this course would be prejudicial to the patient. Otherwise the patient can, within seven days, exercise this right; and the fresh justice is to see the patient and report to the Commissioners, thus reopening the whole question of his insanity, disturbingly, in the mind of the lunatic, and placing the certifying medical men in a position liable to misunderstanding and unduly vulnerable.

A constable, relieving officer, or overseer of a parish, knowing of a non-pauper and non-wandering alleged lunatic, but one who is not under proper care and control, or who is cruelly treated or neglected by those in charge of him, shall, on oath, inform the justice specially appointed under the new Act, who may visit the alleged lunatic if he thinks well to do so, and, whether he visit him or not, shall direct two medical men to visit him and certify their opinion as to his mental state; and the justice, if satisfied that the alleged lunatic is a proper person to be placed under care, may order his removal to an asylum, etc., or may detain him and suspend execution of the order of removal for fourteen days, or may allow a friend to take care of him. But the removal cannot take place in opposition to a medical certificate of unfitness of the alleged lunatic for removal. The reception order holds good for fourteen days, or, if its execution is suspended by a medical certificate, as just stated, it becomes renewed in effect for three days after a reversing medical certificate of fitness for removal has been obtained.

The certificates accompanying the reception order under which patients are to be received under care are not to be signed by persons in any way interested in the payment to be made for these patients, or by the near relatives of such persons.

Neither of the persons signing the medical certificates in support of a petition for a reception order shall be the father or father-in-law, mother or mother-in-law, son or son-in-law, daughter or daughter-in-law, brother or brother-in-law, sister or sister-in-law, or the partner or assistant, of the other of them.

Every medical certificate shall be evidence of the facts therein appearing, and of the judgment therein stated to have been formed by the certifying medical men on such facts, as if the matters therein appearing had been verified on oath.

Hitherto medical men have had the right, under definite statutory regulations, to receive one insane patient ("single patient") into their private houses without obtaining a licence for the reception of lunatics. It is now enacted that the Commissioners may, under some circumstances, allow this number to be increased; this, however, if carried into effect, may bear unfairly on medical men who have gone to the trouble and expense of obtaining a licence for the reception of two or three lunatics into their private houses, and probably of altering those houses as required by the licensing authority.

After May 1st next, no pauper can be sent to an asylum, etc., under order of a clergyman and relieving officer, a method which has hitherto been in use.

Where a pauper lunatic is taken charge of by relatives, with an allowance for his maintenance, the district medical officer shall visit and report on him, quarterly, at a fee of 2s. 6d., in addition to the fees now paid under 16 and 17 Vict., c. 97, s. 66.

A medical visitor of private asylums shall receive such remuneration as the justices for the county or borough for which he is a visitor may approve.

Under the new Act the duties of medical officers of workhouses will be somewhat complicated, and no doubt a full code of instructions will be issued for their use before next May. There is not time to state the provisions of the Act on these points here. They are given at p. 745 of the JOURNAL of September 28th.

EBBW VALE (Population, 17,000).—Epidemic of Measles: High Infant Mortality: Ambulance and Disinfectors Needed.—A severe epidemic of measles during the whole of 1888 had the effect of raising the excessive zymotic rate of the previous year from 5.23 to 6.7 per 1,000. The epidemics of scarlatina and diphtheria, which were the chief causes of zymotic mortality in 1887, died out in the early part of 1888, and the cases which followed were sporadic in character and the mortality comparatively small. There was, however, an abnormal mortality among children under 5 years of age, no less than 180 deaths out of a total of 365 being of such children. Mr. John W. Davies describes this state of things as deplorable, when it is considered that, with ordinary care and suitable food, the mortality might be considerably reduced. With the exception of the preventable diseases, there was a record of fewer deaths in other classes, and the general death-rate was 21.46 per 1,000. An ambulance waggon and a steam disinfecting apparatus are much needed in the district.

A SUCCESSFUL CASE OF TREPHINING FOR EPILEPSY, WITH SUBSEQUENT RESECTION OF TREPHINE OPENING.

By DR. WILLIAMSON,
Physician to Latchford Hospital;

AND

ROBERT JONES, M.R.C.S.,
Honorary Surgeon to Liverpool Stanley Hospital.

THE patient was a young man engaged as a striker at one of the forges on the Manchester Ship Canal Works. Two years ago, while under the influence of alcohol, he fell against the corner of a brick wall and cut his head over the left Rolandic area. The bleeding was profuse, and he was insensible for a short time. He rested for a week, when, feeling better, he went out with some friends, drank, and in consequence got an attack of erysipelas. His head was very much swollen, and he had his first epileptiform seizure. Sixteen fits occurred the same day. He remained unconscious for a few days, and his right leg and arm were paralysed for three weeks. He spoke slowly, and at first incoherently, but this defect wore off in a week. The paralysis of limb disappeared, commencing in the leg. He was treated as an out-patient at one of our large hospitals, but trephining was not suggested to any of the family. The wound in the head soon healed, but has on more than one occasion discharged a little pus. The last occasion was February, 1888. The patient returned to his work in twenty-one days.

Family History.—Both father and mother alive and heavy drinkers. Patient is the eldest of a family of four children, all living. His eldest sister, now 20 years of age, is an epileptic, her fits dating from her first dentition. She is now a helpless imbecile, and averages five fits a week, and is worst at full moon.

Present Condition, two Years after Primary Injury.—Patient considers that stooping may have induced present attack. There is no history of an injury. Has had a bronchial attack for some days past. There is a small triangular depression over the Rolandic area on the left side, marking the position of the old injury. On the night of October 31st, 1888, he was seized with two epileptic attacks, and on Thursday came for treatment to Dr. Williamson. Aperient pills were prescribed, and no fits occurred until November 2nd. On November 3rd he went to bed at 1.30, and was seized with a fit, which constantly recurred, and from which the patient did not recover consciousness until after operation. The fits were short in duration, but recurred every ten minutes. Dr. Eugene Byrne, the resident physician at Latchford Hospital, who had an opportunity of noting the succession of symptoms, describes them in the following words: "They began with groaning and slight movements of right limbs; then tremors of right limbs; then tetanic rigidity of right limbs, accompanied by jerking of the head round to right side, the mouth being also drawn to the right. So soon as the rigidity of the limbs and jerking of the head subsided, the right eye commenced to blink violently. In the afternoon the blinking was followed by rapid nystagmus; but in the evening, when seen before the operation, no nystagmus was noticed between the blinking and relapse into coma." Mr. Robert Jones was sent for in the evening. On arrival he found the patient very low; pulse 95; breathing shallow and accompanied by rales, 25 in the minute; extremities cold and bluish; fits recurring every ten minutes, unconsciousness having lasted eighteen hours. Mr. Jones determined to trephine without delay.

The Operation.—This was performed in a little room in Warington. The operator was assisted by Dr. Byrne and later by Dr. Williamson. The head around the scar was shaved and washed with terebinth, and a subcutaneous injection of morphia and ether administered. A semicircular incision was made down to the periosteum over the scar, the convexity of the curve being upwards. A flap of periosteum was then shaped, and the whole mass reflected, exposing the old depression. A $\frac{3}{4}$ inch trephine was then placed below the site of the cicatrix; the circle of bone so removed had attached to its internal surface a triangular piece of bone diving into the brain at right angles to the cranium to a length of $\frac{3}{4}$ inch. This is shown in Figures 1, 2, 3. The trephine was introduced at the junction of the middle with the lower third of the Rolandic fissure, the largest diameter being opposite the ascending frontal convolution. The widest diameter of the bone lay horizontal to the cortex it pierced. The measurements were

conducted after the method of Thane and Hare. A probe with a bent point was then placed into the trephine space and a little anterior to it; the inner plate felt bare. In consequence, another trephine hole was made $\frac{1}{4}$ inch anterior to the first, and the intervening ridge of bone removed by saw and forceps. This procedure yielded a small piece of necrosed bone. The wound was treated during operation with perchloride of mercury; all bleeding vessels were tied; the cut surfaces dusted with equal parts of iodoform and boric acid; a catgut drain introduced, and the whole covered with antiseptic wool dressings. Owing to the adherent condition of the dura mater to the skull, it was thought more prudent not to attempt any bone grafts. During the operation, previous to the removal of the first round of trephine, the patient had two fits. After its removal there were no more fits, their place being taken by attacks of restlessness.

Fig. 1.

Fig. 2.

Fig. 3.

After-Treatment.—About an hour after the operation the patient was removed in a wheeled litter to the Litchford Hospital, a distance of about a mile, on a boisterous, wet, and cold night. The removal was inevitable. Before starting, he received *per rectum* pot. bromid. grs. 40; hydrat. chloral grs. 30; aq. $\mathfrak{z}$ iij. For two hours after his arrival in hospital he was hovering between life and death. His pulse was so frequent, weak, and irregular, as to render counting impossible; his breathing rapid, shallow, and oppressed with *râles*; his temperature, taken after arrival, 102.6° . For a minute or two after each attack of restlessness (which usurped the fits), he was so weak that the epiglottis had to be raised by lifting the angles of the lower jaw. A rectal injection was administered of tinct. digital. $\mathfrak{m}$ 20. An hour after this he was sufficiently improved in strength to be able to cough up the phlegm which produced the *râles*, and his pulse became stronger and less frequent, though still irregular. During one of his restless phases the dressings were all pulled off his head, and had to be replaced in the best available way. The notes of the next few days are sufficiently interesting to be appended in Dr. Byrne's own words.

November 6th. Sleeping quietly; has shown signs of consciousness. When given a drink, tilted up bottom of feeding cup into his hand. Put out his tongue when requested by Mr. Jones. Urinates incontinently. Lies in a darkened ward.

November 7th. Pulse frequent, regular, soft, slightly bounding. Has asked for a drink and answered a question in a low whisper, but generally signifies by a shake of his head. All day, up to 8 P.M., has lain supine, without a motion of arm or leg, but is very watchful of every movement in the room. At 8 P.M. four of us went into the ward together. He became very excited. His breathing became very shallow, irregular, and obstructed by epiglottis. Pupils all day widely dilated. Micturated into urinal.

November 8th. No sleep last night. Became restless at 6 A.M. this morning and delirious at 11 A.M. Shouts for his father. All his words are distinctly and unhesitatingly pronounced. Fancies he sees things on the ceiling. Micturated in bed last night. To-day, at 1 P.M., after a little persuasion, took dose of pot. bromid. and chloral, 15 grains each. Drank it without seeming to taste it. Quieted him very slightly. Noise seemed to affect him. Mr. Jones dressed wound and opened flap. Calomel, 10 grains. Passed water in urinal at 8.45 P.M., and slept for a few minutes. At 12 midnight requested to be taken out of bed to night-stool. Micturated copiously, but bowels not moved. Slept one hour forty-five minutes in snatches; then became very restless, sometimes violent, requiring to be held in bed.

November 9th. Made several attempts to defæcate; at last a copious enema produced a copious stool. Slept an hour and a half. Restless, but at times rational. This morning asked,

"What's the matter with me? How long have I been bad?" In reply to a question, he said, "I feel burning all over." Mr. Jones got him to extend his knees. He groaned as if the voluntary effort was a great exertion. When he tossed them about in his restlessness, however, he complained of no pain. When lifting him out to the commode he tried to help, but grunted as if the slightest effort at rational movement cost a lot. Once when lifting him from the high bed, he wildly threw his arm behind him as if he were falling down a precipice.

November 10th. Slept quietly for seven hours last night. Quite sensible this morning.

Without going into any further details, it may be mentioned that he continued without any relapse, until his discharge, January 15th. The intervening period, however, was taken up in treating a hernia cerebri, which commenced to trouble him. The treatment consisted of moderate pressure by salicylic wool and bandage. There was a slight degree of headache on the first application of pressure, but this did not continue long. The pressure gave rise to no variation in the character or rapidity of pulse. The eyesight every now and again was obscured, but beyond trivial headaches and a small sinus leading to the trephine hole he gave us no anxiety. The accompanying diagram illustrates the patient's appearance on leaving hospital and the position of wound, while the site of trephine wound is represented by the dotted circle.

Fig. 4.

From the date of his departure from hospital, January 15th, until April 23th, the patient had no fit, but during the whole period there was a little discharge, off and on, from the sinus. On Sunday evening, April 28th, he went to a wake, and drank port wine, but came home perfectly sober and went to bed at 10. At midnight he had a fit, which came on during sleep. During the fit his nose bled, and the original wound where the depressed fracture occurred opened and bled.

Monday, April 29th. On admission, face very red, dark rings around eyes; conjunctiva diffused; wound from which blood came covered with a dry scab; the opening of sinus very much in same condition.

May 1st. Had two epileptic fits during the night, one at 10.30 the other at 11.15. Both came on during sleep; not ushered in with cry; convulsed all over, both sides equally. Not conscious between fits and until two hours after. To-day another fit; convulsions universal. Sedatives prescribed. Complained of a little pain in head.

May 4th. A little pus evacuated from vicinity of sinus.

May 6th. **Resection Operation.**—After hypodermic of morphine, ether was administered. Mr. Jones made a semilunar incision across the anterior limb of the former site, and scraped a

couple of sinuses. Having dissected the flap, the sinus was widened and some of the fibrous filling of the trephine wound removed. At the bottom of the sinus, projecting brainwards, was a small spicule of necrosed bone, which is illustrated by Fig. 5. There was considerable hæmorrhage from the fibrous bridge, which made the operation very troublesome. The subsequent history was satisfactory. There was for some days troublesome ptosis of the left lid, and for a couple of days some difficulty in emptying the bladder. He left the hospital in July perfectly well; has been at work for several weeks, and has suffered no return of brain trouble up to the present, October 17th.

Fig. 5.

Apart from the abatement of the fits, which immediately followed the operation, the case is interesting from other points of view. It denotes a practical recovery of brain function from the fracture of the cranial vault, although the blade of the inner table remained imbedded in an important motor area of the cerebrum. It is also significant that two years later there was no remnant of blood-clot, despite the lacerating of dura and cortex. The blade of bone had united, as shown in the diagrams, to the cranium by firm osseous medium. The probable cause of relapse was, as the patient suggested, excessive stooping, or the coughing induced by a bronchial catarrh. He was placed under the worst possible surroundings for operative purposes—a small room and candle-light, with no opportunity for sufficiently cleansing the scalp. He was removed a mile in a hand-ambulance immediately after operation, and tore his dressings off in hospital. He had an extensive hernia cerebri and a discharging sinus, which a few months later involved a second operation.

These are the main difficulties with which the patient had to contend, and the result has been very satisfactory. We are much indebted to Dr. Byrne for his care and observation of the patient.

CLINICAL MEMORANDA.

SUSPENSION FOR LOCOMOTOR ATAXY.

In the JOURNAL of September 14th, 1889, p. 602, Dr. Saundby gave details of six cases of locomotor ataxy treated by suspension, not one of which cases could, he said, be definitely stated to have derived benefit from the treatment. In the JOURNAL of October 5th, 1889, five cases of locomotor ataxy, similarly treated, are reported by Mr. J. R. Lunn and Mr. Lewis Hickey; in only one case were any favourable results obtained, and in that case the patient during the whole time was taking 15 grains of potassium iodide daily. In an article upon this subject in the JOURNAL of February 23rd, 1889, Dr. Althaus informs the writer of this article "that he has found suspension beneficial in two cases of tabes; lightning pains in one case, and in the other gastric crises have ceased. In a case of severe paralysis agitans the tremor ceased for thirty-six hours after the first suspension." Notwithstanding this early promise of success, Dr. Althaus was silent when the adverse reports appeared.

The Paris Correspondent in the JOURNAL of October 8th, 1887, p. 798, related two remarkable cases of spontaneous recovery from tabes dorsalis, after many years' continuance of pronounced symptoms. I have myself seen two cases almost completely recovered; both were middle-aged men. A young man whose case is known to many recovered absolutely; and the brother of a medical man near Leeds is now improving greatly. None of these patients were suspended. Many patients, however, do not improve either with or without special treatment, and if a new method gives hope and courage to such patients it is a sorry task to decry it. But suspension is no ordinary method; it is troublesome, expensive, perhaps rather dangerous, and in addition, according to the majority of published cases, so far not very successful in England.

Two cases occurred at the Leeds Infirmary in the early part of this year, one of which illustrated the possibility of sudden or rapid improvement in tabes after the symptoms had lasted three years; the other showed no improvement after several suspensions. These cases were therefore published with some remarks, among others that "Dr. Saundby's cases strengthen my own impression that the method of suspension will be found useless." Dr. Althaus having only one case to contend against, instead of eleven cases which he passes by, makes an attack in force: "Dr. Churton has, on the strength of a single case of tabes, in which he used suspension, and apparently also on that of a second case, in

which he did not use it, come to the conclusion that this treatment is useless, and sees no reason why it should be expected to do good."

The contemplation of this opening sentence produced in me a strange sensation of upside-downness. Need I, after what has been said above, stay to set it right? There is, *en revanche*, no want of distinctness in the views and the expressions of Dr. Althaus concerning the importance and injudiciousness of continuing suspension, albeit, with the toes on the ground, for five minutes at the first trial. The patient, however, had entire control over the time; the men of this county are tough and enduring; moreover, we merely followed what was understood to be the plan of the authorities who at that time held the field. I should entirely regret to think that I had given, or had tried to give, the slightest assistance in damaging a really useful method of cure or of alleviation. It is, of course, not to be denied that in therapeutics we must often be content to discover facts first and reasons afterwards; but if a method of treatment certainly fails far more often than it even apparently succeeds, and at the same time has no reasonable theory to support it, the end of that treatment is not far off. And this, so far as I can learn, seems to be the present state of suspension for tabes dorsalis in this country.

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THE NORMAL THORACIC RESONANCE IN LEFT-HANDED PERSONS.

It is a well-known fact in clinical medicine that the normal percussion resonance of the thorax is higher pitched on the right side than on the left; but, so far as I have been able to ascertain, no mention has hitherto been made of an important exception to this rule which exists in the case of left-handed persons. In all the cases of this kind which I have up to the present time been able to collect the difference between the thoracic percussion resonance observed in them and in ordinary right-handed patients has been both uniform and decided. As, however, I do not propose in this short preliminary notice to exhibit a detailed list of cases, I may just sum up the results obtained on thoracic examination as follows: 1. The percussion resonance is higher pitched on the left side of the chest than on the right, this higher pitch affecting all regions of the thorax. 2. The vocal fremitus is greater on the right side than on the left, agreeing in this respect with the normal right-handed thorax. The first of these points has a certain degree of theoretical interest, inasmuch as it confirms the generally-accepted explanation of the higher pitch usually observed on the right side, namely, that it is due to excess of muscular development on that side. It has also an obvious bearing on the diagnosis of an early stage of phthisis affecting the left lung, the points of distinction being: first, that the higher pitch in left-handed patients affects the entire left side of the chest instead of being confined to a particular region; secondly, that the vocal fremitus in the former case is greater on the right or lower pitched side.

I may mention, in conclusion, that I am still collecting cases, and hope shortly to publish a list with further particulars than I am now able to enter into.

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OBSTETRIC MEMORANDA.

CARBOLIC ACID IN PUERPERAL RIGOR.

ON May 29th, 1888, I induced premature labour in Mrs. T., a strong healthy woman with a large family, under the following circumstances.

In July, 1887 she was delivered at full term of a dead foetus, which was accounted for by a fright she had had six or eight weeks previously. I was not present at the labour, but saw her some three or four weeks after. She had made a bad recovery, and though I did not obtain the facts from my predecessor who attended her, I have no doubt had had puerperal fever, as antiseptic douches had been used, which was not his practice in ordinary cases, nor is it mine, this being a country district, in which in nine cases out of ten it would be impossible; besides, puerperal fever is almost unknown.

When I began to attend her she was suffering from pneumonia, but ultimately recovered. In April, 1888, she informed me she was again *enceinte*. About May 22nd she sent for me and said