constipation remains some time without any other bad symptom, the addition of a small quantity of watery extract of aloes to the above drugs; in others, small doses of sulphate of magnesia frequently repeated, have proved most effective, either being at once stopped on the return of any acute symptom.

By these means, most of my cases of obstruction have had a favourable termination. In those which have unhappily terminated fatally, the *post mortem* examinations have shown that abdominal taxis under ether (which I have never employed, although probably of the greatest use in exceptional cases) would have been useless, and that no further relief would have been possible, except by opening either the colon or the small bowel by operation.

In another paper, I hope to be able to give an analysis of a number of cases, also a new mode by which, I believe, obstruction of the colon may be more accurately diagnosed.

DROPSY OF THE AMNION SIMULATING OVARIAN TUMOUR.

By H. W. BODDY, M.B.Lond.,

Assistant-Physician to the Clinical Hospital for Women and Children, Manchester.

ON April 27th, Mrs. E. requested my attendance, complaining of what she thought was dropsy. She was a sallow and rather emaciated woman. She had already borne four children, and was advanced six months in her fifth pregnancy. She was in her usual health, and had gone on as in former pregnancies until about a month ago, when her abdomen began to enlarge rapidly. She was confined to bed. She said that within two or three days she had felt the movements of the child. On inspection, the abdomen appeared much and uniformly distended. On percussion, fluctuation was unusually distinct, showing the presence of fluid in large quantity. The umbilical and hypogastric regions were unduly prominent; both iliac regions were resonant to percussion, and there was dulness along the centre line of the abdomen. The heart was normal in its sounds. The urine was scanty, with much deposit of urates, but not albuminous. On vaginal examination, the os uteri was with difficulty reached by the finger; it was closed, and of usual size. The whole of the abdomen was occupied by the tumour; and the patient complained much of the dyspnoea and pain caused by the excessive abdominal distension.

My diagnosis at this stage was that of a large unilocular ovarian cyst, complicating pregnancy. A purgative and a diuretic mixture were given to increase the flow of urine.

At my next visit, the woman was out of bed, and able to go about, saying she felt much better,—evidently the result of the purgative and diuretic. Two days after this, however, she was again confined to bed, complaining greatly of the abdominal distension and pain. Next day, the patient complained of something like, though differing from, labour pains. I again made a vaginal examination. The os was slightly dilated, and the membranes protruding. With the finger of one hand within the vagina, fluctuation was distinctly felt when the abdomen was percussed with the other hand. The case then became clear as one of excessive dropsy of the amnion. I then punctured the membranes, and a very large quantity of fluid gradually drained away. Two days after this, labour set in; it was very lingering, lasting for a day and a half. The pains gradually became weaker and less frequent. I therefore applied the long forceps to the head, and completed delivery without much difficulty. The head was enormously hydrocephalic. The body and limbs were small, much as would be expected in a six months' foetus.

The lingering character of the labour was to be accounted for—1. By the difficulty of forcing an enlarged though soft head through the passages; 2. By there being so small a bulk of body and limbs for the uterus to contract upon; and 3. By the over-distension, as well as want of development, of the uterine muscular fibres, diminishing the propulsive power.

It appears to me that the diagnosis of dropsy of the amnion, though it occurs somewhat frequently, is not sufficiently insisted on, and, in fact, is hardly mentioned in our best text-books on midwifery and diseases of women. Very little, indeed hardly any, mention is made of it in either Barnes's, Playfair's, or Leishman's manuals. It cannot be an excessively rare disorder, as I myself know of four cases that have occurred.

The diagnosis of this disease is not very easy; for Dr. Kidd lately read a paper before the Dublin Obstetrical Society, in which he said he had tapped a case of amniotic dropsy through the abdominal walls, believing it to be an ovarian tumour, without bad result, for the patient recovered after the birth of dead twins, and has since had a normal

pregnancy. Still it would be desirable not to run the risk, by this operation, of possible extravasation of blood or other fluid into the peritoneum, and consequent peritonitis.

With ordinary care, the mistake of confounding this disease with ascites could not be made. A multilocular or solid ovarian tumour would also be distinguished from an over-distended uterus by the irregularities in its form. The greatest difficulty would be to distinguish this disorder from an ovarian monocus associated with pregnancy. The rapid growth of the tumour, and its always central position, would be means of distinguishing hydramnios; also, on vaginal examination, as Dr. Kidd says, the position of the uterus would help us, for in amniotic dropsy the os uteri is high up, while in ovarian tumour it is forced lower by the superincumbent mass.

Since writing out the previous case, I have seen, in the JOURNAL of September 7th, an account of another case of dropsy of the amnion by Dr. Hunt of Wolverhampton. It differs in several respects from mine, but the suggestion thrown out as to the cause of hydramnios seems a very probable one. The suggestion is that it is due to obstructed circulation through the umbilical cord and placenta.

As a rule, dropsy results from impeded circulation, and more especially impeded venous circulation; as, for instance, ascites results from obstruction, either to the portal vein itself or to its radicles within the liver. In an exactly analogous manner, disease of the umbilical cord, or of the placenta itself, would cause a transudation of serum through the amniotic covering of the cord and placenta, and so hydramnios would result. In my case, both placenta and cord were too soft and decomposed to give any information. There may have been some latent syphilis, as the husband had been twenty years a soldier, but there were no signs of it either in him or his wife. The four previous children are all quite healthy.

The phenomenon of hydrocephalus in the foetus was doubtless causally connected with the amniotic dropsy, resulting from venous congestion of the foetal arachnoid membrane.

ON CASES OF CEREBRAL TUMOUR AND OTHER FORMS OF BRAIN-DISEASE, WITH SPECIAL REFERENCE TO THE DOCTRINE OF LOCALISATION.*

By T. R. GLYNN, M.B.Lond., M.R.C.P.,

Physician to the Royal Infirmary, Liverpool.

THE cases to which I am about to direct your attention are, with one exception, cases of cerebral tumour which have recently come under my care, and in which I have had opportunities of making careful *post mortem* examinations.

The characters of the clinical phenomena which patients with cerebral tumours exhibit depend, in large measure, on the nature of the tumour; the rapidity of its growth; the existence or not of inflammatory action, or hæmorrhage, about it; the implication or not of membranes or of nerve-trunks; and also, and perhaps in larger measure, on the site occupied by the tumour, on its relation to convolutions and ganglia.

The extraordinary progress recently made in our knowledge of the structure and functions of the brain renders the study of the symptoms attending affections of different parts of it very interesting.

The first case to which I shall allude is not one of cerebral tumour, but of *embolic obstruction of the left posterior cerebral artery*. I refer to it, because it seems to me to afford authoritative evidence as to the nature of the functions of the posterior lobes of the brain.

CASE I.—John H., aged 36, was admitted into the Royal Infirmary on February 13th, 1877, suffering from advanced phthisis. He was an intelligent man, but weak and emaciated. He progressed favourably till March 1st, when I learned that his manner had become suddenly strangely altered, and his mind affected. I was told that he had got out of bed during the night, it is presumed to go to the urinal; while walking, he staggered and his right hand became clenched; a nurse went to him, and, with her assistance, he walked back to bed. He was fidgety and restless all night after this.

I found him lying on his back; his expression perfectly vacant, his eyes open, and directed as if looking at something on the opposite side of the ward. When spoken to, he did not turn his head or eyes in the direction of the speaker; a light passed before his eyes was not noticed; the pupils were normal in size; they contracted slowly when a light was held close to them. The left pupil was smaller than the right. When asked if he saw a lighted candle we held near him, he looked

* Read before the Medical Society of Liverpool.

quite in the wrong direction. He generally repeated every question like an echo. Thus, when I said "Put out your tongue", he repeated "Put out your tongue". There was no thickness of speech. He made no complaint of discomfort, nor referred to his loss of sight. We found it very difficult to make him do what we wished. There was no paralysis of the face; no deviation of the eyes. He drew his feet up when tickled, and moved his arms. There was no rigidity. He took his food from a feeding-cup put to his lips, but never asked for anything. He flinched when his arms and legs were pricked. There seemed to be hyperaesthesia of the right arm, as he drew it away, when lightly touched, with an expression of pain. Temperature in axilla: morning, right 101.4 deg. Fahr., left 101.6 deg. Fahr.; evening, right 102 deg., left 102.6 deg. His usual temperature had been about a degree lower. Pulse, respiration, and physical signs as before.

March 6th. He was very restless all night, tossing about in bed, but was not noisy. He slept a great deal in the daytime; mouth open; lips and teeth covered with sordes; tongue dry; pupils dilated. Sight was tested again; its loss appeared to be complete. He struck savagely at the clinical clerk, who was testing the sensibility of the skin by pinching the right arm. He passed his urine naturally; it contained no sugar, and appeared otherwise normal. During the next few days there was no decided change in the brain symptoms, but he lost strength rapidly.

March 9th. There was complete paralysis of the extensors of the right hand. He drew up his feet, as before, when pricked.

March 10th. The temperature commenced to fall. It was, in the morning, in right axilla 100.8 deg. Fahr., in the left 100.8 deg. Fahr.; in the evening, in the right 100.4 deg., in the left 100.6 deg. The next day, it was a little lower; and, on March 12th, the temperature was, in the right axilla 99 deg., in the left 99.4 deg., just before death, which appeared to be due to exhaustion.

Post Mortem Examination.—The left posterior cerebral artery was distended by a non-adherent cylindrical plug, which reached from the commencement of the artery to the posterior part of the left crus. The left occipital and the temporo-sphenoidal lobes in their lower parts were softened. The latter in its anterior and outer third was hollowed into a cavity the size of a hazel-nut; the left crus did not appear to be softened; there was no decided softening of the corpora quadrigemina. There were no other abnormal appearances in the brain. The apices of both lungs contained cavities.

REMARKS.—The embolon, probably originating in a pulmonary vein, had reached the brain by an exceptional route, through one of the vertebrals, the basilar and left posterior cerebral. The evidence furnished by the symptoms in this case favours the views of Hughlings Jackson, Bastian, and others, who regard the posterior lobes, and not the anterior, as the seat of the higher intellectual faculties, rather than the views of Ferrier, who looks upon these lobes (the occipital) as the seat of the organic or visceral sensations. The alteration in my patient's mental condition was as strange as it was sudden and striking. From an intelligent man, he was reduced to something like an automaton. He was not in the helpless condition of a patient with right hemiplegia and aphasia, but his expression was far more fatuous. He was not emotional, given to tears or laughter—his mind was too weak—but was decidedly irascible, as I have shown. Thought and will seemed to be annihilated. He repeated words immediately after a question, but could not give any account of his condition. He no longer complained of cough or discomfort, never referred to his loss of sight, asked for nothing, and rarely moved unless it was at night, when he became restless. Dr. Bastian, in his *Lectures on Paralysis from Brain-Disease*, points out that, as the corpora quadrigemina are supplied by branches of the posterior cerebral arteries, impairment or loss of vision should follow obstruction of one of these, and that in the eye opposite the plugged vessel. My patient suffered from complete loss of vision of both eyes. On the other hand, though the posterior cerebral arteries supply the cerebral crura, the only evidence of loss of muscular power we could detect was the paralysis of the extensors of the hand. However, as the man was too weak to walk, and it was difficult to make him do what we wished, it was impossible thoroughly to test his strength.

CASE II.—In this, a fibrous tumour, springing from the dura mater, implicated the left supramarginal and angular gyri.

E. Williams, aged 30, was admitted into the Royal Infirmary, April 24th, 1877. Before admission into the hospital, he was attended by Dr. Townsend, to whom I am indebted for the history of the early symptoms. He had been an intelligent steady man. About nine months before admission, he commenced to suffer from headache; his intellect became very weak, and his memory so bad that he was found to be quite incapable of conducting his business. Two months before admission, the headache became very violent in the temporal regions. There were general weakness, vomiting, loss of appetite, and restlessness. He gradually became more apathetic, and lost his memory completely.

He occasionally became quite wild at night, talking incoherently, and rambling about his room. On one occasion, he was caught holding a large piece of blazing paper, which he was regarding unconcernedly, though the flames were dangerously near him. He used to walk about the house without taking the slightest notice of, or interest in, anything. He never had a fit of any kind, or apparently any affection of sight.

The first motor disturbance occurred about fourteen days before he came under our notice, when his right arm became weak and his speech affected. It was noticed that he forgot the names of familiar things. He walked up four flights of stairs into the ward with a little help, dragging the right leg slightly. He was perfectly listless; lay on his back in bed, occasionally putting his hand to his head, as if in pain. His head was turned to the left; the eyes were partially closed and directed downwards, and to the left; the pupils were dilated from atropine. He did not answer when spoken to; showed little signs of intelligence, closed his fingers when told to do so, but did not squeeze as firmly with the right as with the left hand. He raised the left leg from the bed, but not the right, when ordered to do so. There was no rigidity. Pulse small, 72; respirations 12; temperature in left axilla 97.2 deg.; in right 98.8 deg. Fahr. The tongue was dry, stripped of epithelium. He had no notion of feeding himself, but swallowed liquids without difficulty. The abdomen was flaccid. The urine was alkaline; it ran away when the bladder was at all distended; he could not pass it voluntarily. There were no bed-sores. Ophthalmoscopic examination showed that there was double neuritis.

He continued much in the same condition for a few days. He said "drink" when he wished for water, but asked for nothing else. He very seldom moved the right arm. The right hand often became flushed and hot. Temperature on the 27th: in left axilla 98 deg.; in right 99 deg. Fahr.

On May 2nd, he seemed better, and told us his name; but, after this date, he became worse, bed-sores appeared, and the temperature gradually rose, till, on the 5th, it was in the morning, in the left axilla, 102 deg.; in the right 103.6 deg. Fahr.: in the evening: left axilla 103.6 deg.; right 104 deg. Fahr. The pulse was very small, 170; respirations irregular, 36. On the 7th, he became comatose, the respirations became much hurried, and the temperature rose very rapidly; in an hour and a half, it was, in the left axilla, 109 deg. Fahr.; in the right 110 deg. Fahr. Cold sponging was resorted to, and the temperature fell in half an hour—in the left axilla to 106 deg. Fahr.; in the right to 107 deg. Fahr. It rose again, and, a short time before death, was 109.3 deg. Fahr. in the mouth and rectum.

Post Mortem Examination.—On removing the skull-cap, a small fibrous tumour, about the size of a chestnut, was found attached to the dura mater and buried in the left hemisphere, near the termination of the Sylvian fissure. On close examination, it was found that it had implicated part of the supramarginal and angular gyri, and that the brain in the vicinity of the tumour was softened. The rest of the brain appeared to be healthy.

REMARKS.—A correct diagnosis as to the existence of a tumour was made in this case by the aid of the ophthalmoscope. From the profound impairment of the mental faculties, and the absence of decided motor symptoms till towards the termination of the case, I considered it probable that the growth was situated in one of the posterior lobes of the base, and, as there was paresis of the right hand, probably in the left. Ferrier considers the supramarginal and angular gyri to be the centres for vision. Sight did not appear to have been decidedly affected. It was impossible, owing to the man's condition, satisfactorily to test the sight; it may have been impaired in both eyes from the neuritis. However, he seemed to see as well with the right as with the left eye, and there was no inequality of the pupils.

Dr. Ferrier found that, when the angular gyri were irritated in animals, the head was turned away from the injured side. In this case, as happens frequently in cerebral lesions, the head and eyes were turned towards the injured side.

The paresis of the right upper and lower extremities may be accounted for by the inflammatory softening round the tumour involving the neighbouring convolutions regarded by Ferrier as the centres for the movements of the leg, hand, and wrist, the superior parietal lobe and ascending parietal convolution.

It is interesting to note that the patient became aphasic as he lost power in the right arm and leg. His intellect was so much weakened, that it was impossible to estimate the extent of the aphasia. The lesion was situated at a considerable distance from the third frontal convolution.

The rapid elevation of the temperature, and the difference between the temperatures of the two sides, were curious features in this case. The increase of bodily heat was not, I think, due to any intercurrent inflammation, but rather to the implication of some vaso-motor centre.

Many eminent observers consider such a centre to be situated near the optic thalami.

CASE III.—In my next case, a large myxomatous tumour was situated in the white substance of the brain, and involved the upper part of the right ascending parietal convolution and superior parietal lobe.

George H., aged 13, was admitted into the Royal Infirmary, under my care, on April 13th, 1877. He had suffered from occasional headache two years, with convulsive attacks at long intervals during that period, in which the left side only suffered. He lost his sight five weeks before admission. He was an intelligent healthy-looking boy, and, though blind, was animated and cheerful.

He had one slight fit under observation in the hospital, when in bed, in which the left hand and arm and the left side of the face were convulsed. He suffered from occasional headache and sickness when he became depressed. There was sometimes some rigidity of the left arm; it was decidedly weaker than the right. The left leg started at times, and was weaker than the right. There was consecutive atrophy of both discs. This fact, and the limitation of the convulsive movements to one side (the left), with the paresis of the arm and leg, led me to consider the boy to be suffering from a tumour, and that it was near the right ascending frontal and parietal convolutions, as it was found to be. He was ordered large doses of iodide of potassium, and continued much the same till June 13th, when he was seized with violent frontal headache and vomiting. He cried and rolled about in bed. His temperature was 99 deg. Fahr.; complexion pale; pulse full, 90. The abdomen was retracted; the tongue clean.

He was ordered a mercurial purge and large doses of bromide of potassium. He was relieved, and was able to leave his bed, but suffered afterwards from several similar relapses. The loss of power became marked and his mind weaker. He grew unnaturally drowsy, sank into a comatose state, and died. The temperature was seldom above 99 deg., and there was no marked difference between the temperatures in the axillæ; it fell before death to 97.8 deg.; the respirations became slow (9-10 in a minute), the pulse being 156 in the same period.

Post Mortem Examination.—The skull-cap was found to be remarkably thin; in some places, particularly near the right parietal eminence, it was scarcely thicker than strong paper. The convolutions were flattened; the left hemisphere had the usual firmness, whereas the right, felt through the dura mater, was softened, especially near the central fissure. On cutting through the brain in the middle of the most softened part, a tumour about the size of a small orange was found; it was pinkish in colour; its circumference was very soft, its centre harder; it was situated in the white matter, but approached the surface through the gyri on each side of the upper end of the right central fissure.

CASE IV.—Here an abscess was situated in the first temporo-sphenoidal convolution. The patient, a girl, was admitted into the Royal Infirmary on June 2nd, 1877. She was eighteen years of age, well developed, and healthy-looking. She complained of disordered menstruation, and of pain under the left breast and in the left side of the head.

We learned that, about ten months before, she had suffered from violent pain in the head, and vomited continually after food. She had also had three fits, in which she screamed and rolled her eyes, but did not bite her tongue nor struggle. I examined her eyes, though the case looked like one of hysteria, and found marked double neuritis. Iodide of potassium in large doses was ordered. The discovery of the neuritis led us to subject her to a closer examination, and we found that the sight of the left eye was impaired; that there was some difficulty in directing the movements of the left eye; and that there was occasional diplopia. She complained of noises in the ears, and we found that the noise was referred to the left ear. In tracing the progress of the case, I need only describe such symptoms as seem to be important in the order of their appearance. These symptoms pointed to the brain or nervous system, but were by no means very positive. The girl preserved her nutrition. Her pulse averaged about 70. Her tongue was clean; digestion good; urine usually of low specific gravity. She was generally out of bed by day, and was cheerful and animated till within a week or two of her death.

On June 5th, there was very slight ptosis of the left eyelid, and the left pupil was smaller than the right. She suffered much from neuralgic pain, referred to the temporal region and above the ear, where there was decided swelling of the scalp.

On June 11th, she had a bad night, being kept awake by the neuralgic pains and "by the noise in the left ear". A crop of herpes came out on the left ala nasi. She stated that everything seen with the left eye appeared colourless; she could not distinguish individuals with it; she could not hear the tick of a watch applied to the left ear. There appeared to be slight falling of the left angle of the mouth. She stated

that food lodged occasionally in the left cheek. The left masseter did not become tense on biting.

June 14th.—She complained that she could not taste her food, and so did not enjoy it. On putting salt or sugar on her tongue, we found that she could scarcely recognise them. She did not do so, indeed, till the tongue was drawn into the mouth, and she had held them there some time. She could not smell anything. She chewed a piece of assafoetida for some time, and said "it might be chocolate, but she was not sure".

June 22nd.—The neuralgic pains had left her, and her sight was good. At her own request, she was discharged, and ordered to report herself weekly.

July 6th.—She complained particularly of the loss of smell, stating that she could not smell a single flower. We held various things to her nose, but she did not recognise any of them.

July 17th.—She was readmitted, as her sight had become worse, her headache more troublesome, and she felt weak. Her hearing had improved; "the noises in the head were less loud". There was no longer any ptosis or weakness of the masseter. The pain was still referred to the same area, a district supplied by the first and second divisions of the fifth nerve. Subsequently, it was referred to the inferior dental, and she insisted on having a tooth taken out. When this was done, she lamented that the wrong one had been drawn, as the pain was no better. The sight failed, and evidence of atrophy of the discs became marked.

On August 9th, there was decided psychical disturbance; she was under the impression that one of the clinical clerks had proposed to her. She soon afterwards had two or three convulsive attacks, which were described by the nurse as very like hysterical fits. Her mind became weak, and she remained much in the same condition till September 10th, when she began to suffer from violent general headache. On September 12th, she had another fit, which was witnessed by Mr. Huey, house-physician. The attack lasted about five minutes; she screamed and struggled; her face was not drawn; her eyes were directed to the left side; the pupils were widely dilated. Pulse 50, respiration normal. She vomited during the paroxysm. Temperature after fit, in the right axilla 97 deg., in the left 96.2 deg. The night after this, Mr. Huey, when going through the ward, found her dead. She had died so suddenly and quietly that none about her knew of it. During the day, she had complained of the violent headache.

On *post mortem* examination, we found the convolutions flattened, and a circumscribed abscess, about two inches in length, involving the anterior part of the first temporo-sphenoidal convolution; it extended inwards and downwards towards the base.

REMARKS.—The anosmia was a very striking symptom in this case; and it is interesting to find that the lesion was situated near that part of the brain which Dr. Ferrier regards as the centre for the sense of smell. I do not think the loss of smell was due to implication of the olfactory nerves themselves, as the abscess was at a considerable distance from these. The loss of smell was complete; it was not one-sided, and it is difficult to account for this. Dr. Hughlings Jackson observes that, unlike loss of taste, loss of smell is usually double. I have described other sensory affections, which, as well as several motor symptoms, were not very pronounced, and were for the most part only temporary. I refer to the deafness, the subjective sensation of noise, the neuralgic pain, the herpes, the slight facial paralysis, the ptosis, the contracted pupil, and the motor weakness of the eyeball. These symptoms were, I think, due to a temporary extension of the inflammatory mischief to nerve-trunks, which, in the middle fossa, would run near the abscess.

In these cases of tumour—I may call the case of abscess tumour—the symptoms varied immensely; and this diversity in the symptoms was due, I think, more to differences in the position of the growths than to anything else. True, the abscess and the myxomatous tumour were large, and grew probably very quickly; but the symptoms were nothing like as pronounced in the cases where they were found as they were in the case of fibrous tumour, which was small and probably grew slowly. In these cases of cerebral tumour, and in many others that I have seen, the diagnosis has been arrived at solely by the aid of the ophthalmoscope. The symptoms are frequently far from marked, and sometimes indeed hardly point to the head at all. Convulsions, paralysis, or coma may be the first decided indications of brain-disease. The girl whose case I have described would, during the earlier days of her illness, have been looked upon as simply hysterical, had not an ophthalmoscopic examination been made. This boy (exhibited) does not look as if he were suffering from grave disease; he has a good colour, is stout, and intelligent. There is no weakness of limb or muscle; his senses are perfect. Yet, he is suffering probably from a tumour in the middle lobe of the cerebellum. He has double optic neuritis, and in all his movements there is want of precision; he suffers from vertigo and occasional headache.

Death, in cases of cerebral tumour, is often remarkably sudden, as in the case to which I have referred; and it is well to remember, as Dr. Hughlings Jackson has pointed out, that violent headache is often the precursor of it.

CLINICAL MEMORANDA.

DOUBTING MADNESS.

DURING the past five years, a case of the *folie du doute*, described recently in the JOURNAL, has been, at intervals, under my care. The patient is a young man aged about 31, of delicate and phthisical appearance; he was formerly employed in a music warehouse. His disease gradually supervened upon a severe attack of hæmoptysis five years since; eccentricity declared itself in various little particulars, such as travelling only by omnibuses of a particular colour, carrying with him numerous bottles of various prophylactic remedies (none of which were ever used), etc. Then he could not walk from his home beyond a certain (and gradually decreasing) distance; and could only sit on a chair which no one else had recently used. He perplexed himself by various frivolous questions—though these were not usually addressed to his friends.

The patient has now relinquished his occupation for some time, and remains entirely at home, where he occupies himself in copying music. He has no delusions; is perfectly rational and intelligent; converses about his malady—that “distressing want of confidence,” as he calls it—with perfect coherence and consistency. The patient’s walks abroad are bounded by the nearest lamp-posts; occasionally he has tried to cross the street, but when half-way over, has been overtaken, he says, by nervousness, and forced to return. The general health has been fairly good till lately; now there is much emaciation; and the young man complains sometimes that he is too nervous to procure a complete evacuation of the bowels.

A phthisical temperament and too great fondness for reading are the only causes for the disease which I have been able to assign. I cannot ascertain the existence of any hereditary taint, or of any excess, sexual or other. Change of air and scene for many months has been ineffectually tried; and the complaint appears to be slowly advancing.

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SCIRRHUS OF THE BREAST DURING PREGNANCY.

IN connection with the case of scirrhus of the breast commencing during pregnancy, under the care of Mr. Savory, which appeared in the JOURNAL of September 7th, I would beg briefly to record a somewhat similar case that occurred in my practice last year. I was consulted in June of that year by a lady aged 45, who had been confined in the previous September of her third child (which she did not nurse, however), about a tumour of one of the mammae, which she had noticed shortly before. It had quite the feeling and hardness of scirrhus, and there was an enlarged axillary gland. There was a history also of hereditary malignant disease. I had no doubt that she was suffering from the same, though her appearance was healthy, and she did not suffer much pain. On my recommendation, Dr. Heron Watson saw her, agreed that the tumour was scirrhus, and strongly urged its removal; but to this she would not consent, owing to a dread of taking chloroform. She afterwards had recourse to some medicine reputed to cure cancer. In the end of October, she sent for me, stating that she believed herself to be pregnant again; and, after a little time, I was satisfied she was so. I examined the breast, which, as I expected, had enormously increased in size; and some enlarged glands were also to be felt above the clavicle. She was still apparently in very good health otherwise, and arranged for her confinement about the end of January. About the end of December, however, she was seized with severe pain in the abdomen, accompanied by extreme irritability of stomach, followed by coffee-ground vomiting, which resisted everything that was tried; and she finally sank on January 6th, about a month before her expected confinement.

The question of induction of premature labour was suggested by a medical friend, but, on consultation, was negatived. On *post mortem* examination, in addition to the large scirrhus mamma, the liver was found to be largely disseminated with small masses, which were pronounced by Dr. Hamilton, pathologist to the Royal Infirmary here, to be cancerous. There was also considerable extravasation of altered blood, similar to what had been vomited, under the mucous membrane of the stomach. There can be no doubt that, in this case, if the scirrhus did not commence during pregnancy, it could not have existed long before; and that the course of the disease was unusually rapid—

not much more than nine months, if so long. I think it is not improbable that the extension of the disease to the liver was hastened by the pregnant condition. That pregnancy should have a prejudicial effect on the course of malignant disease, and especially on that of the mamma, is what I think, *à priori*, might be anticipated; and, had my patient not succumbed to the effects of the extension of the disease to the liver, I confess I should have expected that the ulceration, etc., of the mamma after delivery would have been unusually rapid. Fortunately, the coincidence of pregnancy and malignant disease is not very common.

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SURGICAL MEMORANDA.

THE TREATMENT OF GENU VALGUM.

MR. REEVES, in his paper upon the treatment of knock-knee, remarks, “I must tell you of another new operation which I have recently tried for the remedy of moderate cases of this deformity. I divided the tendon of the biceps, the ilio-tibial band, and the external lateral ligament, and then at once forcibly straightened the joint”.

A girl, fourteen years of age, was admitted into the Wolverhampton and Staffordshire General Hospital in March of this year suffering from severe left knock-knee. An osteotomy was contemplated, but, at my suggestion, it was agreed to try a milder operation; accordingly, on March 21st, under ether, the left biceps tendon and the adjacent tendinous structures were completely divided. A few days afterwards, the skin wound being firmly united, under the influence of chloroform the knee was forcibly straightened and maintained so by a box-splint, and, the report says, “the deformity was altogether removed”. The patient remained in the hospital for three or four months, and, upon her discharge, it was noted that as she walked the ankles almost touched. I have not published this case before, as I hold it is not fair to practical surgeons to report operation cases as successful before sufficient time has been allowed to test the permanency of the success obtained. I intend to give the above treatment of genu valgum an extended trial, and afterwards I will publish my cases.

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THE TREATMENT OF HYPOPYON ULCER.

FOR some time past, my experience of the treatment of hypopyon ulcers and other suppurative affections of the cornea has led me to think that the use of the knife is very rarely necessary. I am glad to find, in the JOURNAL of August, this opinion corroborated by Drs. Argyll Robertson and Andrew.

Since witnessing Sämisch’s operation at Moorfields, I have been constantly on the look-out for cases in which to practise it, but almost invariably find that they recover without it. The most essential point in the treatment I consider to be the maintenance of mechanical rest, by means of a compress bandage applied as firmly as the patient can bear it. To effect this, no little nicety is required, and, to ensure success, the surgeon should apply the bandage himself at least once in twenty-four hours. The best material for padding the eye is Dr. von Bruns’ wound-dressing cotton, which is cotton-wool freed from all oil. This absorbs discharge, and does not act as a plug, like ordinary cotton-wool. A roller of flannel or domette should be used, by which pressure can be regulated to a nicety, which cannot be effected by any form of tie-bandage. When the treatment is carried out by a skilled nurse, the bandage should be changed every four hours, and the eye bathed with hot water or hot belladonna-lotion, and atropine (two grains to an ounce) instilled; but, in the absence of such assistance, the bandage applied by the surgeon should be kept on, if comfortable, twelve hours. If, after the application for twenty-four hours of the compress bandage, there be no manifest improvement and the eye be painful, I am in the habit of prescribing (whatever other constitutional treatment may be indicated) one-twelfth of a grain of morphia and three grains of the extract of hyoscyamus every four hours. For the knowledge of the utility of this formula in all painful inflammatory conditions of the eye, I am indebted to Mr. Vose Solomon. In severe cases, it is sometimes necessary to bandage both eyes for a time; but, as a rule, the sound eye may be left uncovered and protected by a broad shade. It should be borne in mind that suppurative affections of the eye are indicative of debility, for which there are no better tonics than light and fresh air. In no case should a patient be condemned to the misery of a dark room.

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