

1863

Report of Medical Cases
with
Commentaries

T. Arthur Wood

I cannot present the following cases without some apology, 1st for the undue length to which they extend, and 2^d for the meagreness of the commentaries made upon them.

The thesis itself might be truly defined, as one of the last resort; because after having been engaged for a length of time in investigating the subject experimentally for that purpose, I eventually found I could not possibly have it ready in time; so that at the eleventh hour I was ^{again} compelled to look about for a new subject on which to write. Finally, however, I settled on the six following cases, (consisting of four of fever - two of typhus and two of typhoid, and two of pneumonia) with the nature of which I became early deeply engaged, and of which I retain vivid recollections; hence my excuse for collecting them here. My intention was to have adduced them in support of the statements I have made on the subjects to which they refer, but my time became so short that I found it impossible to argue at such length as would be necessary

for that purpose; so that little or no use
is made of them. I had in fact, to confine
my line of argument within such
limits as were compatible with the time
at my disposal; and that was such
that I felt ~~induced~~^{averse} to touch upon
anything that would in any degree pro-
long the ~~statements~~^{scope of the remarks} - fearing
such a procedure would lead me
too far; in consequence of which they
(the cases) go for little or nothing, and are
just as much waste papers.

I regret, also, I have not had time to
rewrite them. They are just as originally
hastily copied into. Had time permitted
I would not only have corrected them
considerably in the recasting, but would
have ~~endeavored to~~ extended the
commentaries, and thus endeavored to
make them more worthy the name, which
in their present limited and meagre
condition I fear they scarcely merit.

In conclusion I would beg that little
notice be taken of the cases as reports,
in which respect

in which respect some of them ^{at least} are ~~very~~ ^{sadly} deficient - the fault not being mine; but that the attention of the readers be more especially directed to those portions for which I am entirely responsible - the Commentaries and remarks.

I may mention that the subject I had originally taken up was a surgical one - a branch of the profession to which I fear my predilections have strongly turned. That which I selected was "Injuries of the Head" - a subject full of interest, not only from the exceedingly unsatisfactory condition of the ^{present} treatment of many of these injuries; but in consequence of the extreme urgency of the symptoms which often accompany them demanding treatment at once prompt and definite, ^{so} that we should know ^{exactly} the proper course to adopt under different circumstances. There is so much discrepancy of opinion as to when we should trepan, when deplete, when give Calomel, when do nothing for the

that little or no reliance can be placed
on what is at present written on the
subject. It would be a very easy
matter to write a thesis on a subject
of this kind, merely passing in review
the various opinions held in regard
to it; but as that could be of no possible
use I ~~had undertaken~~ ^{undertook} to investigate it
somewhat extensively, and performed
numerous experiments to that end, and
I may add in my own mind have
come to pretty definite conclusions on
the subject. But as it is necessarily
a long one - and I should have
illustrated it by cases and by
drawings - time interfered with my
being ^{able} to put it up in the shape
of a thesis at due season.

The experiments themselves were con-
ducted as follows: - I took two similar
animals of the same kind (cats young pigs etc)
and injured their skulls to the same
extent and at the same time (or nearly,
as possible) and present to produce various

symptoms and degrees of injury; but
the same in two similar cases. I then inter-
fered in the one case, and did nothing
in the other. If there were symptoms
of embolism with depressed fracture
in which they apparently depended,
I trephined me & left the other. Again
in cases of depressed fracture ^{of all kinds} without
~~the usual local tenderness~~ but symptoms, I did likewise - perhaps
better treatment so to speak. In other
cases without fracture and no immediate
symptoms, but in which some vague
ones, as drowsiness &c. came on sometimes
after undisturbed & slight exertions by
taking the opportunity of
I forewarned the effects of bleeding. I also
had opportunities of knowing how far
the symptoms bore out the diagnosis
of cl. as to ^{the situation of} ~~where~~ clots, where they
and the probable results of trephining
under such circumstances. In short
I did all manner of things, which
when ^{an} opportunity allows I hope to report,
and ^{to be able} corroborate the results I have al-
ready arrived at.

Case 1 Typhus Fever

Magdalen Brisbane At 35 Widder

Admitted Nov 26th 1862

The patient, who works in a wool-mill, states that she ^{has always been} a very healthy woman, and with the exception of having had Rubella and Varicella enjoyed good health until Saturday 22nd Nov^r, when, in the morning of that day she experienced a rigor followed by general febrile symptoms, and accompanied with pain in the lumbar region, slight cough, and suppression of the eyes. She did not rise from her bed on that day.

On Monday 24th - the third day of the fever, she received medical advice, and a whiteish powder, ~~with~~ having a few tincts was given; The throat at this time became slightly painful.

On Wednesday 26th - the fifth day of the fever, she noticed for the first time an eruption to make its appearance on the body. She then applied to the Infirmary to which she was admitted Nov^r 26th 1862. No infection or contagion known of.

November 27th or sixth day of the fever:-

Circulatory system - Cardiac murmurs healthy.

Pulse 122 small & moderately strong.

Respiratory System. Eyes ~~depressed~~, and there is some depression from the nares: expectorates a little frothy mucus and has a slight cough. Respiration of thorax normal.

Auscultatory Phenomena. Murmurs and rales rhonchi can be heard more or less over the whole thorax. The complaint of catching pain when coughing.

Nervous System. Complaint of pain in the occipital region sometimes extending round to the frontals: does not sleep well at night: aching pains in many of the joints but not severe. The pain in the back has nearly gone; and she seems to be slightly deaf.

Digestive System. Lips dry: bad taste in the mouth. Tongue dry & much pained, edges deep red. Fauces of normal appearance: appetite bad: throat pained; felt considerable nausea several times during the night; but did not vomit; has some pain in the epigastric region: bowels not relieved since the reg.

Genito-Urinary System. Catamenia normal; menstruated two weeks ago. Urine sp. gr. 1020 - acid, dark amber-color, with a slight sediment of urates. Albumen is present in considerable quantity: Chlorides normal.

Integumentary System. Complication of a dingy aspect, expression anxious: skin dry and hot, and covered with numerous small spots, slightly elevated and of a dusky pink colour; they are most numerous in the trunk, less so in the arms. Temperature of mouth 100, of axilla 101. The patient was ordered on admission ~~saline~~ an antimonial saline.

Nov-27th - sixth day of fever. At 10th Bennett ordered enema of starch.

Nov-28th seventh day. The night nurse says that the patient did not sleep well last night; was very restless & moaning continually. An enema was administered last night - which she relieved the bowels. The alv. secretions were said to be in concrete masses of a dark-brown color. The skin is The eruption shows no disposition to be formed in ex-centric groups.

On auscultation the same sounds were heard as yesterday. The cough is better, but the expectorant of tenacious masses of mucus floating in a darkish salivary-like fluid. This seems to consist partly of some vomited matter. Pulse 132 of good strength. The patient seems anxious that symptoms are beginning to make their appearance in the shape of

muttering delirium; she is exceedingly restless.

Urin sp. gr. 1023 with large sediment of urates. albumen still present. Temp: of mouth 103° of axilla 108°. Nov 29th Eighth Day of Fever. The night nurse states that the patient was restless during the night. The bowels were not relieved, the motion being of a dark Coffe. color. Tongue moist and coated with a yellowish fur. There is considerable Bronchitis: Sonorous rhoncus of a coryng character, and mucous rales are heard profusely.

Pulse 124 of good strength: is restless and has a severe headache. ~~skin~~

The eruption, which is best marked on ^{the} abdomen, is ~~not~~ now generally acknowledged to be the characteristic mulberry colored spots of Typhus. Long this, as some doubt was expressed as regarding their shape to be in the present instance. Temp: of mouth 104° of axilla 106°. Urin dark amber-color. Albumen in large quantity; no sediment. sp. gr. 1020 Nov 30th Ninth Day. The nurse states the patient was restless during the night, & when awake was morning & evening delirious, calling out for alcoholic drinks &c. She had one stool this morning of same appearance as yesterday.

Urine acid 1022. Cloudy but with no sediment.
The chief contents of water. Albumen in large quan-
tity. Chlorides seem deficient. The patient is
getting a double allowance of Prof. tea. Pulse 128
of good strength: cough severe: expectoration pro-
fuse, consist of frothy mucus. Tongue dry
and coated along the dorsum with a yellowish-white
fur. The skin is ~~warm~~^{hot} & dry, the eruption is
fading. The patient has a mild expression
of countenance. She is quite sensible when roused
is taking Soda water to quench her thirst.

Decr 1st (1. day) The night nurse states that the
patient was awakening & restless during the night.
Continually calling out for something to drink.
Pulse 136 of good strength: cough a little better:
expectoration profuse & frothy: Tongue dry and
coated with a brownish fur. The bowels have
not been relieved since yesterday morning.

Lips & throat have some soreness on them. The eruption
presents same appearance as yesterday. The patient
is very deaf. Urine Sp. Gr. 1015 Albumen present
in considerable quantity. Chlorides almost absent.
Skin is hot & feels a peculiarly fatigued colour.
Temp^o of mouth 102 of rectum 101°.

Decr 2nd (Eleventh Day) same states the patient-
slept till 10 this morning when she awoke kept moving
my scullery for doork until day light - Sputum
has a trace of rustiness, and is more scant, and
tenuous than before. Little mucus mixed with
coughs. Tongue dry & brown: not fissured. The
bowels have been twice relieved this morning; the
stools having a chocolate colour. Temp. mouth 96 of rectum 99

Decr 3rd (Twelfth Day) The patient has been
very restless during the night, and did not sleep
till seven in the morning: passed her urine in
the bed: has had two stools which some think
are of a pea-soup character. Pulse 116 weak and
soft: cough better: expectoration less but more ten-
acious. Tongue covered by a dense brown fur,
and fissured, the bottoms of which are red. She
always lies on her back & does not seem to
understand what is said to her today. Diet
Bapt ten o'g to be given in small quantities
at frequent intervals night & day. She also
gets some porridge & milk, and from ounces of
Port Wine a twenty-four hours, to be increased
if it agrees with her: she gets half an ounce every
three hours: damp cloths are applied to the head.

Urine of amber-color: very acid sp. gr.: 1017. Albumen
abundant: chlorides deficient. It contains a cloud
of mucus. During the afternoon the patient kept
moving her hands languidly about her front of her.
Respire Pulse 100; strength has improved since
the morning. When asked to push out her tongue
she opens her mouth widely and does not seem
capable of protruding it. The saliva is running
from the mouth. The eyes are suppressed & the patient
is lying in a motionless state. The eruption is
still present. Temp of Rectum 101°. She took her
porridge & milk this evening & seemed to enjoy it.
The nurse says her appetite has not been very
bad since she entered the Hospital
Dec^r 4th

See next page

(This was omitted { mistake })

Decr 4th (Thirteenth Day) The night nurse states that the patient passed a better night and when awake took beef-tea and port wine. The bowels have not been relieved since yesterday morning. She passed her urine in bed this morning. Pulse 120 of tolerable strength. Patient refuses to show her tongue. On palpation the ~~face~~ tenderness over abdomen is general and not confined to any particular region. She was ordered eight ounces of wine daily to day and the following draught:-

R
Spir. Chlor. bid 3j
Aq. ad 3ij

Half at bed-time, the remainder in the morning

She is still somewhat delirious and goes on muttering &c. Bowels have not yet been moved. Tongue coated with a yellowish fur. Temp: 104.

Decr 5th (Fourteenth Day) The night nurse says the patient passed a better night. The bowels have been twice relieved this morning. Pulse 104 of tolerable strength. She looks better but has still a wild expression of countenance.

Tongue moist and covered with a dirty white
fur. Urine contains large sediment of urates,
chlorides more abundant; albumen still present.
Decr 6th (Fifteenth Day) The patient passed a
better night. Pulse 96 good strength. The deaf-
ness is less marked. Tongue cleaner; bowels
moved twice. The patient expresses a desire
for animal food & was ordered four ounces of
steak at visit. Skin still hot but ^{moist} ~~not so dry~~.

Temp mouth 101° axilla 102°

Decr 7th (Sixteenth Day) Nurse says the patient
slept pretty well last night, but has been
slightly delirious this morning; is more deaf than
yesterday & says she does not feel so well.

Pulse 116 small & throbbing strong as before.

Decr 11th (Twentieth Day) The patient has been
gradually, but slowly improving up to this date.

Pulse 96 of good strength. Tongue clean but pale.
Urine of an amber color, with slight sediment; no
albumen; chlorides abundant.

This patient's convalescence was uninterrupted;
though she remained in the house for a consid-
erable time, in consequence of the extreme degree
of debility to which she had been reduced by
the attack, & violent head & violent attacks of fever.

Commentary.

The above recorded case was exceedingly characteristic of the class of fever to which it belongs, so much so, indeed, that it might justly be called a typical case of Typhus, presenting itself in an exaggerated degree; which is all the more marked from that very ~~cause~~ ^{reason}, every feature of the case, so to speak, standing out in bold relief, leading to the one and evident conclusion, that it was nothing more and certainly nothing less than a pure case of Typhus, neither rendered obscure by collateral symptoms, nor yet uncertain from deficiency of unmistakable ^{ones} ~~phenomena~~. In short, it was just one of those cases which a rigorous writer with poetical tendencies will depict as ~~the~~ what we should find in all cases of so grave a character; ~~and when saying~~ ^{After saying} this, I think, ~~it~~ ^{its} ~~will~~ ^{nature} be readily understood ~~the nature of the case~~ have endeavoured, though faintly, to indicate - say faintly because I am quite sure the accompanying record, though somewhat lengthy, is yet so deficient in many of the most characteristic symptoms

symptoms (which were most accurately present but not noted) that it will convey a very inadequate - if indeed the unobtest-conception of the severity of the case. In truth, little or no hope was entertained of her recovery, as she appeared beyond all reasonable expectation, not even the most sanguine prognostication anticipated anything but one termination and that a fatal one, especially for a day or two preceding the critical period, which in her case was unusually well-marked. It ~~was~~ ^{was} so striking, indeed, that one could scarcely believe it ~~to be~~ ^{was} the same patient in the morning of the fourteenth day - the change being as sudden as it was signal. The patient instead of presenting the apathetic ⁺ soporific appearance - lying unconscious with open eyelids as if awake, and her muttering delirium without - which she did in the previous day, looked ~~as if nothing had~~ ^{through} ~~happened~~ quite calmly and complacently - lying in fact, as if nothing had happened; saving the apparently helpless condition in which she lay on her back, indicating very clearly the extreme degree of prostration which had taken place.

Before taking leave of this already too long
a case, I may remark that it was one of
extreme interest on many points of view.
Not only from the fact of its being so typical
of the kind of fever to which it belongs,
about which there could be but one opinion,
thoroughly showing in itself the "non-identity
of Typhus and Typhoid", but more espe-
cially was it interesting in a therapeutical
sense as it shows what nature-unaided
nature - at least as far as drugs are concerned
is capable of performing, or rather should
suffer enduringly with impunity, because had this
been anything else but fever, (it being uni-
versally acknowledged that fever at least
cannot be cut short) drugs would have
been given, and those too ⁱⁿ quantities large
and varied enough to accomplish the end
saw - viz the speedy annihilation of the
disease, and most certainly to drugs would
have been ascribed the cure or more properly
speaking the favorable termination of the
~~disease~~ which took place. In this sense it is
I think that extreme fever-cases which get

recoils, learn us so important a lesson, and
one which should not be lost sight of in the
treatment of other diseases, especially those
of an acute character.

Case II Typhus Fever

Mr Macaulay Oct 25. A light porter

Resident at 139 Grassmarket - admitted Dec 8th
1862.

With the exception of having had some slight mental derangement some years ago, for which he was confined to an Asylum, the patient has always enjoyed good general health. He has always had a good appetite, and plenty to eat. On Sunday November 20th the patient was out walking, and on his way home a flood for a considerable time in the street listening to the preacher. On his arrival ~~home~~ (9 p.m.) he experienced a rigor with general febrile symptoms. Next day he went to his work as usual, but had to return in consequence of feeling so ill, which went on rapidly increasing. No exposure to contagion can be ascertained; neither was there any fever, saving a case of measles, in the close in which he lived, which is said to be the cleanest in the Grassmarket.

Second day of admission. The patient is very languid and apathetic, taking little notice of what is going on around him, and with dis-

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which he lived, which is said to be the cleanest
in the Grassmarket.

Second day of admission. The patient is very
languid and apathetic, taking little notice of
what is going on around him, and with dif-

difficultly can be put to answer questions. He complains of severe headache; skin hot and dry, pulse 118 weak; tongue coated with a whitish fur. The patient says he has had four or three stools daily since the commencement of the attack; though much reliance cannot be placed on his statement. They are run off a liquid character and chocolate-stool, no tenderness of abdomen. There is a profuse increased eruption all over the body giving the skin a mottled appearance; some of the spots present a dusky pinkish hue, feeling slightly elevated to the touch, fading but not disappearing in pressure; whilst there are more of a brick-dust colour. There is also some bronchitis with hoarseness; slight cough and expectoration which is frothy tumorous.

Dec. 4th (10th day of Fever) The night nurse states that the patient slept from about 12 to 2 a.m. but during the remainder of the night was restless and moaning. He reacts sensibly when addressed, and has shown no signs of mental aberration as yet. He got both bowels & urine at intervals during the night. The teeth and lips are encrusted with dried; tongue furrowed & fissured transversely.

He has had three stools since last visit of same character as before: there is some tenderness of abdomen but not confined to any special region. He complains of intense headache, and is extremely thirsty: pulse 116 weak: temperature of axilla 104. Urine of an orange color Sp. Gr. 1020, contains a trace of albumen, except of phosphates and chlorides in abundance; has been receiving series of enemata six times of warm daily, brief ten every two hours, and an antimonial saline.

Decr: 10th (11th day of fever) The nurse says the patient was muttering and delirious more or less from 12 to 5 a.m.; he then became quiet and remained so the rest of the night: he repeatedly threw off the bed clothes. He has had no stool since last visit; one passed in the bed. They are scanty and of same character as before. Urine passed in bed; tongue covered with a dense brown fur; dry, moist and red at edges. Pulse 114 soft and small; skin hot but moist; some of the spots are changing a colour.

He says his headache is better today.

Decr: 11th (12th day of fever) The patient has had a good night, slept for a considerable time, and

has been generally quiet and drowsy. His ex-
pression, which has been hitherto very anxious, is
more composed to day, has had five stools since
last visit; tongue still brown and red at edges;
complaint of sore throat; temperature of axilla 107°
thigh hot and pungent. Pulse 126 soft. Urine
of an amber color with a floating cloud sp. gr. 1025
Phosphate in casts; chloster normal in fair amount.

Nov: 12th (13th day of fever) The nurse states that the
patient was restless during the night especially during
the early part when he was very noisy, which it
appears he has been more or less in the evening
since admission - shouting aloud, but more of a
singing in joyful character than wild delirium.
He continues to be very thirsty; had had six
stools since yesterday, some of which were passed
in bed. The urine was also passed in bed.

Tongue covered with brown coat, edges red
and moist, centro cracked; expression calmer,
headache better; no pain over abdomen; hearing
impaired; eruption profuse but fading - skin cool.

Dec: 13th (14th day of fever) The night nurse states that
the patient was restless and boisterous during
the night till about 4 a. m.; was constantly

shouting and singing; throwing off the bed-clothes but not coming out of bed; Her has had six stools since yesterday, passed some feces in bed; has been quiet and sleeping the greater part of the morning; not so thirsty to day; tongue of same colour but moisten; lips dry and teeth covered with sores. Pulse 100 full soft Urine amber-colour, with a cloudy sediment. G. G. 1025 Chlorides scanty; Urates abundant. The nose ordered ~~and~~ mild anodyne mixture to day.

Decr 14th (15th day of fever) The nurse says the patient was very restless during the night. shouting continually and had little or no sleep. He ~~has~~ passed all his feces ~~urine~~ in bed. He perspired freely during the night, and to day is quiet and inclined to sleep. He is unconscious and does not answer sensibly the questions put to him; is extremely thirsty. Tongue dry but not coated. Pulse 108.

Decr 15th (16th day of fever) Delirium troubled during night; little sleep; passed feces twice in- voluntary Pulse 96; skin warm but moist; very dry

Decr 18th (19 days fever) For the last three days there has been little or no change in the patient's condition, saving less delirium and more sleep. To day however ^{he} is much improved. What his appearance testifies. He also expresses himself much better. Pulse 60 soft. Has been sweating profusely during the night and forenoon.

Tongue nearly clean, a little white fur on dorsum, hearing improved. Urine contains a copious sediment of urates; no uric acid in teeth. He asked for, and eat greedily, steak to day; ^{the} eruption ^{has} nearly all disappeared. The diarrhoea which has been incessant and continuous up to this period has also ceased; ~~though the stools~~

Decr 20th (21st day of fever) The patient has been perfectly quiet during the whole ^{night}, slept the greater portion of it. On the two previous days, though in every other respect much improved, he was still delirious ^{especially} during the night. He is now quite rational & expresses himself much better. Pulse 60 soft; hearing almost normal. Tongue moist; no thirst. Clear natural heat & moist.

From this period the patient rapidly improved. He got up for the first time on the 30th being

the thirty first day of his illness. His appetite
is, and has been for the last few days, voracious.
There is always a tendency to diarrhoea.

Commentary:

This was also a very severe case of Typhus,
the patient sinking beyond recovery. It was
peculiar, inasmuch as there was a critical
change on the 14th day, but that for the ~~whole~~^{course}
both the diarrhoea and delirium becoming
very much exaggerated. The persistency of
the diarrhoea was another peculiar feature
in the case. It was regarded on that account
by some ^{who} observed it to be a case Typhoid,
but that is quite inadmissible as there was
not one sign or ~~single~~ symptom of Typhoid
to be discerned save the diarrhoea, and
even it bore no resemblance to the diar-
rhoea ~~observed~~^{met with} in Typhoid. ~~It was all~~
~~along~~ ~~was~~ The face was all along more or
less in rashes, accompanied by a great
deal of flatulency, with little or no distension,
certainly not amounting to a tympanitic
condition, and with much pain in pressure,

the little (pain) there was being general, and not confined to any particular region of the abdomen. I don't think it was Typhoid therefore, simply because there was diarrhoea, even had it presented more of the character peculiar to that ^{kind of} fever. But, as I before observed, it bore not the least resemblance whatever to the diarrhoea met with in Enteric fever, not only from its constancy, which alone is very characteristic, but it was not of that light ochry-colour, (though sometimes more resembling coffee-ground) which we should expect to find, were it Typhoid. I may here remark what I conceive to be a frequent source of fallacy as regards the liquidity of the faeces. That they are as a rule liquid in enteric fever does not admit of a doubt. But when the fever is supposed to be of a doubtful character, probably in eruption present, or any other ~~the~~ well-marked symptoms, saving the supposed diarrhoea. Then comes the examination of the faeces, as a further corroboration of the already summed-up diagnosis.

When beheld they are found to be liquid, which alone, under these circumstances, seems enough to satisfy some observers that the fever must be entire, and is consequently, "ceteris paribus" put down as such. This, I say, I have known to occur, feeling at the same time convinced that the fever was not only not entire, - which, the sequel of the case fully verified - but that the stools were not naturally liquid - accounted for by the fact that the faces had been sometimes in the urine prior to voiding, were dissolved so to speak, by voiding time. This I know from having seen them in napkins shortly after the evacuation, and the same stool in the pseudo-liquid condition at the time above mentioned. But to return from this digression, - saying it does not apply in this case, as the faces though frequent were acknowledged to be incoercible. I think the ^{more} frequency can be accounted for independent of the fever. The patient, ~~who~~ ^{being} of a very weakly and nervous habit, and as such more readily influenced by an acute disease of any kind, left me so ~~prominently~~ prominently protruding

as Typhus, - was so far favorable to the production of diarrhoea, consequent on any existing irritation, and certainly no more forcible source than that of the fever poison can be well imagined. Though in this case not acting specifically on the intestines, yet its mere presence in the system was ~~enough to cause diarrhoea~~ ^{sufficient for its production} through sympathetic irritation, more especially when we remember the greater tendency of ^{the} typhus poison to affect the nervous centres. The case was, however, so characteristic in these respects as to require no further corroboration here by the enumeration of the individual symptoms, the most striking of which were, the copiousness of the ~~fecal~~ ^{fecal} destructive excretion, the character of the delirium, the general prostration, and lastly but by no means least the peculiar alteration in the physiognomy.

Case III

Typhoid Fever

Alexander Malcolm At 25 Clock

Resident 10 Hill Place - admitted Dec- 24th 1862

On admission the patient was delirious and no history could consequently be obtained from him. His landlady, however, ^{who} states that he came to her lodgings on the 10th ult. says he complained to her of feeling ill on the previous day; but no distinct rigor could be traced. A fellow-lodger informs us that though he felt ill and languid for some days previously, it was not till the 18th ult. ~~the~~ ^{she} became markedly so, on which day a medical man was called in, who, on finding febrile symptoms and constipation ordered a ~~tonic~~ purgative & emetic saline medicine from which he is said to have experienced relief; but the symptoms returned more acutely on the 20th followed ^{on the 22nd} ~~that day~~ by delirium.

Dec- 24th Symptoms on admission. As before noted the patient was delirious when brought into hospital, and could with difficulty be restrained, having got out of bed several times. His pulse was very feeble and surface of body cold. There were several (about a dozen) small ~~cutaneous~~ ^{peripheral} spots of a pink-rose

slightly raised
colour, disappearing on pressure, but returning on its
removal, scattered over ~~the chest and abdomen~~ ^{the chest and abdomen}.

The patient was ordered to have a table-spoonful of
brandy and wine alternately, beef-tea frequently,
and hot bottles to the feet.

Decr 25th The night nurse states that the patient
did not sleep for more than two hours during the
night, being more or less delirious and muttering
aloud. He is very thirsty. Pulse weak. has had
four stools during the last twenty-four hours, liquid
and of dark colour. He has made several attempts
to get out of bed. Brandy, wine and beef-tea
administered at short intervals.

Decr 26th The patient has been very restless and
delirious during the night. Pulse 120 soft and
fable. skin hot. Tongue coated with a dirty
white or grey fur, moist and red at edges. There
has been five or six evacuations since last visit,
liquid and resembling coffee-ground. Urine
murky. Sp. Gr. 1025. Urea Phosphate in supp;
no albumen. Cholesterol normal: slight epistaxis
was also observed.

Decr 27th The patient slept very little all
night, was delirious and noisy. ~~not~~ sleeping

for more than half-an-hour at a time. Pulse 110
small and weak. Chills flushed. Tongue coated
with yellowish fur, but moist, especially at
edges. He has great difficulty in protruding
his tongue; not able to get it ^{out} further than the
lips. Lungs clear, covered with rales - the
latter very dry & parched; has had three
stools, of dark colour and former consistence
than ^{the} last one. Chlorides absent from urine;
no Pneumonia or other morbid condition of res-
piratory system. To have some simple Chalk
mixture.

Triplex. The patient has been very restless all
day, constantly trying to get out of bed. He
has a frightened look; breath has a faint
alarm, breathing hurried and somewhat lab-
~~oured~~oured. Pulse very weak, its frequency
could not be ascertained a consequence of
constant tremor of the arms, the whole body
participating.

Decr 20th The patient was restless, violent,
and delirious during the first part of the night,
after which he became ^{more} quiet, towards morning
drowsy in which condition he remained for
sometimes.

Pulse 140 very feeble; cannot protrude the tongue. There is general tremor over the whole body. The pulse rose to 120 during the day. The patient has been alternately quiet ~~during the~~ and delirious ~~during the day~~ - the delirium showing itself in fits of loud screaming, accompanied with incessant restless agitation, and a wild expression of alarm. Respiration hurried, the breathing still retaining its fetid odour. No aboive evacuation since yesterday; the chalk has discontinued.

~~From~~ Decr 29th (20th to 21st of fever) ^{of fever} The patient has passed a better night; having had two hours consecutive & several half hours sleep, occasionally bursting into loud screams. He has been sweating profusely during the morning; is quite sensible and understands what is said to him. When asked he protrudes his tongue the dorsum of which is covered ^{with} a black coat. The expression is more calm than it has been since admission; breathing not so hurried or laborious, ^{the} breath has lost the fetid odour. Urine of dirty cream colour sp. gr 1025. Urea & Phosphates in excess, with large amount of albumen.

Pulse 140 very feeble; general tremor and submities
of lower extremities. Abdomen tympanitic. He
looks very excited when he awakes, which is
affected by the slightest noise. Towards evening
his pulse became stronger & the paroxysms of beating
returned, and does not appear to recognize anyone
Apr 30th He has passed the most restless night
since admission. There are violent twitchings of
the muscles, with occasional loud screams.
Breathing short & hurried; expirations pro-
longed. Respiration thirty per minute. He
has been vomiting profusely during the night.
Pupils dilated. The patient has not been sensible
since last night. Skin hot; feet cold to which are
applied hot-bottles. Countenance deeply livid.

Teeth covered with mucus; breath fetid. Had
a copper-ground condensed stool early this morning,
since which he has frequently passed feces
in bed; general tremor.

I don't happen to have further notes of this case,
but the patient died in the night of the 30th
or 21st day of the fever. Post-mortem examination
revealed extensive ulceration of the ~~small~~ ileum.
No other lesion worthy of note.

Commentary

Regarding this case little need be said here, the accompanying notes fully testify its nature. It is typical, so to speak, of a severe form of enteric fever running its course unabated and without intermission, gradually developing itself into symptoms of a more formidable nature as it advanced. It was one from the beginning (at least from admission) from which little ~~could~~^{was to} be hoped, but a great deal to be feared, the special symptoms presenting character of evil augury, especially the delirium, which not only made its appearance early - an unusual phenomenon ~~in mild cases of enteric fever~~^{in typhoid of favourable type} - but showed itself in fits of loud screaming, unaccompanied with incoherent utterings of agitation, and a wild expression of alarm. This continued till the last day, when the patient became quiet from apparent exhaustion in which condition he sunk. As a confirmatory proof of the distinctive character of this case I may mention the presence of an eruption of small circular spots of the usual pink-rose colour, disappearing on pressure &c

Case IV Typhoid Fever

William Cleverhuc At 25 Policeman at Portobello
Admitted on the 14th December 1864.

He states that whilst on duty on Sunday night
the 12th Dec^r he experienced a severe rigor
followed by heat of skin, perspiration, headache
there-~~to~~ in consequence of which he returned
home took a dose of Castor oil & went to bed.
During the night and morning he was purged
four times, but did not feel relieved, not-
withstanding which he ventured on duty
in the afternoon, from which, however, he had
down to return. He was then seen by a med-
ical man, who gave him a powder which
acted three times on his bowels, though he
(the medical man) had been told the result
of the castor oil. The next day he remained in
bed, and received two powders from his
medical attendant; they did not purge him,
but he was seized with vomiting. On the
following day, (Dec^r 17th) being the fourth
of his illness, as he was no better he was then
sent to the Infirmary by the Inspector, where he
presented the following symptoms:—

Face flushed; languid expression; headache,
lips dry; very thirsty; nausea and vomiting
after eating; bad taste in mouth; tongue furred
in center, moist; no appetite; skin hot and dry,
somewhat pungent; no eruption; bowels not
opened to day, no tenderness over abdomen.

Urine sp. gr 1030, chloride deficient, contains
albumen. Pulse 103 full and strong; some
subcostal and umbilical tenderness over ~~right~~^{left} chest;
respirations 20, no cough, no expectoration;
ordered a saline mixture.

Decr 18th (5th day of fever) - Nurse states that
the patient slept ~~very~~ little during the night.
Complained much of pain in head; but was
quite sensible. Pulse 101 not so full as yester-
day. Tongue much furred, moist; no nausea
or vomiting; slight bronchitis, but no tender-
ness. no stools since admission. Skin hot and
dry, no eruption; feeds milk, but tea over.

Decr 19th 6th of illness: Slept better than the
night before, no delirium. Pulse 110 of fair
strength. Tongue covered with a yellowish film
on dorsum; tip and dorsum dry, edges moist,
pink throat; passed one solid stool today.

slight purpling, but no tenderness over abdomen;
skin hot and dry; no spots; murmur sales
heard over left chest, with occasional
vibrations. The patient is very listless and
dull, always lying on her back. Her face
has a very characteristic aspect - malar flush &c.
Dec: 20th 7th day of fever. Patient was very quiet
during the night, but did not sleep much, was
muttering a good deal. Pulse 116. Tongue coated
with ~~brownish~~ ^{brownish} fur over dorsum; dry, scab at
edges where she still moists. She continues
hot and dry, no eruption. There has been two
liquid, cherry-colored stools; no purging nor
typhoid condition; no tenderness on pressure
over abdomen. She lies in a semi-unconscious
state; answers questions very vaguely. Hair to
be cut & cold applied to the head. (Eruption was observed
to day)
Dec: 21st 8th day of fever. Did not sleep during
the night; was very restless, and persisted in
getting out of bed. Pulse 110. Tongue dry and
furred; teeth covered with scales; bad odor
from mouth; has had four liquid stools of
"pea-soup" color; pain in right iliac region,
manifested by wincing on pressure, passed

urine involuntarily in bed. Skin hot and dry; nine or ten well-marked rose-colored spots have appeared over abdomen & chest, distinctly disappearing on pressure. Patient lies, at all times, in a semi-unconscious state and appears much depressed; subcutaneous tenderness was observed today, no further eruptions.

Dec 22nd of the Day of illness. Patient ~~was quiet~~ ~~during the night~~, ~~but~~ made several attempts to get out of bed during the night, but was otherwise quiet; slight delirium. Pale & weak; slight eruptions. Tongue covered with blackish-brown coat, curving apparently for the back part of roots; cannot protrude it further than ^{the} teeth. Teeth and gums encrusted with scales; passed four liquid, pea-soup coloured stools; well-marked pain on pressure in right iliac region. Urine contains a dense precipitate of urates, ^{with} a trace of albumen. Skin hot and dry, spots as before. Patient is stupor and depressed; very evident subcutaneous tenderness. To have in addition to his usual diet, which consists

of milk, beef tea &c, the owner of mine
Decr 23rd (10th Day) - Nurse states that the
patient was more delirious during the
night than on any previous occasion, and
attempted to get out of bed several times.
This morning he appears ^{very much} depressed, and mut-
ters continually. Pulse 110; no cough, no chest
symptoms; profuse epistaxis last night and
this morning; five stools since last visit, liquid,
and of same colour as before - "pea soup"; Pain
in iliac region continues. Tongue - which is
better protruded to day - dry, fissured, and
covered with dories. Urine abundant - precep-
itate of urates, trace of albumen. Takes a
table spoonful of Wine every two-hours;

Decr 24th (11th Day) Passed a better night -
Pulse 105; no liquid, pea-soup stools, pain
in femur; abdomen tympanitic. Tongue, dry,
fissured covered with dories. Urine passed
in bed, headaches ~~disappeared~~ better; spots
fading

Decr 25th (12th Day) Was delirious and attempt-
ed to get out of bed during the night. Pulse
104; epistaxis diminished; four liquid, light colored

stools. Tongue, ^{firm} dry, and hard in centre, moist at
edges; is able to protrude it. Urine clear, acid,
no sediment, trace of albumen. Ordered an
astringent mixture

Decr 26th (13th day) Was less delirious during
the night; ~~had~~ has had seven liquid, light-
coloured stools since last visit; pain on pressure
continues, the astringent mixture has been taken
every four hours. Skin not so dry; some more spots
have appeared over the shoulders, in other respects
he came as last report.

Decr 27th (14th day) Nurse states that
the patient has had a good night, sleeping
for several hours and had to be aroused to
take food. Pulse 90 of notable strength; ex-
tremities re-appeared. Tongue dry in centre, moist
about tip and edges, a ^{ridge} ~~ridge~~ of brown fur
along the dorsum; has passed six stools of
same character as before - liquid, fecal except
(the astringent mixture has been continued)
Urine, clear; no sediment, Chlorides abundant,
no albumen. Skin not so hot, moist. The
patient looks much more lively to day, and
answers questions readily and correctly.

Decr 28th. 15th Day afternoon. Passed a good night, only waking twice and on such occasions he was quite sensible. This morning he re-joins himself much better & ~~to~~ ^{at} which his appearance testifies. Pulse 90 good strength. Tongue moist, the brown-ridge in centre quickly disappearing, 3 stools less liquid. There is cough and expectoration to day; mucous rales are heard over right chest ^{hyperaerated} with occasional wheezings. In other respects as before.

Dec 29th 16th day of Nov. Patient says he is much better, and slept well during the night. Pulse 82 good strength. Tongue moist & ligand, but dark-coloured stools. Urine mostly ~~and~~ with a deposit of Mucous half an inch thick. Chlores abundant, during the evening of this day the Patient perspired freely which continued more or less all night. This was the first time profuse sweating took place. On the following day he had only one stool of normal consistence, which continued to be the case for the next two or three days, after which he became somewhat constipated; though the strongest injections had been discontinued some time.

Commentary.

This was a mild and uncomplicated case, the symptoms continuing without marked variation till towards the middle of the third week, when a gradual abatement of the more prominent symptoms took place, especially of the deafness; but it was not till the twenty-first day that a well-marked cure was effected. Though but of moderate severity it was not the less characteristic. All the symptoms were remarkably uniform, and ^{complete} in keeping with the nature of the case. The delirium was transient, indicated only by confusion and incoherent answers when the patient awoke. ~~This~~ The physiognomy too, was particularly striking, forming a key to ^{the} whole case. Anyone who saw the patient as he lay in bed could but come to ^{the} one conclusion as ~~to what he was suffering from~~ to the nature of the case - an expression of countenance that spoke for itself, and too plain to require any special description here.

Additional remarks.

The "Non-Identity" of Typhus & Typhoid Fever is now so well ascertained and so universally acknowledged, that it would almost demand an apology to make any observations regarding it, or to say the least, require very strong reasons to warrant such a procedure. Notwithstanding which, however, attempts have been made from time to time to disprove the correctness of that doctrine - the doctrine of non-identity, which, in common with all other new-doctrines that ever have been, ~~and~~ I dare say ^{that} even will be, brought forward, it has ^{like} shared the fate of - a very plausible one no doubt, in order to obtain precision, and to ^{be able to} discard vague hypotheses and vain speculations - a desideratum not the least to be valued in medicine, especially in these days of theorizing. On that account alone, the doubts originally entertained respecting the non-identity of these two forms of fever can not only be readily understood, but were absolutely justifiable - if not to be commended, as the ~~only~~ best, if not the only means, by which any new theory can ever become when thoroughly investigated -

- having been examined and found correct - an established and indisputable fact. Though originally reasonable for that very reason, at the present time however it is difficult, if not impossible to conceive how, after having stood the combined tests of investigation, description and experience - and what can be more severe, after this, I say it is difficult to understand, how any doubt can exist in the mind of any one, who is ⁱⁿ the slightest degree acquainted with their respective phenomena, as to their true nature. To say, then, that these two totally different forms of fever are "identical", amounts in my opinion to little short of absolute nonsense. At the same time for one in my position to undertake to prove their non-identity would be alike unprofitable and unwearied, seeing how much has been said and written on the subject; and that too, by men pre-eminently fitted to settle the question, not only from the ample opportunities afforded them of thoroughly investigating the subject; but from the fact that they are well distinguished from the laboriousness of their research than the soundness of their judgment; and I may ^{add} justly the universally acknowledged

accuracy of their conclusions in medical topics
in general and in fever in particular. Need
I mention the names of Jenner, Bland, Marchesini,
and a host of others equally distinguished, but
too numerous to ~~mention~~ detail. What the original
famous descriptions of Dr Jenner failed to
convey and convince, the recent elaborate inves-
tigations of Dr Marchesini have so fully
corroborated, as not to leave the shadow
of a doubt, regarding their exactitude and
correctness. And were I to cite my own neces-
sarily limited experience it would be but con-
firmation of the same conclusion; but it would
serve no good purpose & merely to recapitulate
here, the respective phenomena of these two fevers;
hence I refrain - though with some diffculty I
must acknowledge - from saying anything that
would unnecessarily prolong the scope of
this paper, ^{thence} ~~there~~ nothing could be surer than to
write sufficient on this head ~~alone~~ ^{for the production} ~~to make~~
of voluminous treatise. I may mention, however, what
I think serves as a diagnostic of no small im-
portance in fever, that is, the physiognomy. I have
been in the habit for a long time of remarking the

the fever wards in the Infirmary, and then went
saw such places as fever cases were to be found;
in order to discriminate their nature by the char-
acters presented by the Physiognomy. The result of
which has been, that there not been a case in the
fever ward, during the present seasonal period,
but what there been errors in my diagnosis,
as pronounced to a second person, who I had
asked to accompany me for the purpose. This
statement may seem both presumptuous and doubt-
ful: but it is no less true, in proof of which
I could ^{readily} adduce ^{trustworthy} evidence were it necessary.

If then, one who has seen so little of fever
as there - ~~and~~ as much probably as any one
under similar circumstances, but which cannot
be extensive - (besides which, however, I have seen
a great number of cases, during an apprenticeship
of three or four years, with a practitioner who
had under his care about 8,000 ^{offspring} colliers, ^{families} ~~families~~
about 2,000 ~~immense~~ ^{immense} miners, & their families,
as well as an extensive private practice, a
work-house, & several clubs, keeping in my time
three apprentices, a qualified sextant, and
himself going, with as much as we could do, -

and during one year of which an epidemic of Typhoid prevailed amongst the colliers, with an occasional case of Typhus, between which I believe we never had any difficulty in discriminating.) If then, one who has seen so comparatively little of fevers as I have - a mere tyro as to speak, can distinguish one from the other by simply looking at the patient, the wonder is, not that there should be any doubt about their non-identity at the present time, but that their distinctive characters were not recognised long ere the days of Jenner - that is, the D Jenner of our own day, as Dr Watson facetiously remarks.

I can readily understand the occasional occurrence of an anomalous case. In this, as in all other diseases there must be well-marked exceptions; but that in this particular instance they are rare I have no doubt, inasmuch as I have never one; and that it is possible in a great majority of cases to pronounce correctly the type of fever from the patient's appearance I have just as little doubt, quite irrespective of the ^{more ordinary and} unequivocal symptoms.

peculiar to each characteristic of each, which are so familiar to everyone, that it would be, as I before observed, useless simply to enumerate them, more especially as there nothing to add to the list already so lengthy; so much so, indeed, that Dr Marchand has given them in a tabular form, is the readiest means of perceiving them at a glance - so distinct does he consider them.

Dr Guirauder (Clinical Medicine page 143) in speaking of an anomalous case of enteric fever, that came under his observation, which he considered unique within his own experience, but yet not so far removed (he goes on to say) from precedents as to be without an important bearing on the general study of this disease, in its relations to other fevers and disorders of the nervous system. For in this part (he remarks) of the symptomatology of typhus and enteric fevers, as in others, Compté that states "very different in reality have ^{been} confounded under common names," and a misleading notion of identity. ~~has~~ then well-obvious - To a carefully-observant eye, the restlessness, agitated, often tremulous sometimes violent, always inquiet delirium of the

second week of typhus, passing gradually over into coma or even convulsions, and accompanied throughout by suppressed eyes and a contracted pupil, resembles few other states within a medical man's experience, unless it be some combination of opium and alcoholic poisoning, in cases of febrile delirium tremens; while, on the other hand, the much later developed, and less typical, delirium of enteric fever (even when delirium is present at all, which, in my experience, is comparatively seldom) is apt to be associated with a condition of the consciousness widely different, and marked by an entirely different state of the physiognomy and the pupil."

My only apology for citing this somewhat lengthy quotation is in account of its extreme accuracy, particularly as regards typhus with which I entirely agree. There are some points, however, in respect to the delirium of typhoid which I think not to be quite so correct, and more especially as regards its frequency. For my own part I think delirium is as frequent in me as the other; that is, when they are of corresponding severity. I prefer

I would go further, and say that instead of being "comparatively seldom present" it is "comparatively seldom absent"; though in the mild cases not ^{so} very well marked, being transient, and indicated only by confusion and incoherent answers, ^{and may not be noticed only} ~~or~~ when the patient awakes. This form of delirium, which indicates a mild type of fever, and seldom of even ~~the changes~~ attended with danger, well I think rarely be found wanting. In typhus, however, it is always, as Dr. Guindon observes, more typical and when present at all is well-marked and could not possibly be overlooked, more especially as it is persistent when once developed, continuing throughout the day, and ~~scarcely~~ becoming exaggerated towards night and early morning. Whereas that which accompanies the milder forms of typhoid may be almost if not entirely absent during the day, leaving nothing in the appearance of the patient that would lead an observer to suppose that delirium existed, saying, it may be slight drowsiness or vague unrest. It happens

however, towards evening or when the patient awakes in the morning, because Long remarks the sleep of these patients is not much disturbed throughout the night. Of course, these remarks apply only to mild cases. In the severer forms the delirium ~~is~~ is as typical as it is in Typhus; and in the severest forms nothing can be more so; as for instance Case III of the present series. This case from the noisy character of the delirium was supposed to be one of Typhus, until the post-mortem examination revealed the true state of affairs - extensive ulceration of the ileum. Why it should have been so considered in the face of all facts, or even negative evidence even at a loss to understand; as there was not only the distinctive rose-coloured spots and equally characteristic diarrhoea, but the character of the delirium, though furious, was totally different from that which occasionally, though rarely accompanies Typhus, (Typhomania) seeing that in nine out of ten cases Typhus cases it is of the low, muttering kind. Then com-

commenting on the case I then described its
character, and that in the words of Dr
Traudie, (which I forgot to acknowledge)
who so happily and correctly expresses it
in speaking of the different character of
the delirium in certain fever, he says: "In
others, the delirium shows itself in fits of
loud screaming, accompanied with incessant
restless agitation, and a wild expression of
alarm - a form of delirium of dangerous
omen, especially if it appear early." This
was precisely the condition in the case alluded
to, and I have seen ~~another~~ ^{an} exactly parallel
case ^(in another part of the house) since. A young, ~~robust~~ robust man,
was admitted with delirium of this kind,
which gradually became ^{worse} and died in three
or four days. On examination extensive ul-
cerations were found to exist, but with-
out perforation, as one might be ^{likely} to
suspect from the suddenness of the death.
But I believe it rarely happens that per-
foration ^{occurs} ~~exists~~ in these rapidly fatal cases.
It seems rather to be owing to a large dose
of the poison, which speedily proves too

The nature
of this case
was perfectly
understood
from the
first,
the p. m.
only serving
to corroborate
the diagnosis
which which
this was
never any
doubt and
but one opin-
ion - and
not as

in the former case, to excite surprise that such should
be the case, which in ~~lack~~ of an exam. would have been put down - even

as a typical case of Typhus, at least so
it was said & hence the supposed im-
possibility of distinguishing one from the
others.

much for the patient. No doubt there are just the sort of cases in which perforation would be in all likelihood take place did they but survive long enough to be compatible with that process. To discuss these points however, would lead me too far, and would serve no good purpose for the object in view.

Independent, then, of all the more evident and unmistakable symptoms, such as the "character of the delirium, the condition of the bowels, the appearance of the eruption, the state of the pupils &c &c" - independent of these unequivocal and unequivocal, incontrovertible symptoms the practical eye, or as Dr. Wilson ^{has} ~~says~~ it, "the carefully observant eye" - because I hold that that is all that is necessary - will seldom, if ever be at ~~at~~ a loss to distinguish ~~the one~~ from the other by simple inspection. Of course, he must know for these purposes that a given case is either one of Typhus or Typhoid.

Then again, the origin of these two fevers is totally different; which alone, if not

sufficient in the first instance - before
their distinctive characters were clearly as-
certained - might now that we know the
difference, be not only highly confirmatory,
but amount to absolute and indisputable
proof. No one would think of saying
that "remittent and intermittent" fevers
were identical - no more than they would
that "purpura and scarlatina" were - in
yet even varieties of the same type, though
they undoubtedly bear ^{much} greater resemblance to
each other than typhus and enteric do, especially
in their exaggerated conditions. Moreover they
(the inter: and remittent) arise from similar
causes, which ~~are~~ itself would be some plea
for saying they were, if not identical,
at least belonging to a common type, yet such is
not the case - no such doctrine being held
that I am aware of. Again take the
familiar example of purpura and scar-
latina, as above casually alluded to. These
two diseases in certain stages are exceedingly
like each other - infinitely more so than typhus & typhoid even are
+ and were one to depend ~~on~~
on symptoms and appearances alone, they would

sometimes be considerable difficulty in discriminating between them. In these diseases we have seldom anything else to guide us in the formation of our diagnosis but their respective causes, and when they bear a great resemblance to each other, as they sometimes do, we have nothing else to rely upon. Of course purpura is rather prevented by, or cured with constitutional remedies; but in this not much reliance can be placed, especially in the fresh instance, as it often remains to be feared, and their terminations speak for themselves.

If then, in these diseases confessedly different - we are compelled to resort to their causes, on which to found our diagnosis, should not the same apply to ~~fever here the~~ ^{under consideration} the different forms of fever, even did they resemble each other more than they do. As it is they have little or nothing in common, and certainly nothing whatever to lead to the idea of their being identical.

Case v

Pleur-Pneumonia

Lauchlan Shorthouse Et 23 Forbman
Admitted December 7th 1862

The patient, who has always enjoyed good health, states that he experienced a rigor on Thursday evening 10th followed by a stitch in the side with general febrile symptoms.

Symptoms on admission. Expansion of chest equal on both sides. Respiration thirty per minute. Patient lies on his back with inclination to right side. Complaints of sharp cutting pain in left side over folio-rib, increased on deep inspiration; frequent short ^{dry} cough. On Percussion there is a patch of comparative dulness over right infra-axillary region; elsewhere normal. On auscultation purile respiration over left front; harsh over right-infra-axillary region; double friction of grating character audible over infra-axillary region, extending round to infra-mammary. Patently occasional sublent and sinuous crackles over upper right third, with fine crepitation over lower two-thirds. On left side ^{patently} ^{an} occasional murmur-like with inspiration over middle third, and fine crepitation over lower third. There is increase

of vocal resonance over right infra-orbital
region, extending, but not so marked, over lower
half of right chest posteriorly. In neither pos-
ition is it either distinctly Bronchophonic or Eg-
phonic. Pulse 100 full. Skin hot and ^{moist} dry. Tongue
covered by a dirty white fur; no appetite; very
thirsty; has been freely purged by medicine
previous to admission; no stool since. Urine
normal, as also in other respects: Ordered
continued Loline.

June 8th Pulse 108. Urine loaded with a
brick-dust sediment; purifying freely: pain
in side less intense. In other respects same as
yesterday: ordered Loline with nitro ether; wine
prep. two or

June 9th Patient lies on his back; says he is
quite well; has been delirious during the night
shouting aloud, and persisting in getting out of bed
which he managed to do in the nurse's absence.
Fistula about. Pulse 120 slightly jerky. Tongue
clean. Cough less troublesome, no expectoration
Nas. hot; bowels opened three times since last
visit. Urine muddy, with ^{only} sediment. Chlorides
diminished: no albumen.

Decr 10th The patient has been very restless during the night, and delirious shouting aloud. This morning he has made several attempts to get out of bed in which he persists. Percussion notes ~~detected~~ decidedly dull over lower two-thirds of right lung posteriorly, and over a small patch at base in the left side - lower third. Over the area of dullness the respiration is of a tubular character, and of metallic quality, above which it is harsh and puerile especially on the right side. On the left there is occasional crepitation at the end of inspiration; nothing remarkable continually except exaggerated respiration on right-side which is of harsh quality. Bronchophony heard over whole back of dullness; resonance showing normal. Pulse 120 full & good strength; face flushed; ^{and anxious} tongue dry & furred in centre, edges moist; skin hot and moist. Respiration 26. Colour of urine of a brick dark colour; chlorides deficient. No expectoration.

Decr 12th Patient has had a better night, and looks ~~both~~ more complacent this morning. Dulness & bronchophony greatly diminished.

Final crepitation is now audible over whole ~~area~~ of late dulness. Pulse 70. Skin moist, has been sweating profusely during the morning's height; tongue cleansing; moist. Appetite returning. Chloride present in Urine in fair amount. From this date the patient gradually got better. Convalescence was ~~rapid~~ ^{rapid} and ~~uninterrupted~~ ^{uninterrupted}. The patient leaving the hospital quite well in about 12 or 14 days. Commentary.

This was a severe case of double-pneumonia, with limited pleurisy of the right side, which, however ~~disappeared~~ ^{terminating} by a crisis two days after admission. The abundant deposit of water, ~~and~~ ^{with} profuse sweating occurring simultaneously with the disappearance of the friction leave not a doubt as to its dissolution. The friction sound, which was distinctly audible for two days after admission, did not return; so that it is not likely it ever proceeded to effusion; yet there is no doubt there must have been pleuritic exudation, as the ~~sound~~ friction was not only very loud and double, but was of a distinct rubbing or grating character, and such as could scarcely be produced by a mere dryness of the parts concerned; though

The shortness of its duration might lead to that conclusion. Notwithstanding the speedy termination of the Pleurisy, there was ^{no} ~~no~~ ^{no} abatement of the Pneumonia. On the contrary, just as one had attained its ~~climax~~ ^{crisis}, the other had reached its climax - the condition of hepatization, is confirmed by physical signs. In fact, there is no doubt, but that it was for the Pleurisy, the patient sought admission, as the physical phenomena indicative of Pneumonia were extremely doubtful when first examined. It was a disputed question whether there was crepitation present or not, as the only indication of its presence was a very fine sound ~~at the~~ heard over base of right lung at the end of a deep inspiration, but so fine, and so peculiar as to lead me to express my opinion, as examining pupil, that it was the characteristic crepitation of the exudation stage of Pneumonia which the sequel of ^{the} case fully confirmed. The case was a severe one. The amount of lung ^{tissue} involved ~~was~~ ^{became} extensive, giving rise to symptoms of a very dangerous character, so much so, indeed, that the patient's life was despaired of.

The delirium, and greatly protracted pulse-respiration rates, were both signs of unfavourable augury, the latter was just what we ~~expected~~ should expect from such extensive evulsion. The delirium too, was of anything but a favourable character. The patient affirming when rational that he was quite well &c, which in conjunction with the dingy countenance and livid lips, indicated the disturbed circulation and its proximate effects on the brain. These bad signs soon passed off, and the patient made a good & rapid recovery. The treatment consisted of the "supporting system" by which I mean a free allowance of ~~nutrient~~ nutritious diet - milk, beef-tea &c, and alcoholic stimulants, in this case wine, ~~which should also be considered~~ in quantity according to circumstances, which should also be considered as nutriment, and need not be particularly specified as stimulant, the former being the object desired, and by giving it in small, and frequent doses, is undoubtedly attained.

Case 27 Double Pneumonia

James Potter At 47 Quarryman

Resides at Puthes. Admitted Dec 19/64

History: The patient, who is a strong robust man of not the most temperate ^{habits} status that whilst working in a tunnel on Wednesday the 17th Ult. being wet and cold at the time and exposed to a great draught, he was suddenly seized with a severe cough about 3 p.m. which continued for some time. He was preceded by headache, and followed by general febrile symptoms, in consequence of which he returned home at 5 p.m. After going to bed, taking powder for his symptoms became increased; and a medical man was called in at 7 p.m. who bled him ^{from the arm} to the extent of 18 or 20 ounces. From this he experienced ^{'marked'} relief. During the night, however, and especially towards early morn, the symptoms returned to an exaggerated degree. He was got a sweating powder? and some effervescent salts; but ^{in consequence of being} ~~finally~~ no better next day, he was sent into the hospital.

The patient also states, he has had three attacks of a like nature on former occasions.

The first occurring eight years ago, the second
six years, and the third as late as last
February, on which occasion eight leeches were
applied; his illness extending over ten weeks.
Symptoms on Admission: 48 hours after regim.
The patient, who is exceedingly weak and ex-
hausted, breathes when lying quietly with com-
parative ease; but on the slightest exertion, such
as rising to the sitting posture in bed, the dys-
pnea becomes exceedingly urgent. Cough frequent,
with profuse expectoration; very viscid and of
an olive-green colour; catching pain on right
infra-mammary space on deep inspiration;
no friction sound audible. On ~~auscultation~~
Percussion anteriorly there is slight comparative
dullness over right side extending from the
second to the fifth rib: left side normal.
Auscultation reveals over right side minute
crepitation to the extent of the lower two thirds,
especially well marked over mammary
space; over upper third respiration exaggerated
and harsh. On left side, respiration exaggerated,
but of natural breezy quality. Vocal resonance ^{increased} ~~normal~~.
Posteriorly; percussion note is also slightly altered

on right side - not quite so clear; but dulness
scarcely perceptible; fine crepitation over
nearly the whole right ~~side~~ chest. On left
side there is some fine crepitation at - very
showing normal exp. excepting pericardial ex-

piration. Pulse 106 soft, not small, & of fair
strength. Tongue furrowed in center, moist;
has been purged twice since admission by me-
dicine received before he came in. Stool soft,
and dry. Urine orange colour, Chlorides present,
but not abundant; large amount of albumen.

Dec^r 20th. 4th day of illness. Patient slept at intervals
during the night, was otherwise quiet, receiving beef
tea twice every two hours. Pulse 100 Respirations
38. Physical signs same as yesterday, saving
that tubular breathing is now audible over a
limited space of right back - a few inches in
the vicinity of ~~the~~ inferior angle of right
scapula. Bronchophony audible over same
site. In other respects his condition is similar
to that of last report. Ordered an Antimonial
Saline

21st Dec^r 5th day of illness. Nurse says the patient
has been very restless during the night, & slept

very little, being frequently disturbed, as if
suddenly wakened up by apprehensive dreams.
He is very exhausted, so much so, that it was
deemed inadvisable to examine his chest
thoroughly. Anteriorly there is ~~some~~ dulness
a few centimeters over whole of right side, es-
pecially marked over lower half, also tub-
ular breathing, ~~and~~ but not very distinct or
extensive. Respirations 14-2 Pulse 90 ~~irregular~~
slightly irregular & jerking. Lips dry; very thirsty.
Tongue coated with brown fur over dorsum,
dry & cracked in center, moist and red at
edges; no appetite; gets beef tea, iron and
mixture. Skin hot & moist. Chlorides scanty.
22nd Dec^r 11th day of illness. Patient has passed
a better night. Auscultation anteriorly similar
to last report. Posteriorly there is tubular
breathing, with bronchophony over lower
two-thirds of right side, harsh & exaggerated
at apex. On left side also there is a patch
of dulness below the scapula, over which
tubular & bronchophony are audible. There
is an occasional musical rale with inspiration
over some parts of same lung.

Cough very troublesome; expectoration very tedious & difficult, of the color of green-pige juice. Respirations 40. Pulse 80 weak & irregular. Tongue furred in center, throat in center at edges; in very throat; no appetite. Skin hot but moist. Chlorides still scanty in urine, albumen present. The patient is exceedingly weak & exhausted, the slightest exertion rendering him almost breathless; during fits of coughing he seems as if he would sink in the attempt to ~~expectorate~~ ^{expectorate}, though when lying quietly and undisturbed he breathes with comparative ease, saving the quickness & shortness of the respirations. 13th Dec^r 7th day of illness. Patient passed a better night & expressed himself better this morning, to which his appearance testifies. In other respects there is little difference.

14th Dec^r 8th day of illness. Passed a much better night than on any previous occasion; was much relieved during the greater part of the night, would have slept continuously were he not disturbed to take food.

Over the area of dulness (which is not so resistant & wooden in quality) the tubular breathing is much

less sharp and metallic in quality, not so in
time, more of a simple diffused blowing type,
approaching to more harsh respiration. The bron-
chophony, too, is losing its ruffling quality.
And so the case goes on improving.

Discharged on the 26th of January on the
41st day of illness. There was some con-
densation of right apex remaining when he left
the house.

Circulation was extremely tardy.

Commentary.

It will be observed that this was
also a very critical case, and was certainly
not expected to survive the attack. The exhaustion
at one period was of the last degree. It seemed
as much as his life was worth to ^{try to} raise him up
in bed, even when gently raised, and most care-
fully supported. Notwithstanding the desolating
signs of the Pneumonia at an early period, yet
he could not be pronounced moribund before
the 12th of January on 23rd day of illness - so
poor was the prognosis that it was feared
he might suddenly sink at any moment.

Additional Remarks.

The proposition is now so unanimous in regard to the Pathology and Treatment of inflammation generally that there is scarcely any discrepancy of opinion at present worthy of remark. The vague expressions of "pain, heat, redness, tenderness, swelling; and the so-called and once much-lauded antiphlogistic treatment are now happily events of the past. ~~They~~ ^{And} will find a fitting place in the ^{past} history of medicine amongst many other crude doctrines of a like nature which have not stood the test of scientific investigation. This is especially true of the particular kind of inflammation now under consideration. There are some, indeed, who still adhere most strenuously to the old routine practice in regard to inflammation of other organs, but who readily admit that it is not the proper treatment for Pneumonia. Why this should be so it is difficult to comprehend. What we understand by the "term inflammation" in its modern and correct sense is the same whatever structure it may affect; and a priori requires

this same treatment. Not that any system
should be followed ^{as a} ~~in~~ routine; but ^{upon} ~~in~~ ^{the} ~~the~~
principle modified according to collateral
circumstances. And one would think, looking
at the organ involved, that pneumonia is
the very disease ^{above all others} ~~where~~ who treat some in-
flammations by the lowering, and others by the
supporting system, ~~they~~ ^{would} ~~should~~ endeavour
to "cut short", as they are pleased to term it,
instead of the reverse; for in pneumonia
the severity of the symptoms ^{may immediately} ~~presently~~
depend on the extent of the disease and
could we but cut it short at the onset, or
in any way retard its progress by ~~the~~ ^{the}
remedies at our command a great and
brilliant stride would be made in the
advance of medical science; ~~but~~ unfortunately
this much to be desired end cannot be
accomplished; and from the very nature
of things is never likely to be.

The supporter of this paradoxical system,
as I would call it, will tell you, that though
it is not right to cut short a pneumonia,
yet it is the proper ^{line of} procedure in ~~it regard to~~ ^{regard to}

inflammation of many other tissues, as for
instance that of the peritoneum. To this I
would reply, "What is success for the joint
is success for the peritoneum", - a homely, but appli-
cable phrase. Moreover instead of being
favourable to the joint at issue it is just
the reverse. In the case of peritonitis a few
minutes more or less of coagulation is not so
immediately important as when it occurs
in the lung, where, as I have observed, the
mortality is as a rule in direct ratio
to the extent of structure involved
to the ~~unavoidable~~ end not as in the former
case, where it more depends upon ^{integrity of the system} the degree of the
consequently not that urgent necessity
for its prevention. The theme, however,
certainly merits enquiry; ^{as it is now} ~~and it is now~~ is now
generally admitted to be plainly erroneous;
and my own conviction is that whatever
turns the inflammatory process affects
it cannot be cut short; and that Opium
has no more power in retarding the progress
of a peritonitis, or meningitis as a microbial
or causing its absorption, especially in the
acute and inflammatory stage in which
it is present

It is proven (because it does become absorbed
or assimilated, that is no reason
for alleging the power to the effects of
the drug, seeing that it is a natural one
and goes on independent of artificial
means) than continuing here in fermenting
or retarding the advance of "bronchitis" or
a pneumonia, which it assuredly has none.

Now have I a better opinion of their
great skepticism of some authorities, viz
~~Dr. H. H. H.~~ ^{Dr. H. H. H.}, is with intention of "cutting short".
May it be from bad to worse, of which
case of the accompanying series affords
an admirable example. Not that I draw
any inference from a solitary case, but from
the theory it (the bleeding) involves.

Allow me briefly to recapitulate this case, by
way of illustration: A strong, healthy man
^{truly healthy} is taken ill whilst at work, has a rigor, goes
home, takes some food, feels no better; sends
for a medical man, who sees him about
three hours after the seizure. Finds it Pneumonia,
(I say pneumonia, because at that ^{early period of the disease} ~~time~~ there
could scarcely be any general symptoms

or physical signs developed in which he could positively rely; more especially as the practitioner happened to be a very old man in the country, and consequently, not likely "to be off" in his physical diagnosis; but from the man's history, seeing he had had two previous attacks, therefore he ~~had~~ suspected what was coming, and acting upon ^{this} he adopts the old adage - as well as the old fracture - of "prevention being better than cure" - bleeds him copiously, (to twenty ounces) purges him freely, gives him antimony - in emetic doses at first, ~~and~~ keeps him quiet, and lastly, but not least (in his opinion I should think) enforces low diet.

A case better calculated than this to prove the utility or inutility of the antiphlogistic treatment we can scarcely imagine, not only from its nature, but more especially from the period at which the treatment was put into force. Rarely does it happen, and seldom of even in hospital fractures, that cases

came under observation in such an early
stage as this. Well let us see what was
the ~~present~~ result of this favorable case.
On the second or third day the Doctor found
that his patient instead being radically
cured or in any way improved, is actually
much worse. He now sends him into the
Infirmary (by train at the risk of his life) where
we find him in a dreadfully exhausted
condition, ^{and} though he appeared to breathe
with comparative ease when undisturbed, yet
when roused ^{the purpose of being examined} for ~~examination~~ the respiration
became so hurried, and the indications
of exhaustion so extreme, that the attempt
seemed as much as his life was worth
- though most cautiously supported.
He lay on his back, apparently powerless,
looking more like a case of severe typhus
than anything else ^(as regards position), from the extreme
prostration, never moving in any direction
- though perfectly internal. No one - not
even Dr Bennett - had the slightest hopes
of his recovery. In this, however, we were
pleasantly disappointed. With the aid

of stimulants, - and plenty of them, he rallied and recovered, though his convalescence was a tardy one.

Here, then, is a case in point which forms to all intents and purposes the perfect exemplification of the one system - you were there, and the thorough efficiency of the other, to which the patient must undoubtedly owe his life. It will be observed, too, that the case was as unfavourable for the latter treatment, as it was favourable to the former; and had this man died it would have been no proof of inefficiency of the treatment pursued. As it was, however, it actually brought him out of the jaws of death.

This, though the ~~fore~~ greatest, is by no means the only advantage accruing from this system. It is no uncommon ~~very~~ occurrence for patients convalescent from Pneumonia to have incipient softening of the apices, or more correctly the apex, for it is the right ^{apex} ~~apex~~ ^{which} is most frequently affected in these cases, as it is the right base in Pneumonia. Such in fact as the condensation

terminates in one and it commences in the other,
(that is the induration which often intervenes
between the ^{walls of the} ~~the~~ chest and the tuberculous matter
in this early stage, and gives ^{rise} to the physical
phenomenon of increased vocal resonance, which
with ~~slight~~ ^{slight} dulness on percussion, and may be
a little harshness of the respiration, especially
the expiration which is also unduly prolonged,
— are the only indications of its presence)

Now, so far as my observation goes — and
it has not been very limited on this point —
I have no hesitation in saying that it (the
tubercle) is a much more frequent sequelae
in these cases, ~~which~~ ^{though} have been treated
antiphlogistically than in those which have
been fortunate enough to get plenty of
expectoration and bronchus from the first;
or that stimulant as the cure might
recipitate. And much frequent of all
is those who have been largely bled.
If we can rely upon the statements of
old authors, who talk so much about
"consumption following inflammation of
the chest" — a term vague enough to
mean ~~any~~ of which Dr. Walshe thinks little or no chance can
be made; unless there be an accompanying ~~stage~~ dry or humid
coughing. (Wils.)

to mean anything; But in these days they had no means of ascertaining the precise state of affairs, at least they knew not how to apply them.

I may mention that the man, whom we have just related, went out with considerable understanding of the right apoc. No doubt it seldom occurs but in those who have a phthisical tendency, though there may have been traces of tubercle previous to the pneumonic attack, which served it as it were to ~~excite it~~ ^{arise & bring its dominancy}. This man, however, was an exception (if the statement can be considered a general rule) as he was of a highly arthritic diathesis.

~~For~~ To discuss the treatment of Pneumonia satisfactorily, would necessitate in the first place, a review of the various theories of inflammation itself, and secondly the natural tendency of an inflammation - that significant phrase the "vis medicatrix naturae"; and lastly the influence of therapeutic agents, both singly and ^{combined} collectively.

Though this question has been often and ably
discussed, a great deal could still be
profitably said ^{about it} ~~on the subject~~ and
were it not that my time is so limited
it would afford me great pleasure to
enter into the subject fully, without
which it would be useless touching on it.

There is a point, however, in regard to
the pathology of pneumonia, ^{the} which has
a special bearing on the diagnosis
~~which~~ ^{that} I cannot pass over without notice.

The theory generally held supposes the
effusion to take place into the ~~ac-~~ ^{ac-} cuses
and ultimate bronchi. Now were this
the case the passage of air into the lung
would not only produce a noise - the
crepitation, ~~by~~ ^{passing} through the fluid,
but would also produce a noise similar
in kind, though ~~less~~ ^{less} in degree as it
is ^{through the effusion} ~~expelled~~ out of the lung; hence there
would be a sound both with inspira-
tion & expiration, and this sound re-
sembles that of a moist character, seeing
it is produced ~~by~~ ^{by} the passage of air

through fluid. In this, the competent
stage - if I may be allowed the expression,
for I am speaking of the mechanism of
expiration, there is only one sound audible
and that co-existing exclusively with in-
piration. The sound too is a dry one.
"Dryness is one of the best marked acoustic
properties of true expiration (D. Walke)"
How then are we to account for this dry
sound & peculiar to expiration. I think the
theory first proposed by D. Walke is by far
the most probable, if not the correct
one. He supposes (as everyone knows, but
I may be allowed to quote it here in
connection with my case) that the respiration
takes place, not into the bronche or air-tubes,
but into the parenchyma of the lung, ~~substance~~
adhering to the air sacs, and that ^{they act off} ~~the~~
expiration ~~which~~ suddenly expands these
empty sacs, which are closed by the pressure
of the condensed matter in their exterior, and
that this sudden expansion is the cause of
the ~~noise~~ noise produced. To do justice
to this ingenious theory and its accomplished

author. I think I had better quote in our words.

He says: "It seems however, most probable, that the phenomenon ~~occurs~~ occurs in the parenchyma of the lung itself, especially in those portions of it immediately contiguous to, and actually forming the walls of, the ultimate terminations of the bronchi; and that its physical cause is the sudden and forcible expansion of that parenchyma, forced together, as it were, by the viscid exudation with which it is impregnated. Each single crepitation or click would thus signify the expansion of a cell, and be produced by the unfolding of surrounding glutinous tissue necessary for that expansion. Thus conceived, as ~~it~~ respects its mechanism, the chief phenomena of the crepitant rhoncus become perfectly intelligible: its dryness and sharpness; the sensation of minute size attending the sounds of which it is composed; the similarity to the sound of minute ruptures of tissue, and the total absence of the bubbling character; its ~~occasionally~~ occasionally accompanying the entire inspiratory act, and sometimes appearing

only at its close, according as the infiltration
of viscid lymph less or more completely
prevents expansion of the vesicles. We can
on this supposition also readily understand
why crepitation should exist in inspiration
only: though the rapid and abrupt unfolding
of the plaited mass be productive of crack-
ling noise, it is very unlikely that the
comparatively slow and equable retraction
of the tissue to its previous collapsed state
would be thus productive, - indeed the
presumed physical cause of crepitation has
ceased to exist. On the other hand (this
part has been already quoted in principle
from) there is no reason why in the ~~ordinary~~
ordinary thing crepitation should not
as regularly exist, though not with the
same loudness, in expiration as in
inspiration. The air is presumed in
expiration to have passed through a
certain fluid; if so, it must repass
through it during expiration, and ac-
cordingly with a noise similar in kind,
though less in degree: When rhinorr-

are manifestly produced by the passage of air through liquids, they attend both inspiration and expiration.

That this is the true condition of the lung in pneumonia is not only highly probable, but amounts almost to certainty I think, especially when taken in connection with the auscultating phenomenon: and that the crepitation of pneumonia is a dry sound I have just as little doubt. It differs materially from the fine mucous rales characteristic of capillary bronchitis, which accompany both inspiration and expiration. Peculiar enough then who hold that the ventilation takes place into the air-cases don't admit of dry sounds, unless it be the sibilant and sonorous rhonchi of the dry stage of bronchitis. They say the crepitant rhonchi of pneumonia is not a dry sound. How they distinguish capillary bronchitis from the first stage of pneumonia, or again the vesicular crepitation, by auscultation, I am at a loss to understand. In fact I conceive it to be the small bubbling rhonchi of Dr. Walshe

a frequent source of error, the consequence
of which is that cases which are simply
bronchitis are put down as Pneumonia.
They consider, too, that it is not essential
to constitute a case of pneumonia to have
~~such~~ ^{such} ~~they~~ ^{mixed} ~~in~~ ⁱⁿ rusty sputum and
such like concomitant symptoms, as
all these may be, & frequently are,
absent. What really is essential for
the diagnosis of the post stage of pneu-
monia, - the estimation of these matters
now I should very much like to know.
If it be that unfortunate term for cre-
pitation ~~it may mean almost anything,~~
we wonder why so many mistakes, as
it may mean almost anything, and
~~so~~ different things by different authors.
Some apply it to numerous rules fine
or large; others to the crepitant rhoncus
of pneumonia and so on. When a man puts
his ear to the stethoscope and says there
is crepitation what are we to understand.
Many a time I have been provoked by
such a reply, & would fain ask the

auscultation what he meant. Often have I
heard one who was considered to be
an accomplished auscultator say, when
examining a patient supposed to have
pneumonia that there was large in-
creased crepitation, and that was all
which the diagnosis was apparently
furnished in. How does the very fact
suggest a doubt, and render it highly
probably the case was nothing more
in lungs than bronchitis. Pneumonic
crepitation is never large or loud.
On the contrary smallness and dryness,
^{connection} ~~connection~~ with rapidity of evolution, and
persistence when once evolved are
amongst some of its best characteristics.

Much as I admire simplicity in every-
thing, so long as it is compatible with
precision, and no less in the diagnosis
of disease, at the same time I can't help
thinking an attempt has been made
to bring it too far in regard to aus-
cultation, which has been not only at
the sacrifice of accuracy, but of what

is of far greater consequence, the cause
of error in diagnosis. Moreover I am
quite convinced the supposed simplicity
has formed a positive embarrassment.
It was so in my own case, and from
what I can observe is so with others.
And no wonder when we consider its
cause. What can be more perplexing
to a beginner than to be told, a "mucous
râle" indicates bronchitis; crepitation
indicates bronchitis; and that crepitation
again indicates pneumonia, &c. on; and
that this same crepitation is always a
moist sound. If such a term is to be
used at all it would be rendered much
more intelligible by the use of a qualifying
word, as dry or "pneumonic crepitation"
must in bronchitis &c. Of course this
would not tally with the other things
as to its cause. But it is far better to
dispense with such vague terms altogether,
and make use of those which are expressive
of the physical condition giving rise to
such sounds. To Dr. Walshe is due the

merit of introducing a description, it is so
simple, expressive and precise. There are
also many good descriptions, especially those
of Dr Latham & Haller; but certainly none
better than the former gentlemen, which
I consider invaluable - Had almost said
indispensable, to the beginner in physical
diagnosis, if he wishes to obtain a clear
and precise conception of the import of
morbid sounds, and so be able to
interpret them correctly, which I know
I never was till I became familiar
with the admirable treatises of Dr Walsh.

It is not enough to say that a moist
sound is a sign of bronchitis or friction
of pleura, but we should be ^{not only} able to
account for the physical condition pro-
ducing ~~or~~ rise to every conceivable variety
of morbid sounds heard within the human
chest; but we should also employ a nomen-
clature wherein there were terms expressive
of each individual sound, hence the ad-
vantage of dividing them into genera and
species as Dr Walsh has done, which still

I think admit of considerable extension.
 For example we might speak of varieties
 of the various species, which would be far
 better than making use of all sorts of
 gross and meaningless names, as is often
 done just as it strikes the fancy of the
 listener. To Dr. Walke's genus "Whistling rhinoceros"
 and species high-pitched and low-pitched,
 I would add medium-pitched, with a
 corresponding variety, as for instance:

Genus	Species	Varieties
Whistling rhinoceros	high-pitched	substant rhinoceros
	medium-pitched	Crowing rhinoceros
	low-pitched	snoring rhinoceros

and corresponding varieties might be
 similarly added to many other
 species, which species themselves might
 also be extended. I cannot, however,
 pursue the subject further here. I have
 already carried it beyond the limits
 of my intention, and had no notion of
 touching upon the physical diagnosis when
 I commenced; but we get unwittingly
 lead into argument. In conclusion I can't
 help comparing Dr. Walke's classification
 ours

of morbid sounds to Mr Paget's description
of morbid growths, previous to which
~~every kind~~ ^{was} of tumour ~~was~~ called a
sarcoma, just like every kind of
sound is at present ~~called~~ called, by
many, a crepitation!