I have ventured to publish this short description as I think it may be useful to my brother officers who are in charge of Station Hospitals, and as experience has shown that this system adds so materially to the comfort and well-being of the patients.

A PECULIAR CASE OF SURGICAL EMPHYSEMA.

By CAPTAIN L. BOUSFIELD.
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An Egyptian bugler was blowing his bugle when he was suddenly seized with a sharp pain in his chest near the manubrium sterni. On the following day his condition was as follows:—

He had no severe pain, but complained of aching in his neck. A diffuse crepitant swelling was found, spreading over the neck from just below the maxilla to about one inch below the lower border of the manubrium; at the sides it spread over the sterno-mastoids, and there were two lateral wings which extended outwards three-quarters of the length of the clavicle along its posterior aspect. The swelling was symmetrical, and its extent is shown in the accompanying diagram. On palpation there was no pain, but crackling could not only be felt beneath the fingers, but could be heard, even without the aid of the stethoscope. Though complaining of slight pain, he was not in any way seriously ill. There was no fever; pulse-rate, 70; respirations normal in

![Diagram showing Extent of Emphysema. Shaded area is that of the surgical emphysema—the darker the shading the more the air.](image-url)
number, and apparently having no influence on the size of the swelling. He presented no signs of lung disease (emphysema or tubercle), nothing abnormal was seen in his pharynx or larynx, and there were no enlarged glands in his neck. He gave no history of previous lung trouble, and was in appearance a strong and healthy man.

This must have been a case of traumatic rupture of an air vesicle of the lung from excessive straining when blowing his bugle, the air escaping probably through Burn's space, otherwise it would be difficult to account for its distribution. The air seemed to lie between the skin and the superficial layer of the cervical fascia, but how it gained access to this space from the lungs or the trachea is a problem, having to pass through the visceral and parietal layers of the pleura if from the former, and the deeper layers of the cervical fascia if from the latter.

The absolute symmetry of the distribution of the air is also of interest, evidently indicating places where the connective tissue joining the skin to the superficial layer of the fascia is very loose, hence showing the lines that suppuration would probably tend to take in this region between these layers.

In the limited amount of literature at hand, I can find no reference to such a case, and I believe it to be of very rare occurrence, and so worthy of being placed on record, especially as this case shows no signs of emphysema or tubercle.

A CASE OF LIVER ABSCESS DUE TO A DIPLOCOCCUS SIMILAR IN APPEARANCE AND STAINING-REACTION TO THE GONOCOCCUS.

By Captain L. BouSFIELD.
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NAFAR MOURSI MOHAMED ISMAIL was admitted to the Kassala Military Hospital on July 22nd, 1907, suffering from pyrexia; temperature, 101°F. He looked ill and was thin. He made no complaint, except that he had fever with the accompanying headache and pains in the back and limbs. He presented no physical signs of disease, and no malarial parasites were found in his blood. His temperature at night rose to 104°F., accompanied with considerable perspiration. He had slight diarrhoea, but there was no blood or slime, and no history of dysentery. His urine was normal.

His temperature remained high, varying mainly between 102°—104°F. for the next twenty-four days. His spleen was slightly enlarged to percussion, and about a week after admission to hospital there were a few râles and rhonci in the chest; there were no rose spots. He had been having quinine prophylactically and, in spite of no parasites being found in his blood, he was given a long test with this drug, but it had no effect on his pyrexia.