anatomy of the prostate, it is stated that its muscular power appears to have been exaggerated, and exception is taken to the conclusions drawn in reference to this point by Professor Viner Ellis.⁴ It seems difficult to reconcile Mr. Griffiths' views with such illustrations as I have ventured to draw from the practice of surgery bearing upon the function of this part.

NOTES OF A CASE OF WEIL'S DISEASE.¹

By SURGEON-MAJOR W. B. MILLER, Medical Staff.

PRIVATE J. N., aged 21, of two years' service, and belonging to the 2nd West Riding Regiment, when on parade on May 24th last, suddenly felt faint, and had at the same time a burning sensation all over him, with a feeling of exhaustion. On admission to hospital the temperature was found to be 103.6° F. He complained of slight headache, his face was dusky, the conjunctivæ were congested, he complained of a disagreeable taste in the mouth, his tongue was moist, indented, and covered with a dirty yellow fur. The heart sounds were faint, and respiration was slightly increased. He had no diarrhœa. The urine was dark coloured, in fair quantity, specific gravity 1022, and contained no albumen. He developed slight jaundice and congestion of the abdominal organs. Three days after he had a mucous expectoration of a dirty brown colour, while the lungs presented no physical signs to account for it. There was considerable gastric disturbance.

On May 28th he complained of pains in the calves of the legs. There was no œdema of the parts or swelling of the muscles. Gastric disturbance continued, and the first sound of the heart remained weak.

On May 29th there was a marked diminution of the slimy expectoration and the pains in the calves. There had been no eruption. The temperature gradually went down, and on the last day but one of the month the circulation had improved and the tongue was much cleaner. At night he had a sharp epistaxis, and while he had been heavy before it, he became much relieved and brighter. On the last day of the month there was an absence of fever.

On June 2nd both pulse and temperature were subnormal, as well as the respirations.

On June 4th these were normal, as also were the secretions and excretions.

On June 9th he was convalescent, and was allowed to be out of bed, and was discharged fit for duty on June 16th.

Diagnosis.—This might have been a case of non-specific continued fever from exposure to heat, or might have been supposed by some to have been enteric fever. It had not, however, the appearance of ardent fever, while its mode of commencement, with severe general symptoms, rapid pulse, and pains in the calves, the absence of diarrhœa, together with the other symptoms and the temperature chart, helped to distinguish it from enteric fever.

A word of caution regarding temperature charts may here be given. They are not so valuable as they formerly were as helps to diagnosis, as by antipyretics in general use the chart becomes more a guide as to the effect of these remedies than a clinical aid in detecting diseases.

This case was diagnosed as Weil's disease. Weil's disease, the cause of which is at present unknown, is said to attack the male sex at the prime of life, and develops usually during the hot season of the year. It was described by Dr. Weil in 1886, and was thought to be an abortive form of enteric fever; but Dr. Fiedler, who has given some attention to it, says that it is not so, but is a distinct, acute infectious, or toxic affection. The case under review presented the general characters, namely, fever which lasts eight or ten days, headache, gastric disturbance, jaundice, and muscular pains, especially in the calves of the legs.

Prognosis.—Had it been a case of enteric fever the prognosis would have been very guarded, as complications at any time might have arisen; but being a case of Weil's disease, the opinion formed was of a favourable nature.

Treatment.—The man was isolated on account of the infectious nature of the ailment. A purgative draught was given on May 25th. There was nothing of an unusual character in the stools. The temperature was reduced by sponging; quinine was afterwards given, and, later, iron. The diet at first was milk or milk and soda water; towards the end a little brandy was given, and he was put on solid food some days before his discharge from hospital.

HYSTERICAL CHOREA.¹

By P. BLAIKIE SMITH, M.D.,

Physician and Lecturer on Clinical Medicine at the Aberdeen Royal Infirmary.

THE case of hysterical chorea which I shall presently introduce to your notice is that of a woman, aged 22, who was admitted into the infirmary under my care on February 20th.

There is nothing important in her family history, but her personal record and the origin of her trouble are highly significant. She stated that about five years ago she acted for six months as nurse to a child the subject of St. Vitus's dance, and that three months ago another child, also affected with this complaint, resided near her house. Towards the end of last year she got a great fright by a dog suddenly running against her legs, and ever since then she has suffered much from nervousness; but she dates her convulsive trouble from four days before coming to the infirmary, when a violent pain temporarily seized her right foot, and coincident with this her "shakings" made their appearance. When I first saw her she was lying in bed with closed eyes and half-averted face. Her shoulders and arms were in constant movement. Each shoulder alternately was either violently raised or brought forward, and then suddenly lowered or retracted, while the arms, as they lay on the coverlet, were constantly being rotated inwards or energetically flexed. The movements of the shoulders seemed to have no relation to those of the arms, and both sets of movements were liable to sudden and unaccountable exacerbations. There were no spasms of the muscles of the neck, nor any contortions of the face. The tongue was protruding quietly, and remained out for inspection until the patient was told to withdraw it. Speech was unaffected. The grasp of both hands, notably the right, was much impaired. The superficial reflexes of the legs and trunk were greatly diminished, the knee-jerks much exaggerated and capable of being produced by tapping the rectus tendon on the front of either thigh. Rectus clonus, too, was present on both sides; ankle clonus was absent. The legs were free from spasm. The heart-sounds were normal, and its action regular.

A few days after admission it became evident that the spasmodic movements were performed with a certain amount of regularity; it was also noted that they ceased during sleep, that they were intensified by mental emotion, and that, however violent they were, they could occasionally be kept under control. For instance, the patient could feed herself without spilling her food; she could also knit, but, strange to say, she was quite unable to sew, and, though she could write, the agitation of her hand rendered it almost impossible to decipher what she had placed upon the paper.

When she walked, her body swayed from side to side, and her progress was erratic. She repeatedly knocked up against the furniture in the ward, and there were frequent sudden flexions of the body, now to this side, now to that, as she went along, while all the time her shoulders and arms continued in a state of active movement. Her mind was clear, and she was generally bright and cheerful, but occasionally she had fits of crying. For nearly three weeks there was little change in the symptoms just detailed. The movements persisted with varying intensity. The condition of the reflexes, too, was not constant; sometimes they were nearly normal, at other times they were in excess; hardly ever were they equal on the two sides. During this period the treatment consisted first in the administration of large doses of

⁴ *Med. Chir. Trans.* Vol. xxii.

¹ Read at a meeting of the Bermuda Branch of the British Medical Association.

¹ Read before the Aberdeen, Banff, and Kincardine Branch of the British Medical Association.