specialists considering this affection, as Mr. Browne had done, in connection with obstruction to venous circulation in the chest and abdomen. He also asked if there was any one local condition that produced pharyngeal tenesmus more than another. In reference to treatment one should have two objects in view, namely, to promote the welfare of the general circulation as well as the local condition, and it was important to be clear as to what region required treatment the most.—Dr. JACOB wished Mr. Browne would define more exactly the conditions which led to those symptoms which seemed to him to proceed from a large number of morbid conditions of the throat. Was tenesmus more likely to be caused by hypertrophy of the lingual rather than the other tonsillar bodies? With regard to "neuroses," he thought the number of such cases would be likely to diminish as knowledge increased. Neurosis being mainly an increased irritability to react to stimuli, in a neurotic person a smaller cause had to be searched for.—Mr. LENNOX BROWNE, in reply, said that in his experience mild astringents and vapours were useless. Hypertrophy of the lingual tonsil was rare in children, but common in adult life at a time when the other gland had shrunk. He had not alluded to the form of hypertrophy mentioned by Dr. Hill, but agreed with him as to its being often the cause of the symptoms described in the paper. He agreed, also, with Dr. Downie that the condition was undoubtedly due to a neurosis, and so he had always insisted, but it was rare that objective evidences of the neurosis could not be found if searched for. Many of these cases were mistaken for pulmonary hæmoptysis, and yielded to proper treatment. Replying to Dr. Donald Stewart and Dr. Jacob, he believed that the condition he described was an extension of ordinary pharyngitis, and he personally had been far more successful in treating that troublesome affection since he had recognised lingual tonsillar hypertrophy and varix. The condition was undoubtedly more common in women, probably because their vasomotor system was generally more debilitated than in the male sex. He concluded by saying that it was of primary importance to recognise and treat underlying constitutional and exciting functional and other causes; but this was true of every other disease, and should never be lost sight of by the specialist.

Insufflation of Medicated Air.—Dr. HARTNETT read a paper in which he pointed out the advantages of the insufflation of medicated air over inhalation, and described and exhibited an apparatus which he had devised for that purpose.¹—Dr. BRONNER thought such instruments were mainly useful for occupying the patient, and were of only a palliative character.—Dr. WALKER DOWNIE said he had found Dr. Hartnett's apparatus useful in several cases of granular pharyngitis. Guaiacol he had found a useful substitute for creasote. It was a powerful germicide, readily miscible with oil, and was free from the disagreeable odour of creasote. In combination with menthol, he used it largely as an intralaryngeal injection.—Dr. HARTNETT, in reply to Dr. Bronner, said pharyngitis and other affections of the membranous lining of the respiratory tract were often but the local manifestations of constitutional disease, and it would be as irrational to neglect the local treatment as it would be for a surgeon to neglect dressing a wound, and attend only to the constitutional symptoms.

Large Nasal Polypi.—Dr. WALKER DOWNIE (Glasgow) exhibited specimens of unusually large nasal polypi, and described the methods used in their removal. The first one was removed from a lady, aged 74; it measured 2½ inches in length, and 1½ at its greatest depth. Two specimens taken from another woman, aged 49, were also shown, the larger of which was 3½ inches in length. Another specimen was removed from a man, and, after prolonged immersion in spirit, still measured 2½ inches in length. Another polypus shown weighed a few grains short of half an ounce, and had occupied the postnasal space. All of these polypi were removed with forceps with long blades, hollowed out along the centre line of their inner surface, and furnished with fine teeth along the edges; the handles were provided with a lock. The forceps was introduced under good illumination with the blades open, so as to include the whole area from which the polypus sprang, along with a thin scale of the lower edge of the bone. They were then closed, locked, and left in position, by which manœuvre the vessels leading to the growth were so crushed that little or no bleeding followed the removal of the polypus. After two or three minutes the forceps was gently turned round, and, when half or two-thirds of a complete turn had been given, the mass readily came away. The nasal fossa was then plugged with

antiseptic wool, and the patient left for a week, when if any other polypi were visible they were dealt with in the same way. The mucous membrane in the neighbourhood of the parts from which which they sprang was then carefully seared with the electric cautery. In the case of small polypi with distinct pedicles, he used the galvano-caustic loop, or cold wire snare, followed by cauterisation of the site of the growth. In every case cocaine was used before the operation.

Pharyngeal Tonsil and So-called "Relaxed Throat."—Dr. ADOLF BRONNER, Surgeon to the Bradford Eye and Ear Hospital, drew attention to the frequent occurrence of diseases of the pharyngeal tonsil or adenoid tissue at the vault of the nasopharynx. Enlargement of this tonsil, commonly called postnasal growths, was very common in children. About 4 or 5 per cent. of all children had postnasal growths. These growths were of great importance in connection with diseases of the middle ear. Nearly 90 per cent. of children with postnasal growths had affections of the ear. The growths also prevented the normal development of the chest and predisposed to diseases of the lungs. This fact was of very great importance, and not sufficiently appreciated. In most cases of postnasal growths there was enlargement of the turbinated bones and also of the faucial tonsils. In these cases they ought first to remove the growths, and then, in many cases, the other affections subsided without any local treatment. Dr. Bronner had seen numerous cases in which the galvano-cautery had been applied to the nose and faucial tonsils in a most vigorous manner, and the pharyngeal tonsil not treated; also cases in which all three parts had been treated, when the removal of the postnasal growths alone would have sufficed. He used Hartmann's curette in removing the growths, and very rarely gave an anæsthetic. The operation for removing the growths would never become popular as long as surgeons used large and clumsy instruments and gave anæsthetics. Towards the age of puberty the growths underwent spontaneous degeneration; but in these cases the pharyngeal tonsil very rarely became normal. On careful examination they found chronic catarrh or atrophic catarrh or Tornwaldt's cysts. If the growths were removed they rarely found any subsequent changes in the tonsil. In most cases of chronic diseases of the nose or pharynx the pharyngeal tonsil was found to be affected. Tornwaldt's cysts were very common, though not always in the middle line of the tonsil, as Tornwaldt asserted. Dr. Bronner used a modification of Hartmann's curette for the removal of the cysts. In most cases of postnasal catarrh or relaxed throat the seat of mischief was in the pharyngeal tonsil.—Dr. DONALD STEWART said he always used an anæsthetic in removing the growths, and he held that in slight cases an alkaline wash would effect a cure; and, further, that if the operation were once properly performed, it would not again require to be repeated. In giving due attention to this affection, the surgeon had the most gratifying results in ear and throat affection.—Mr. MARSH said he had operated upon a considerable number of cases of nasopharyngeal growths. In children he invariably employed an anæsthetic, both to avoid the fright and struggling and to ensure thorough removal. He preferred the recumbent position with the head low over a pillow, and had never had the slightest difficulty from blood passing into the larynx. He used either a curette—and thought in the position he placed the patient a straight one was more easily manipulated than Hartmann's—or Walsham's modification of Löwenberg's forceps, preferably the former, on account of the greater rapidity with which it could be used. Personally he had been quite unable to remove these growths with the finger nail, and thought where this was possible no operative procedure was needful, but that careful local treatment would prove quite as efficacious. His results had been very gratifying both as regards the rapid benefit to the patient and the non-recurrence of the growths.—Dr. GRÉVILLE MACDONALD dissented strongly from the practice of removing postnasal adenoids without an anæsthetic, and advocated the employment of forceps in preference to curettes.

REMARKS ON FUNCTIONAL APHEMIA.

By ERNEST H. JACOB, M.D.
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FUNCTIONAL disturbances of the faculty of speech are by no means uncommon. Megrim may be attended with a very considerable amount of aphasia. There are few cases of chorea without some impairment of speech. The dumbness of fright and emotion, as is well known, and functional paresis of the laryngeal adductors

¹ See BRITISH MEDICAL JOURNAL, August 23rd, p. 462.

is one of the commonest nervous affections seen by the laryngologist.

By aphemia I mean a pure motor aphasia, in which the intellectual faculties are unaltered and the patient is able to understand perfectly and to express himself without difficulty in writing. In spite of the classical objections to the use of the term "aphemia" (infamy) it is a convenient one to express this condition.

In a lecture on "A Case of Hysterical Mutism in the Male," Charcot describes, with his characteristic clearness, a case of functional aphemia, remarking how rare a symptom this is of organic brain disease, and in an appendix to this lecture, as published in the New Sydenham Society's translation, Dr. Cartez gives an abstract of 20 cases in both senses which may be classed under this head, six of them from Charcot's clinique, and notes the laryngological phenomena. Of these two are taken from Dr. Wilks's book on nervous disease. But records of cases of this kind are rare in English literature. Dr. Bristowe has published two, and one described by Dr. Bastian in his opening address in the Medicine Section of the British Medical Association at Dublin, may perhaps come under this head. The special interest of the subject for this Section is the fact that functional aphemia may complicate or alternate with functional aphonia, which is so common, or, as one of my cases shows, supervene in the course of an ordinary laryngitis.

This is not the place to discuss the vexed question of the localization in the brain of the functional defect, whether, according to Dr. Ross, it bears on the question of the value set on Broca's convolution as a real centre of speech; or involves merely a break in different internuncial fibres in their course from the left glosso-kinesthetic centre to the articulatory centres in the bulb, as held by Dr. Bastian. The condition resembles superficially in many respects the loss of speech in advanced bulbar paralysis, though happily there is very little danger of confusing them.

Two cases of functional aphemia have been recently under my care, and in addition to these I have seen a third case in which somewhat similar symptoms were noted, but on the absence of organic disease in this last I am by no means sure.

The first case was in a man aged about 50, who applied for relief at the out-patient department of the Leeds Infirmary, bringing a paper on which was written: "I have pain in my shoulder, I can hear but not speak." The history, obtained subsequently, showed that he had had fits in infancy, but enjoyed good health till he was 34, when after monetary losses he began to show signs of mental instability, violent temper, etc., and when agitated was unable to speak. He gradually became perfectly dumb, though he retained for some years the power of saying "yes" and "no." For the last five years he had not spoken, communicating with his wife by means of signs and writing, but understanding perfectly what she said. He seemed quite intelligent, could cough and blow out a candle. He resisted laryngoscopic examination, but I was able to ascertain that the cords could be approximated, and occasionally a hoarse sound uttered. There was no attempt at articulation, though he willingly made attempts when urged to do so.

The pain in the shoulder was found to be due to dislocation. No account could be given of this, except that six days before he had wakened in the night and found his arm in pain, (In all probability he had had an epileptic fit and fallen out of bed.) Thinking to investigate the aphasic symptoms later, I asked my surgical colleague, Mr. W. H. Brown, to reduce the luxation. To facilitate this, ether was administered, and on recovery from the narcotism he began to speak clearly and volubly, evidently much pleased at recovering his power of speech, and determined to make up for lost time. Some weeks after, when I saw him again, he was speaking well. I wish to point out here that there was no wilful dumbness, such as is not uncommon in cases of insanity. The man was greatly pleased at recovering his power of speech; nor was there the entire loss of phonation which obtains in functional aphonia, though there was great want of tension of the vocal cords. The patient was not morose or melancholic, though occasionally giving way to passion.

The next case occurred in a healthy-looking miner, aged 34. He applied on January 13th, 1890, suffering from slight hoarseness, and his cords were injected. He gave a history of having had some epileptic fits eight years ago, six in all, and at one time he had been intemperate. Some zinc chloride was applied to his larynx, and a pine-oil inhalation prescribed. A week later he appeared with a paper, on which was written, "Five days ago I

lost my voice. I feel as well as ever I did, but I have not been able to talk, and I cough." Inquiry showed that he had been quietly talking with some friends on no very exciting topic, feeling rather hoarse, when he was suddenly seized with dumbness. His larynx was now rather difficult to examine, but the cords could be approximated without tension, and an occasional hoarse grunt elicited. After a few trials he managed to utter one or two vowel sounds. Remembering the effect of the anæsthetic on the former case, I had ether administered. After he had taken one or two breaths the inhaler was removed, and he articulated "Yes" in answer to a question, and after recovery from narcotism could talk freely. He remained an out-patient for a few weeks, but there was no return of the dumbness.

A third case is perhaps worth mentioning, though the history is by no means complete.

A man, aged 35, temperate, stated that eight months ago he was seized with vertigo in the street (four months previously he had fallen from a bicycle and hurt his head). He walked home without assistance, but an hour after he became unable to speak, though he was otherwise perfectly intelligent, and this inability lasted about twelve hours. I have no note as to whether he could write. When seen he was suffering from a general nervous condition, with inequality of pupils, some wasting of the left leg, and slight hesitancy of speech, suggesting an early condition of general paralysis. He has, however, greatly improved under treatment, and is now nearly well. There was no history of syphilis.

On the last case I do not offer a very positive opinion as to whether or not the lesion might not possibly have been an organic one. The two others, however, are strictly comparable with those collected by Dr. Cartez. Taking the whole series of recorded cases, we see they vary very greatly in point of severity. Case III of the French list, that of a girl who was dumb for eight days during an attack of chorea, records a by no means uncommon phenomenon. Case VI was that of a man aged 20, who became both deaf and dumb, after a severe disappointment, for fourteen days. Case IV was that of a lad, aged 19, suddenly seized with mutism and a number of characteristic hysterical symptoms. On the other hand, the English cases showed a much more severe list of symptoms, such as a status epilepticus, lasting many hours and frequently repeated—a condition of nervous discharge with consequent exhaustion, which would be likely to produce very serious effects. We are comparatively unfamiliar in England with true hysteria in the male, at all events, in adults, and I consider my second case, occurring as it did in a strong Yorkshire miner, with a not very well-marked neurotic history, as very remarkable. I regret no further search was made for other hysterical symptoms, anæsthesia, etc., in this case.

I would further point out that in neither of Cases I and II were the adductors of the larynx completely paralysed, though the tensors were paretic. The laryngoscope shows very different degrees of paralysis in these cases. In one case, reported by Dr. Johnson, of Chicago, the cords were in the cadaveric position, later the cords could be somewhat approximated, but the arytenoid remained powerless. In another case there was paralysis of one adductor. In mine, as I have noted above, the cricothyroid was mostly involved.

It is said to be easy to induce this condition artificially by hypnotic suggestion in suitable cases. This may possibly give a hint towards treatment where other means have failed. I can find no note of the treatment of this condition by anæsthetics, though the method is well known as a treatment for hysterical aphonia. Electricity has frequently failed. One of Dr. Bristowe's cases was laboriously taught to speak in the same way as a child learns. In many cases the voice returned gradually of itself after a condition of stammering or hesitation lasting several days.

In conclusion, I cannot but think these cases must be rather more common than is generally supposed. To quote the words of Dr. Bristowe: "When one considers the nature of the nervous disturbances by which aphonia and aphemia are respectively caused, and the close functional relationship there is between these two factors of speech, it seems odd that aphemia should not be a more common outcome of hysteria and more often associated with hysterical aphonia than it is."

At a recent meeting of the Academy of Sciences, Paris, M. le Baron Larrey presented Dr. Bateman's treatise on Aphasia. According to the *Transactions* of the Academy, the work was so well received by the Academy that it was referred to the committee for the prize in medicine and surgery for 1891.