}$ j, and rapidly increased it, and I found that the first few doses were best taken floated on the surface of a bitter acid infusion. A dose of 8 grains of salicylate of soda was also given in a mild saline purgative before breakfast two or three times a week during the administration of the oil. The patients sought for the passage of a stone in the fæces, but did not detect one.

CASE I.—A man, aged 63, was seen by me in April, 1892, for a severe attack of biliary colic. He was a strong, healthy man, of temperate habits, who had never had any bad illness since the age of 22, when he had inflammation of the right lung. The attack for which I saw him came on suddenly without obvious cause, although he had suffered from acidity, flatulence, and dyspeptic pains for some months previously. The attack was not followed by jaundice. I saw him again in April, 1893, and he then said that he had returned to work in May, 1892, after the first attack, and was as well as he had ever been for ten weeks afterwards, but since then he had suffered from severe attacks of biliary colic about once in every three or four weeks; in the intervals his health was fairly good, but he had lost 30 lbs in weight during the year. The pain came on quite suddenly at any time of the day or night, without any cause. The attacks were preceded by indigestion, from which he appeared to suffer a great deal. The pain was so bad as often to necessitate morphine injections, and was accompanied by violent sickness; the whole attack lasting for six hours or longer, leaving him quite exhausted. When I saw him he was slightly jaundiced, but he stated that he had not had jaundice before, and that until the preceding two days bile had never been absent from the motions. He looked thin and anxious. The liver edge could be felt below the ribs, the gall bladder was not detected. The urine contained a quantity of bile pigment, which reacted well to Gmelin's test. He was recommended to take olive oil twice daily, beginning with a dose of $\frac{3}{4}$ j, and increasing the dose as quickly as possible until $\frac{3}{4}$ vj to $\frac{3}{4}$ viij were taken at a time. This he did without much inconvenience, not disliking the oil, and he continued the treatment for about two months. The jaundice soon disappeared, and he had no return of the attacks from the time of taking the oil. I met him in the street recently looking hale and hearty. He said that he felt perfectly well, and had had no return of the attacks now for twelve months, and had regained his former weight.

CASE II.—A gentleman, aged 30, living in London. In September, 1888, I attended him for an attack of catarrhal jaundice, unattended with pain or with any symptoms of gall stones. I next saw him at Christmas, 1893; he was on a visit to Clifton, and had been taken suddenly ill with typical biliary colic. This first attack was not a severe one, and was not followed by jaundice; and he returned to London in a few days. During the late winter and spring of 1894 he suffered from repeated attacks of biliary colic at frequent intervals. Some of these were very severe, laying him up for several days, and leaving him exhausted by the pain and vomiting. His general health suffered, and he lost flesh. After the more severe attacks he had slight jaundice, and after all of them the urine was loaded with bile, and the fæces clay coloured. He tried various methods of treatment with-

out obtaining any permanent relief, including a month's residence at Llandrindod Wells for a course of the waters there in the early summer of 1894. After this he was a little better for a short time, but the attacks recurred as badly as ever during the months of July, August, and the first half of September. On the average he had an attack about once in every two or three weeks. During the whole time he had been careful to follow out the usual dietetic restrictions. On September 24th he applied to me for advice, and I recommended him to try the olive oil treatment. This he carried out thoroughly, beginning with a small dose and increasing it up to $\frac{3}{4}$ iv, or occasionally $\frac{3}{4}$ v, twice a day. He took the oil for from two and a-half to three months, leaving it off gradually. The result has been that from the time that he began to take the oil he has had no recurrence of the attacks, and has remained quite free from pain. The large amount of oil gave him little inconvenience, until towards the end of the treatment, when it began to excite nausea.

CASE III.—A stout woman of 40, who had had a large family, and who came to the Bristol General Hospital as an out-patient suffering from jaundice with repeatedly recurring attacks of severe biliary colic. Treatment by olive oil at once stopped the attacks. She had more difficulty in taking the oil than the other two patients, and could not manage more than $\frac{3}{4}$ iij at a dose taken twice, sometimes three times, daily. She attended as an out-patient for six weeks, and then ceased as she appeared quite well. I have not been able to obtain any subsequent information about her; but it is probable that if the attacks had recurred she would have come to the hospital again, as she was very pleased with the result of the treatment.

PERMANGANATE OF POTASSIUM AS AN ANTIDOTE FOR OPIUM POISONING.

BY NATHAN RAW, M.D., ETC.,

Medical Superintendent and Pathologist Dundee Royal Infirmary.

I HAVE read in the BRITISH MEDICAL JOURNAL of June 22nd with great interest the original communication on the new antidote for opium poisoning by Dr. William Moor, of New York, and beg to record my own experience of the efficiency of the drug after careful trial in five cases of opium narcosis.

CASE I.—M. G., aged 27, admitted March 17th, 1893, had swallowed $\frac{3}{4}$ j of laudanum. She was profoundly unconscious and evidently in the last stage of narcosis. Her stomach was at once washed out with a warm solution of Condyl's fluid ($\frac{3}{4}$ j to a pint of water) until the washings were quite colourless. She afterwards was given $\frac{3}{4}$ j of liquor potassii permanganatis every hour for four hours. Artificial respiration was kept up for two hours in addition. She made a good recovery.

CASE II.—E. S., aged 59, was admitted on August 28th, 1894, having swallowed a large quantity of tinctura opii. She was comatose and could not be roused. The pupils were "pinpoint," the respirations 6 a minute. Her stomach was at once washed out with a warm solution of Condyl's fluid, and $\frac{3}{4}$ j of liquor potassii permanganatis given every hour. In a quarter of an hour she showed improvement, and in an hour she was able to speak. She recovered.

CASE III.—J. H., aged 35, a chemist, was admitted, having been found in an unconscious condition in his shop. He had evidently taken opium several hours previously, and the amount was afterwards found to be over a pint of tinctura opii. The same procedure was adopted, and in addition I was about to inject permanganate of potassium subcutaneously when he suddenly died from respiratory paralysis.

CASE IV.—C. M., aged 52, was admitted on November 16th, 1894, in a profoundly unconscious and comatose condition from opium and alcohol. Her stomach was at once washed out freely with Condyl's fluid, and the effect was marvellous. In ten minutes she was answering questions, and it was thought she had recovered; but she relapsed into a comatose condition, when potassium permanganate was given in $\frac{3}{4}$ j doses every hour for three hours. The stomach was continually washed out with the solution until the washings were quite clear. This patient made a good recovery.

¹ BRITISH MEDICAL JOURNAL, April 20th, 1895, p. 865.