

central parts are less vascular, and the yellowish-white parenchyma is veined with diffuse purple streaks, and a mottled appearance thus produced."

This mottled appearance is always well marked, but abscesses in the glands we have met for the first time in the above case.

The peculiar sudden variations of temperature alluded to as being common, though indifferent degrees, to the agues and enteric fever, suggests the existence between these two diseases of something more than the ordinary fraternity which links together most of the exanthemata, and it seems probable that this intimate connexion between the so-called paludal diseases and the one now under consideration, is one of a common causation, and that we are to look to vegetable rather than animal decomposition, for the principal factor in the production of the typhoid fever of India.

This subject is of such great importance, more especially as perhaps it is in this circumstance we are to find the clue to the great difficulty of diagnosis in many Indian fevers, that I may be excused for reminding those who have been kind enough to have followed me so long, of some of the chief points of similarity between these two diseases.

Both complaints are characterised by profuse diaphoresis, sudden variation of temperature, intense headache, and sometimes by diarrhoea and vomiting. Enlargement and turgescence of liver and spleen are found in both, and autumn is the period of the year in which they are most prevalent. Still more markedly do the accounts (though meagre) of remittent fever point to a close relationship of symptoms, and those whose attention has been drawn to the subject of enteric fever in this country will agree with me in stating that there is no more common symptom met with in the so-called malarious fevers than a peculiar tenderness and gurgling along the course of the great gut, but especially well marked over the angle of junction of the ileum and cœcum.

Those pathologists who hold that the liver is the starting point within the body, in the evolution of a case of typhoid, will see nothing odd in this connection of the two diseases.

Dr. Harley, in the article above alluded to, points out this connection, and shows the frequent occurrence of typhoid and ague under similar conditions, and from the same locality. He quotes authorities to prove the fact of enteric fever being in some cases ushered in by intermittent symptoms, and *vice versa*, as well as the occurrence of remittent or intermittent phenomena in the course of a case of typhoid. The truth of these observations we have seen clinically proved in cases of typhoid fever in India: for example, in some instances the primary symptoms were so like those of remittent fever, and the symptoms of typhoid were so conspicuous by their absence, as to lead to the conclusion that the case was an example of the former, whereas the post-mortem dissection left no doubt as to its having been a genuine case of the latter; and last year, when my colleague and myself were paying great attention to the subject of enteric fever, we were very much disappointed by one of our pet cases. Suddenly the temperature fell, and this peculiar occurrence was followed by most of the phenomena of a quotidian ague.

Dr. Harley believes that the variety which he calls paludal enteric fever is the most common. Arguing from a clinical study of this disease in India from its almost non-contagious character, and from some of the above considerations, I am led to the conclusion that though the paludal diseases and enteric fever differ in many important particulars with respect to symptoms, mode of termination, prognosis, mortality, and treatment, yet we should not lose sight of the existence of certain circumstances which point to a common parentage, and furthermore that the non-recognition of this kinsmanship may account for some of the scepticism and a good many of the diagnostic difficulties met with in Indian fevers.

HAZAREEBAUGH, 9th August, 1872.

DESCRIPTION OF A NEW BULLET FORCEPS.

By Surgeon J. E. TUSON, M.D., F.R.C.S., 2nd N. L. I.

In the *Medical Times and Gazette*, August 6th, 1870, I published a description of a bullet extractor which I had devised for the more easy removal of bullets from deep-seated gunshot wounds.

The instruments now in use I have found to be so inefficient on active service, that it occurred to me that a more complete instrument might be introduced to meet all requirements. I have endeavoured, during my late furlough in England, to make further additions and improvements to this bullet extractor, which, I hope, will be a *desideratum* for use in the field. I have shown it to Sir William Fergusson and many eminent surgeons, and it has met entirely with their approval.

The main points in this bullet extractor are these:—

1st.—It is made in the shape of a probe, with prehensile powers, to seize the bullet the moment the instrument touches it.

2nd.—A central rod, which passes down the shaft of the instrument, with a powerful piercing screw to fix the bullet so firmly that it may be extracted even if it be impacted in a bone.

3rd.—A Nelaton's porcelain probe to pass also through the shaft of the instrument, to ascertain whether it be a bullet or no. The advantage of the porcelain probe passing through the shaft of the extractor is, that there can be no possible mistake as to the instrument grasping the ball, whereas in passing a Nelaton's probe into a deep and tortuous wound, it is difficult to pass the usual forceps into the same part, and to be sure that it secures the same substance that the probe came down upon.

4th.—As an additional diagnostic aid to the surgeon, I have added to the case containing the bullet extractor an electric indicator, which also passes through the shaft of the instrument. All these appliances are included in one case to make it more complete and portable. It is far from my wish to take any credit to myself for the introduction into the case of Nelaton's probe, and the electric indicator. I only wished to make the instrument complete for field service, so as to have all the appliances ready for immediate use.

PHTHISIS SIMULATED BY PNEUMONIA OF THE UPPER LOBES; DIAGNOSIS DISCUSSED.

By Assistant Surgeon J. KELLY, M.D., 1st Punjab Infantry.

PNEUMONIA is a frequent complication of the remittent (or so-called remittent) fever that has been so prevalent since the cold season of 1869-70 at Kohat, Bunnoo, and various other parts of the Punjab. It would be irrelevant here to discuss the nature of the fever, or the grounds upon which the generally received opinion as to the secondary nature of the pneumonia rests; but it is right to state that the pulmonary affection is occasionally considered to be the primary disease, and is spoken of as epidemic pneumonia of a peculiar nature.

The object of this paper is to call attention to the difficulty of distinguishing in some cases pneumonia occurring in the upper lobes from tubercular phthisis, and to state the means employed in the diagnosis; but less with a view to impart than to elicit information from others.

Of 25 cases of secondary pneumonia that were recorded in the 1st Punjab Infantry in the cold season of 1870-71, the disease was limited to the upper lobes in 6; these 6 cases presented many of the local and general characteristics of phthisis, but only one became phthisical.

In cases which have been under observation from an early period, or even in those which come under notice later, but with the fever and other symptoms still high, a careful consideration of the circumstances will remove all doubt; but the cases which present the greatest difficulty are those in which (in addition to dulness or amphoric resonance on percussion, increased vocal resonance, blowing, moist, creaking, or other abnormal sounds