In a very few cases the drill enters, not the antrum itself, but some of the cells opening directly into it, which will be just as effective as opening the antrum direct. In almost every case the drill used may be one-third of an inch in diameter; but, if a larger instrument be used, there will be danger, in a considerable number of cases, of opening into either the lateral sinus or cranial cavity. 4. It was found that in about 15 per cent. of cases, if a three-fourth inch trephine were applied at the point indicated by Mr. Barker for trephining in temporo-sphenoidal abscess, the lateral sinus would either be exposed in the opening or would run along its margin. It is suggested that a point half an inch higher should be selected. The site selected for trephining in cerebellar disease is safe as regards the lateral sinus; but occasionally the trunk of the occipital artery would be injured where it lies in the groove on the temporal, besides the bone at this point is thickly covered. A point two inches behind the centre of the meatus and one inch below the base line would give a site more superficial, and safe from sinus and artery. Mr. Wheeler's operation, if certain precautions be taken, will in the majority of cases afford a means of draining the mastoid cells and exploring the brain; but sometimes the antrum cannot be reached through the opening, owing to the low level of the upper surface of the petrosa. Amongst the minor details, a case of solid mastoid with entire absence of antrum is recorded; the varying distance of the lateral sinus from the back of the meatus and from the surface of the skull behind the ear is given. It is pointed out that occasionally the sinus is only one-twelfth of an inch from the surface, and the danger of incautious perforating at this part is dwelt upon. A point is given at which the sinus may always be reached by trephining. The position of parts represented on the upper surface of the petrosa is described, some inaccuracies frequently found in descriptions of this part are pointed out, and some observations upon the relations of the base line and upon the anatomy of the antrum itself are recorded.

AN ADDRESS ON SOME POINTS BEARING ON LUNACY PRACTICE.

*Delivered at the Annual Meeting of the South Midland Branch
of the British Medical Association.*

By DAVID BOWER, M.D.,
President of the Branch. Physician to the Springfield House
Private Asylum Bedford.

THE point most prominent at present in connection with lunacy practice is the proposal to facilitate the treatment of insanity by providing small hospitals for recent cases with a resident medical officer, and a visiting staff as at our general infirmaries. This experiment has been pressed upon the London County Council by a member of our profession, and his suggestion as to who should form the visiting staff seems to be based on the principle that those are most competent to treat mental diseases who have seen least of them, and that practitioners in lunacy have been standing still, whilst other practitioners have joined in the universal march of progress characteristic of the century. I take leave to deny this proposition, nor do I think it proved because we trust mainly to placing our patients in the best environment for availing themselves of the healing power of Nature, and have not yet discovered any drug which is a specific in general paralysis or dementia, as you have found none for cancer or consumption.

Another argument is that patients sent into our vast lunatic asylums are apt to be lost sight of as drops are in the ocean, and there is some ground to stand on here. The proper remedy, however, for this state of affairs is to be found, not in the establishment of new and separate petty hospitals, but in the fuller development of hospitals wards, either in or near the large asylums where all recent and acute cases could be kept together, and have the required special and individual attention from the superintending physicians. From these they could be drafted to the ward most suited to their needs if they did not recover in two or three months, or if they could no longer benefit by the special care of such a hospital ward. Old cases assuming new phases, or otherwise requiring special attention, could also be sent to the

hospital ward at any time. This plan is in operation in many asylums, and ought to be adopted by all. Were this want universally supplied it would soon show the presence of a further want in the matter of a large augmentation in the medical staff, and a wide extension of the system of employing in each asylum two or three unpaid post-graduate clinical clerks, and would thus utilise an immense field for study, at present very little available for use.

Another point in lunacy practice I have long wished to say something about is the want of more combined work between the asylum practitioner and his brethren in general practice. I am quite sure we in asylums and our patients would benefit greatly were outside medical men to visit the asylums to see with us cases in consultation. Their wider and larger experience in the diagnosis and treatment of bodily ailments, and, when seeing their own patients, their better knowledge of the family and personal history of such patients could not fail to be of great assistance to us in the conduct of our cases. On the other hand, I think the early treatment of mental diseases would be greatly promoted and the numbers requiring to be committed to asylum care largely diminished, at least in the case of non-paupers, if the asylum practitioner were called in in consultation at once, instead of, as is too often the case, waiting till the malady has developed so far that only asylum care is possible. Here I know that the patient's friends want much more educating than their medical man, and that a great obstacle requires to be removed, namely, the "restriction" in most cases, and "the prohibition" placed on consultation practice by the committees of pauper asylums and lunatic hospitals. The special knowledge of asylum physicians should not be for the exclusive benefit of lunatics inside asylums, and denied, as it is now, to those outside; it should be a very easy matter so to arrange that the consultation practice need not be carried on to the detriment of the patients in the asylum. Many properly selected cases of mental disease might be quite as well treated at home as in an asylum if the means of the patient permit; the patient would only require to be seen by the asylum physician once or twice a week in consultation with the family doctor, and would not then be left entirely in the hands of private attendants, who too frequently manage not only the patient but the doctor as well. Private attendants have unfortunately a tendency to retrogression, and although most excellent attendants when they are in the asylum under special medical control, soon get into evil and pernicious habits in their conduct of cases when not so controlled.

The only other point I will trouble you with is the matter of the certification of the insane, and unfortunately here we have to attend to legal rather than medical forms, and we are not now the final judges of proper treatment for our own patients; we must satisfy a magistrate that there are sufficient grounds for placing a patient under asylum treatment—"incarceration," as the lawyers are pleased to term it. The Association did all it could to assert the rights of medical men while the Bills were before Parliament, but now the time for criticism and amendment is past, and we must make the best of the procedure as we have it.

Some of you may have seen a correspondence and leader in the BRITISH MEDICAL JOURNAL on the working of the new Act, and I would again point out that it is very advisable, in the interest of the patient, that early treatment should not be delayed until a justice should be searched for who will know his duties under the statute; but that (as is the almost universal practice in Scotland) one of the medical men certifying should sign the urgency certificate in addition to his ordinary certificate; and this I think he may very fairly do, stating as his ground, that the patient (if not dangerous to himself or others) is not under proper care, and is requiring immediate asylum treatment. This would allow the patient to be sent to an asylum at once, and would throw all the trouble of getting the justice's order upon the asylum authorities, who, with their constant experience, would find it a much easier task than would the general practitioner who has to deal with only a few cases of lunacy in a year. Of course, it may be said, that it is the province of the relatives to take these steps, but we know quite well that in the majority of cases the whole burden of arrangement is thrown upon the shoulders of the medical man, and he cannot often shirk it.

May I, at the risk of appearing to lecture, point out that infinite trouble might be saved if certifying medical men would carefully read the side notes on certificates as they write, and so make quite sure that they are filling up the spaces properly? You will scarcely believe it when I tell you (but it is absolutely true)

that not one medical certificate in six coming to me is filled up according to the directions plainly set forth on the forms.

This necessitates the return of the certificates from the Commissioners to the asylum; from the asylum to the medical men for correction; they have then to be returned to the asylum and again sent up to the Commissioners. It may be said that they are often returned for trivial omissions, such as the want of the number of the street, but to the legal mind such trivialities are very important.

Again, in filling up the "facts indicating insanity," the directions should be carefully observed; as the law requires that not only shall the medical man be convinced in his own mind that the patient is insane, but he must put on paper facts observed on the day of examination, sufficient to convince anyone who has only the written document to go upon. It is always well, if a distinct delusion can be found, to state it clearly, and it is a very good plan to call it a delusion in the certificate; whenever I can, I use the form recommended by my old teacher of medical jurisprudence in Edinburgh, Dr. Littlejohn, as follows: "He or she has delusions, for example—"

It is also well to record any tendency to violence or destructiveness, and where peculiar, or parsimonious, or extravagant habits are set down as proofs of insanity, it ought always to be stated that these are at variance with the patient's usual habits when in mental health. Here I might point out that great advantage would result from what I advocated in an earlier part of this address, namely, consultation with an asylum physician before the patient is sent to the asylum, as not only could he advise as to the proper cases for asylum and home treatment, but could say whether the evidences of insanity obtainable were sufficient to warrant certification.

NOTE ON A CASE OF APPARENT POISONING BY INGESTA OF OYSTERS.

By SIR CHARLES A. CAMERON,

Professor of Hygiene and Chemistry, R.C.S.I.; President of the
Public Health Medical Society.

In a recent number of the *BRITISH MEDICAL JOURNAL* I gave an account of four fatal cases of poisoning by mussels. I have now to place on record cases—fortunately not fatal ones—of apparent poisoning by oysters. On Saturday last, September 6th, twelve persons in Dublin had luncheon consisting of oysters, chicken and bacon; nine partook of oysters, chicken and bacon, two of the chicken and bacon and one of oysters only. The person who ate only the oysters, and eight of the nine persons who had eaten oysters and chicken and bacon subsequently suffered severely from nausea, vomiting, diarrhoea, and abdominal pain. In some the prostration was very great. In some the symptoms appeared on Saturday night, in the others on Sunday morning. At present (September 10th) the majority are still ill, and confined to their rooms. The oysters seemed to be quite fresh. There was a great scare about oysters in Dublin last winter; very many persons attributing to their use attacks of typhoid fever, diarrhoea, etc. The sale of oysters almost died out in Belfast; it was a common impression that typhoid fever had been caused by eating oysters.

At the meeting of the British Medical Association, at Cambridge, I read a paper entitled *Sewage in Oysters*, in which I pointed out that oysters growing in estuaries and other places to which sewage has access must often contain sewage in their juice. Indeed I found this to be the case with oysters collected near Dublin.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

THE TREATMENT OF CHOLERA BY BLISTERING OVER THE VAGUS.

CHOLERA having made its appearance again in Europe, and much interest attaching to all that belongs to it, I desire to make known a method of treatment which I adopted nearly three years ago in India with very remarkable success.

While I was stationed at Neemuch, Central India, in 1887, cholera of a very virulent type broke out amongst the European troops there, and all the cases were at first fatal, collapse setting in in a very few hours, and death speedily following. They were all attended with violent abdominal cramps, and constant vomiting and diarrhoea—even a single mouthful of milk, or milk and soda-water, being immediately rejected. Of course, under these circumstances, all medicines given by the mouth proved useless: given *per anum*, nothing was retained more than a minute, and those administered hypodermically produced no lasting impression.

Being convinced that no treatment could be of any avail till the vomiting was restrained, I considered it possible—all other means having signally failed—that I might attain that result by acting through the nervous influence of the pneumogastric (bearing in mind the distribution of this nerve to the stomach) by stimulating it by blistering along its course in the neck, from the styloid process to the clavicle.

An opportunity was afforded me very soon of putting my theory to the test, a man being brought to hospital with unmistakable cholera, who was attended by two of his comrades, who volunteered for that purpose. The usual methods of treatment, which were adopted at first, having failed to go any good, and the vomiting being incessant, I painted the right side of the neck, along the course of the vagus, with liq. epispasticus, and found, to my great satisfaction that, in from ten to fifteen minutes, the vomiting ceased, and he could now retain whatever was given him, food or medicine. This result lasted some hours, and whenever vomiting recommenced, however slightly, I applied the blistering fluid again, putting it on each side of the neck alternately, as by this precautionary measure nothing more than redness of the skin was produced, and the discomfort of a blistered raw surface was avoided. This amount of irritation of the skin, I found, was quite sufficient to prevent vomiting, and the patient being now able to retain milk, brandy, etc., and a mucilaginous astringent mixture with tr. nuc. vomice, he made a rapid recovery, being out of danger in twenty-four hours. So marked was the effect of the application of the blistering fluid, that his comrade attendants repeatedly voluntarily remarked to me on my going into the tent to see him, that the "stuff" I put on his neck always stopped the vomiting almost immediately.

Surgeon-Major Waghorn, M.S., now stationed at Newport, Mon., who was in charge of the hospital at the time, and who has had very great experience in the treatment of cholera during a residence of nearly twenty years in India, was much impressed with the good effects of my treatment, to which alone he believed the man's recovery was due.

I used the tr. nuc. vomice to brace up the nervous system generally, having observed in all the cases how severe and protracted was the nervous depression which always set in very early. It had also a very good effect on the diarrhoea, indeed, the vomiting being absolutely under control, the diarrhoea became easily manageable.

Since then I have not had a chance of further using this treatment, but I hope this note may obtain for it a trial by all who may have the opportunity. D. V. O'CONNELL, M.D., M.Ch.,
Aden. Surgeon, Medical Staff.

RECTAL OBSTRUCTION IN A CHILD.

I WAS requested to visit T. E., aged 10 years, said to have obstruction of the bowels. Though quite well the day previous, he complained of severe pain in the abdomen, also in the region of the seat when at stool, to which he had frequent and ineffectual calls. Aperients had been administered without effect.

The lad lay in bed in a semi-knee-elbow position, the knees drawn up under the belly, the buttocks being raised and the chest and shoulders low. On examination the rectum was found blocked with a mass of wheat grains, which the bowel was powerless to eject: this was scooped out, with instant relief. An aperient was ordered. Next morning I found the child crying out with the severe abdominal pain and bearing down in the pelvis, and lying in the same position as the day before. The aperient had had no effect, but liquid continually oozed from the bowel; the urine dribbled away. The sphincter ani was seen dilated to the size of a shilling, and a wheat-grain mass could be seen filling the bowel. Immediate relief attended its removal. This second mass of grains had come down from higher up the bowel, aided by the aperient.

It was interesting to note (1) the inability of the bowel (*plus*