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 DIPLOCCUS SIMILAR IN APPEARANCE AND STAINING-REACTION TO THE GONOCOCCUS.

BY CAPTAIN L. BOUSFIELD.

Royal Army Medical Corps.

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 rhonchi 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.
Clinical and other Notes

The blood was again examined on July 27th and August 1st, but no malarial parasites were found, though on July 27th a leucoeytosis was noted, but on August 1st this had disappeared. On August 3rd a slight increase of liver dulness was noticed on the right side beneath the axilla, and slight pain was elicited on pressure over this part. The next day a slight pleuritic rub developed over this region, and the patient complained of slight pain. The following day he was needleed, but only blood was withdrawn. From this time onwards he complained of no pain.

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On August 15th with no result, except that during the next forty-eight hours his temperature fell to normal. His general condition, however, was getting worse and worse, the pulse-rate rising to 136, and he was bathed in perspiration.

On August 17th his temperature rose again to 102° F., and on August 19th, in spite of his very bad condition, he was anaesthetised, as the area of dulness had considerably increased. On needleing, clear fluid was withdrawn, evidently from the pleural cavity, but it was not till the fifth puncture that thick, yellow, creamy pus was withdrawn. The ninth rib in the posterior axillary line was resected for about 1½ inches, and about a pint of clear serous fluid escaped from the pleural cavity; the diaphragm was then stitched to the parietal pleura, an incision made through it by means of the actual cautery, and about 1 ounce of thick pus evacuated from the liver. The cavity was very ragged and appeared to be of a more or less acute formation, as the walls were very friable; there were two small pockets. The patient was extremely collapsed, requiring 20 minims of strychnine and 10 minims of ether hypodermically.

The following day his condition had improved and his temperature reached normal on August 21st, the pulse on August 22nd falling to 102°, and the sweating had gone. The temperature had again risen to 101° F., falling to normal in the morning, but the general condition had greatly improved.

This was taken to be a case of tropical abscess, but the reason for publishing it is on account of the bacteria found in the pus. Pus taken soon after the operation showed many leucocytes and pus cells and a large number of diplococci, kidney-shaped, mainly within the cells, and in some cases present in large numbers. A few were comparatively free, and they resembled in appearance gonococci. They did not stain by Gram's method. There are no conveniences or apparatus here for attempting cultures, so this was not done.

The patient showed no signs of gonorrhoea and denies an attack, and certainly has not gleet, though his word may not be trustworthy, yet at present no sound has been passed to find out if he has an ulcer or slight stricture on account of his serious condition, but the passage of his urine is easy and complete, and there has been no pus or albumin in his urine.
Clinical and other Notes

Microscopical examination shows the cocci to be either gonococci or cocci practically indistinguishable from them, and for this reason the case is worthy of notice.

SALTS OF CALCIUM IN FUNCTIONAL ALBUMINURIA.

By Captain A. O. B. Wroughton.
Royal Army Medical Corps.

Wright and Ross have pointed out (Lancet, October 21st, 1905) that functional or physiological albuminuria may, in some cases, be due to diminished blood coagulability, and they record six cases in which the administration of calcium lactate was followed by disappearance of the albumin. According to these observers, the administration of calcium salts has no effect in organic albuminuria, and their administration is therefore an aid in the diagnosis of these disabilities. The following case appears to corroborate the foregoing remarks.

Private B., 2nd Dorsets, aged 22, was detained on August 27th, 1907, with a mild attack of ague; temperature, 99° F. He complained of feeling cold and was put to bed; an aperient was given which acted well, and he was then given quinine, 5 grains, with phenacetin, 3 grains, and caffeine, 1 grain. His temperature rose that evening to 101·4° F., when he broke out into a profuse perspiration, and the temperature began to fall and was normal by the middle of the next day, the 28th, on which he was admitted, his urine being found to contain a considerable amount of albumin.

Examination on Admission.—Well nourished, though pale and rather anaemic. Nothing abnormal found in thorax or abdomen, although he complained of pain in the splenic region, which was rather tender. No oedema anywhere, or puffiness under the eyes; no headache or retinitis; bowels regular; tongue slightly furred. Urine: sp. gr. 1020, acid, perfectly clear but rather high coloured; no sediment or sugar but a considerable amount of albumin. To make quite sure there was no contamination, I prepared a catheter myself, and drew off a specimen from the bladder; the albumin was the same as in the previous specimen.

Treatment.—He was kept absolutely in bed, on a plain milk diet, and given a diaphoretic mixture, t.d.s.; locally, glycerine and belladonna, spread on lint, placed over the painful splenic area, and dry heat applied over this.

Previous Illnesses.—A mild attack of measles when a child, and two or three mild attacks of malarial fever since coming to India. He was admitted to hospital here about a month ago with malaria, and a specimen of his blood sent to the Divisional Laboratory for examination, before the administration of quinine; no parasites were found. There was no albumin in his urine at this time.