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CASES AND NOTES FROM HOSPITAL AND PRIVATE PRACTICE.

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CASE I.

INDURATION OF THE APEX OF THE RIGHT LUNG.

A young lady, aged 19, of good constitution, was attacked in the spring of 1842 with cough, mucopurulent expectoration, and slight hæmoptysis. These symptoms continuing, she was placed under my care in the summer of the same year. There was no emaciation; figure *embonpoint*; countenance sallow; tongue slightly coated; appetite good; bowels sluggish; catamenia regular, but attended with pain; pulse 80, of moderate strength; complained of erratic pains in the right shoulder and upper part of the chest; cough short and hacking, and most troublesome in the morning; expectoration very inconsiderable, chiefly inspissated mucus; hæmoptysis to a slight extent had occurred on three separate occasions; no nocturnal perspiration.

Physical Signs.—Deficient expansion, and elevation of the ribs on the upper part of the right side.—**Percussion:** Stroke-sound under the right clavicle dull, and of a peculiarly well-marked wooden character, with great resistance to the finger.—**Auscultation:** Respiratory murmur very defective, and deeply seated in the right infra-clavicular region; a faint mucocrepitation audible on deep inspiration; murmur of expiration unaffected. The remainder of the chest healthy.

Treatment.—Emetics of ipecacuanha; the repeated application of two or three leeches under the right clavicle; counter-irritation; gently affecting the system with mercury; strict attention to the digestive organs; subsequently the sesquichloride of iron, with a nourishing but unstimulating diet, and horse exercise.

Under these measures the patient apparently recovered. The physical signs, however, with the exception of a somewhat improved condition of the respiratory murmur, and the removal of the crepitation, remained unaltered. Three years have now elapsed, the patient reporting herself well. She is still, however, the subject of an occasional short dry cough.

CASE II.

INDURATION OF THE APEX OF THE LEFT LUNG.

F. C., aged 18, of slight conformation and pale complexion, in 1843 became the subject of cough and

mucous expectoration, with slight hæmoptysis, and some nocturnal perspiration. His digestive organs were healthy; pulse between 80 and 90. Had previously enjoyed good health. He believed that one or two distant members of his family had died of phthisis.

Physical Signs.—Elevation and expansion of the ribs but slightly affected. No flattening of the infra-clavicular region.—**Percussion:** Marked dulness beneath the left clavicle, with resistance to the finger.—**Auscultation:** Respiratory murmur very defective, with increased vocal and tussive resonance in the left infra-clavicular region; no abnormal rhonchus; expiratory murmur unaffected; respiration in the right lung puerile.

Treatment.—This, with the omission of the mercury, was precisely similar to that adopted in the preceding case. From two to three leeches were perseveringly applied for some months below the left clavicle, every third or fourth week, with marked advantage.

The patient has remained under my observation for more than two years. He is now stout and strong, and quite free from cough. The stroke-sound remains dull, and the respiratory murmur, although more fully developed, is still very defective.

CASE III.

INDURATION OF THE LOWER HALF OF THE LEFT LUNG: EXTENSIVE AMPHORIC SOUND ON PERCUS- SION: RESOLUTION: RECOVERY.

Samuel Brown, aged 14, the son of a labourer, residing in the country, presented himself as an out-patient at the Hospital, August 2nd, 1845. Stated that his illness commenced about the previous Christmas, after exposure to wet and cold, with shivering, debility, pain in, and inability of lying upon, the left side, and slight cough. Subsequently to this, however, he admitted that he had suffered from severe cough, with copious expectoration. Phthisis was hereditary in his family on the father's side. Countenance freckled and ruddy, and strongly indicative of the strumous diathesis; tongue clean; appetite moderate; bowels regular; can now lie upon either side; complains of occasional dull heavy pain in the left side; no cough; dyspnoea on exertion; pulse 80.

Physical Signs.—**Percussion:** Slight dulness beneath the left clavicle, between which bone and the upper margin of the fourth rib is elicited a loud, metallic, amphoric sound; (this latter phenomenon is rendered extinct by carefully closing the mouth and nostrils of the patient;) marked dulness over the lower half of

the left lung, both in front and behind.—*Auscultation*: Respiratory murmur harsh and tubular at the upper part of the left lung; absent, with an occasional sibilant rhonchus, below; resonance, of voice and cough louder over the entire left than the right side; right lung healthy; murmur somewhat exaggerated.

Treatment.—Counter-irritation by blistering; saline medicine; mercury with chalk, until the gums were affected; and subsequently the iodide of potassium.

Under the steady use of these measures the normal permeability of the lung was restored; the amphoric sound on percussion, at the upper anterior third, remaining unchanged.

CASE IV.

INDURATION OF THE RIGHT LUNG: ANTERO-POSTERIOR CONTRACTION OF THE CHEST: RECOVERY.

Philip Hasle, aged 39, a blacksmith, admitted into the Hospital, July 10th, 1845. Stated that he had been ill for three months, his disease commencing after exposure to cold, with slight cough, pain under the right scapula, darting through the chest, and extending to the mamma in front, aggravated by a deep inspiration. Prior to his illness had enjoyed good health.

Present Symptoms.—Countenance depressed, and strongly indicative of internal disease; complexion sallow; conjunctivæ suffused; tongue moderately clean; appetite indifferent; bowels obstinately constipated; complains of dull pain under the right mamma, slightly increased by inspiration; dyspnoea excited by exertion; has very little cough or expectoration; can now lie indifferently on either side; has never had hæmoptysis.

Physical Signs.—Visible flattening of the right side of the chest, both in front and behind; insufficient expansion of the same side on inspiration.—*Percussion*: Marked dulness over the entire right chest, but less pronounced under the clavicle; resonance of left chest normal.—*Auscultation*: Respiratory murmur inaudible over the lower and greater part of the right lung; feeble and deeply seated at the apex; some tubular breathing heard between the scapula and spine; sounds of the heart loudly transmitted over every part of the right side; no ægophony; left lung healthy, with exaggerated respiration.

Treatment.—A single cupping to twelve ounces below the right scapula; counter-irritation by blisters, six of which were applied to the affected side during his stay in the Hospital; the prolonged exhibition of mercury with chalk, followed by the bin-iodide; iodide of potassium, which was necessarily after a short time discontinued, in consequence of its producing an eruption resembling urticaria; and latterly the sesquioxide of iron, with nourishing diet and porter.

Discharged September 24th, at which time the following note of his condition was made:—Feels well, but is occasionally in low spirits; appetite good; no cough; right side of chest flattened both in front and behind; respiratory murmur, although slightly more feeble than on the healthy side, is audible throughout the lung, with the exception of one small spot, of about two inches in diameter, in the right lateral region. Stroke-sound flat, but not dull. I may add that this

patient has continued to amend, the respiratory murmur being now audible over the dull space in the lateral region above referred to.

CASE V.

INDURATION OF THE LEFT LUNG, RESULTING FROM PLEURO-PNEUMONIA.

Emma Noble, a servant, aged 22, admitted into the Hospital, August 27th, 1845. States that she has been ill between three and four months, with cough, pain in the side, and dyspnoea on exertion. Ascribes her disease to exposure to cold.

Present State.—Countenance anxious; complexion sallow; pupils dilated; tongue coated, and indicating considerable gastric irritation; anorexia; bowels torpid; catamenia regular; pulse 72; has slight cough, without expectoration; pain in the left side, with a sensation of dragging, increased by a deep inspiration; decubitus principally on the back; has never had hæmoptysis, and does not perspire at night.

Physical Signs.—Vocal and tussive vibrations diminished on the left side, which side does not rise quite so freely as the right.—*Percussion*: Dulness, extending from the spine of the scapula to the base of the chest on the left side, and in a less degree in the corresponding mammary and lateral regions. Stroke-sound clear in the supra-scapular, and infra-clavicular regions; resonance of right lung normal.—*Auscultation*: Absence of respiratory murmur in the postero-inferior region of the left side; feebly audible in the mammary and lateral portion of the same lung; slightly diminished in intensity below the left clavicle, which is perhaps rendered more evident in consequence of the exaggerated respiration which obtains in the opposite lung. In the supra-scapular region of the diseased side, the vesicular murmur is unaffected; vocal and tussive resonance slightly increased over the lower half of the left side; no ægophony; heart's sound unnaturally distinct.

Treatment.—The remedies used in the case of this patient were very similar to those adopted in the preceding ones. She was twice cupped below the left scapula; had three successive blisters applied to the same region; the system was put under the influence of mercury, to which remedy it showed considerable resistance; alkalies, followed by the iodide of potassium, which latter, in this case also gave rise to urticaria, and was necessarily discontinued; and latterly the dilute nitric acid, with an unstimulating, but nutritious diet.

The patient remained in the hospital eleven weeks, at the expiration of which period, feeling herself well, she requested her discharge. The dulness on percussion at the lower and posterior part of the lung, had much decreased; the respiratory murmur had become audible, although feeble, over the part which, on her admission, was destitute of sound; below the clavicles the breathing was natural; percussion remained dull over a small space above the left mamma, at which spot, (partly perhaps in consequence of the loud sounds and irritable condition of the heart, while being

examined,) the vesicular murmur remained very defective.

Recent pathological investigations have shewn that pneumonia, occurring in, and limited to, the apex of the lung, is not of such unfrequent occurrence as was formerly imagined. The knowledge of this fact should tend to caution the young auscultator against committing the error of pronouncing, without sufficient examination, every case as incipient phthisis, in which exist dulness on percussion at the upper part of the chest, with deficient respiration and bronchophony. Cases one and two present instances of this lesion, (pneumonic condensation,) in a chronic form. These cases, located as is the disease in the summit of the lung, require especial care in the future management of the general health, in order to ward off the super-vention of tuberculous degeneration.

In case three, the extended space over which the amphoric stroke-sound was elicited, is remarkable. When of limited extent, as an indication of a cavity, the occurrence of this sign is by no means uncommon. In this case, from the absence of the phenomena of phthisis, and the permanent recovery of the patient, (the certainty of which I have recently verified,) I am disposed to attribute the sound in question to the existence of a congeries of bronchial tubes in a state of dilatation, and approximated to the walls of the chest by pleuritic adhesion.

The antero-posterior contraction of the affected side which presented in case four, is a very common result of pleuro-pneumonia, and as in this instance, depends upon obliteration of some portion of the air-cells, and finer texture of the lungs, which organs also become subsequently more or less bound down by the adhesion of the plastic lymph effused on the surface of the pleura. The above cases present examples of a very important, and at the same time frequently occurring affection of the lung, and which, if not promptly recognised, is very prone to assume the nature of cacoplastic deposit, and degenerate into tubercle.

Notwithstanding the opinion expressed by Laennec to the contrary, the investigations of recent pathologists have shewn that chronic inflammation of the lung, either as a latent affection, or as the more frequent result of a neglected or imperfectly cured pneumonia, is exceedingly common. Nothing indeed is more frequent than, in our agricultural districts, for patients, too anxious to resume their occupation after an attack of acute pneumonia, imprudently to check the process of resolution, and thus to render the disease chronic.

These patients, although they in some measure recover appetite and strength, do not progress beyond a certain point; they look ill, and sallow, with a peculiar hectic appearance, which is extremely characteristic of their condition: so much so, indeed, that in many instances the observant physician will be directed to search for chronic induration of the lung, by the peculiar and anxious expression which the countenance of the sufferer portrays. There is but little or no cough, which is generally dry, or accompanied by a very inconsiderable mucous expectoration; there

obtains more or less dyspnoea on exertion; the pulse varies, at one time but slightly accelerated, or even slower than natural, at another it is quick and irritable, especially towards evening, accompanied by heat of skin, and sometimes perspiration. The physical signs are dulness on percussion corresponding to the indurated portion of lung; the respiratory murmur is feeble or absent over the affected part, and provided that the larger tubes be free, a blowing tubular sound will be heard on deep inspiration; the character of the voice and cough is eminently bronchial, while the sounds of the heart are transmitted with unnatural distinctness through the consolidated portion of lung. The breathing in the healthy side will be more or less exaggerated.

Of the value of vocal and tussive vibration, as an indication of consolidated lung, I must confess that I place but little confidence. I am now making some observations on this (at present) debatable point, which, however, are yet too limited to enable me to draw any definite conclusion.

This lesion may terminate, first, in resolution; secondly, in a still more chronic state, characterized by a firm, grey, gritty, semi-cartilaginous structure; or, thirdly, it may degenerate into tuberculous disease, and rapidly carry off the patient. As a general rule, the prognosis in these cases should be guarded. If, as the result of treatment, we find, while the aspect and general symptoms of the patient amend, a corresponding improvement in the condition of the lung, evidenced by the reappearance of the respiratory murmur, we may confidently anticipate a resolution of the disease. Or, again, the patient's health steadily and permanently improving, even if the physical signs remain unchanged, the case may ultimately do well, as in some instances the process of absorption proceeds very slowly, and this condition of lung may continue for years, or even for the remainder of the patient's life. Should, however, on the contrary, the patient become progressively weaker, his symptoms fluctuating, a few days better, and again worse, at the same time if we detect a gradually extending deficiency of the respiratory murmur, more particularly if a muco-crepitation be added, the super-vention of tuberculous degeneration will scarcely be questioned.

An improved resonance on percussion does not always obtain in a corresponding ratio with a return of the breath-sound; this is more particularly the case after pleuro-pneumonia, in which the pleura remaining sometimes coated with plastic lymph, the sound on percussion, notwithstanding the improvement in the respiratory murmur, continues flat.

This disease is essentially chronic, and requires often great perseverance in the treatment. General depletion and abstinence are not well borne, and tend to increase the disposition to cachexia. Cupping once or twice repeated, to the extent of eight or ten ounces, beneath the scapula of the affected side, provided there be no special contra-indication, will be beneficial. Repeated counter-irritation, by means of successive blisters; and here I may add, that I believe that I have seen more benefit derived from allowing the blister to heal, and applying another, than by keeping up a

permanently discharging surface. Mercury (hydrarg. cum creta) speedily given to affect the system, becomes almost indispensable in the treatment of this affection; its effect must be kept up, but not to the extent of producing ptyalism. As the lung returns to its healthy state the iodide of potassium becomes a valuable remedy. The tonics best suited to these cases are, I believe, the preparations of iron, and the mineral acids. The application of a large warm bran poultice to the entire side, by removing congestion, and thus depurating the affected lung, affords sometimes a great amount of relief.

The diet should be nutritious, but unstimulating. In very chronic cases, in which it has been necessary to ensure the prolonged influence of mercury, I have seen good results follow the carefully watched allowance of a small quantity of sound porter. I need scarcely add that the patient should be clad in flannel, over which, during the winter and spring months, the addition of a chamois-leather waistcoat will be very desirable,

It is in this class of cases especially, (when occurring in patients with whom expense is comparatively not an object,) that removal to a more southern climate is productive of the greatest benefit.

ON CUTANEOUS DISEASES.

(Continued from page 721.)

DIAGNOSIS.

I shall now proceed to give a brief account of the chief characteristics and distinctions of the various species of cutaneous diseases.

Group I.—Class 1st. Inflammations of the Skin itself.

Order *a*, Papulæ, (papula; *κωνίος*, the sprouting of down or buds, and *ὤλη* [ulè or ilè] matter.) Pimples. *i.e.* small accumulated elevations of the cuticle, with inflamed basis; often terminating in scurf or desquamation.

1.—*a*, Lichen, (*λεῖχην*, lichen,) in adults, or:—

b, Strophulus; red-gum or gown, ("redde-gowne,") the tooth-eruption in children. Duration, ten to twenty days. Red or white papulæ, clustered together or scattered, attended or not with fever and digestive derangement. The most important varieties are:—

Strophulus confertus; rank red-gum. Severe; patches hard and less vivid than usual, generally exfoliating in a fortnight; the cuticle may crack in large pieces.

Lichen agrius, (*αγρίος*, wild.) Severe; great itching and heat; occasionally there are vesicles and exfoliations.

L. tropicus; sudamina. (See Miliaria.) Prickly heat, great tingling.

2.—Prurigo, (prurio, I itch.) Chronic; great itching, often accompanied with pediculi. Papulæ large, nearly of the same colour as the skin, and usually surmounted with a little black scab, (from scratching.)

P. formicans, (formica, an ant.) Very severe. *Diagn.*

Papulæ larger and flatter, with scabs, and of a paler colour than in lichen. (See Scabies.)

Order *b*, Exanthemata (*εξανθήματα*, I break forth, or effloresce.) Rashes, *i.e.*, superficial red patches irregularly diffused, and terminating in cuticular exfoliation.

1.—*a*, Erythema, (*ερυθμα*, red,) in adults.

b, Roseola, (roseus, rosy,) in infants. Duration, four to five days. Usually acute; superficial redness, with burning pain, disappearing momentarily on pressure; in roseola, circular or oval, with tingling or itching.

Erythema tuberculatum. Slightly elevated patches, (like peas.)

E. nodosum. Large, hard, and red bumps.

2.—Urticaria, (urtica, a nettle.) Diffused redness, and white elevations, (wheales.)* *Diagn.* Itching, and the appearance and evanescence of the eruption.

3.—Rubeola, (ruber, red;) measles. Duration eight to ten days. Commences eight or ten days after exposure; catarrhal symptoms for three days, then eruption on the fourth day; red dots, which coalesce into irregular patches, (semicircular, or crescentic.) *Diagn.* Irregular roughnesses, larger than in scarlet fever.

4.—Scarlatina, (scarletta, a red-coloured cloth;) scarlet fever. Duration six to seven days; pyrexia one to two days; then eruption. Commences three or four days after exposure. A close and diffuse effervescence of the skin; mouth and fauces of a high scarlet colour. *Diagn.* Minute roughnesses; colour more vivid than in measles.

5.—Erysipelas, (*ερυσ*, I draw; *πιλας*, adjoining.) On the third or fourth day of fever the skin becomes sore, swelled, red, and hot. Asthenic inflammation of the integuments, with diffused tumefaction, and a disposition to spread. *Diagn.* Redness in patches, often with vesication.

Order *c*, Vesiculæ, (diminutive of vesica, a bladder;) Elevations of the cuticle, with watery collections, (serum;) the serum may be clear, transparent, colourless; or opaque, whitish, or coloured; the eruption may end in scurf or scab.

1.—Miliaria, (miliun, a millet seed;) sudamina. (See Lichen tropicus.) Duration seven to ten days. Commences on the third or fourth day of fever; red or white vesicles of the size of millet seed, at first transparent, then opaque, and ending in desquamation; there is sour sweating, (like rotten straw.) Cause, after serious diseases, or a heating regimen, and confined air. *Diagn.* Copious perspiration and scattered vesicles.

2.—Herpes, (*ερπ*, I creep;) tetter. Duration eight to ten days. Not contagious; clustered vesicles, with inflamed bases and tingling, concreting into scabs. *H. Zoster*, (*ζώνη*, I gird;) shingles; a belt round the body.

H. phlyctænodes, (*φλυκταινα*, a pustule,) in separate clusters.

H. circinatus, (circus, a ring;) ring-worm; circular

* A wheale is a longitudinal elevation, with a white head.