nature of neuralgia may at times attack the ovary, an organ well supplied with nerves.¹ If so, it is reasonable to treat such a condition in the same way as neuralgia elsewhere. If drugs have failed, then operate. The injection of alcohol would hardly be recommended for ovarian pain, but the nerve supply, or a considerable part of it, if not all, may be cut off by simply dividing the suspensory ligament of the ovary. This, of course, means division of the ovarian artery and vein too, but the ovary will still have a sufficient blood supply to keep up its nourishment, and, that being so, ovulation and endocrine secretion should not be interfered with, unless the division of its nerve supply should so far impair these functions, which is not likely.

This treatment would particularly apply if there were only one remaining ovary in a patient who had not reached the menopause. The pain must be relieved in some way, and the ovary must be spared if possible. On the left side the division of the ligament may serve to straighten out the pelvic colon and thus help the flow of contents. No claim to originality is made here for the idea of dividing the ovarian nerve supply, but the suggestion seems a practical and reasonable one, and therefore I emphasize it.

I should like, in conclusion, to stress the two points brought forward early in this paper:

1. Diagnose neurasthenia last of all, after excluding all likely causes of pelvic pain.
2. In cases of pelvic pain make it a rule to examine first of all without an anaesthetic, even if such is necessary for a full diagnosis afterwards.

REFERENCE.

¹ Abel and McIlroy: *Proc. Roy. Soc. Med.*, Obstet. Sect., May, 1913, vol. 6, No. 7, p. 240.

DIPLOPIA IN ENCEPHALITIS LETHARGICA.

BY

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THAT diplopia is one of the earliest symptoms of encephalitis lethargica is well known. The diplopia may, of course, be that typical of an involvement of one or more of the extrinsic ocular muscles and may occur with or without a manifest squint, but cases also occur in which the diplopia cannot be attributed to this cause. The patient in the following case is typical of many who, during a recent epidemic of encephalitis lethargica in this city, applied to the ophthalmic clinics for relief of the diplopia.

A girl, aged 19, complained of diplopia. Two evenings before seeing me she had headache and giddiness and felt sick; on the following morning she awoke with diplopia; it was very troublesome when looking at distant objects, but was hardly present at all in near vision. There was no drowsiness. The temperature was 101°. There was no history of any recent illness. Examination of the eyes showed no ptosis, no manifest squint; the pupils were normal in size, equal, and reacted to light and accommodation. The movements of both eyes were normal. Both optic discs and fundi were normal. Examination of the diplopia showed it to be homonymous, with erect images, the unusual feature being that there was no alteration in the relative positions of the two images in any of the six cardinal directions of gaze. The first examination was carried out with the candle at 3 metres from the patient; a second examination at 5 metres showed the two images to be further apart than they were when the examination was performed at 3 metres, but again their relative positions remained the same in the six cardinal directions of gaze. On approximating the candle to 2 feet from the patient the diplopia ceased to exist in any of the six cardinal directions of gaze.

This case could not have been one of paresis of any individual muscle, as there was no increase in the distance between the true and false images in the direction of action of any muscle; nor could spasm of accommodation produce this type of diplopia, as in this case the double vision would have increased as the object was brought nearer the patient and diminished the further it was removed.

The diplopia disappeared in a week from its onset and the patient made an uneventful recovery, for the time being at any rate. No convergent squint ultimately appeared, as has happened with some of the patients under observation.

It is probable that these cases represent a rather rare condition of paralysis of divergence. Dunnington¹ of New York describes in detail three exactly similar cases occurring in an epidemic of encephalitis, and Holden² one such case, but these writers would appear to consider the condition to be one of great rarity, whereas in our series of cases this type of diplopia was so common as an early symptom that we began to regard it as pathognomonic of the disease in this particular epidemic. Another interesting fact was that this type of diplopia, with giddiness and rise of temperature, were the only symptoms complained of, and that many of the patients showed no other symptom but made a rapid recovery. That we were dealing with encephalitis lethargica was clearly manifested by the fact that a few of the patients with these symptoms developed the more serious accompaniments of the disease at a later date.

Duane³ points out that the power of divergence is an active as well as a passive movement, and is brought about by a simultaneous equal contraction of both external recti accompanied by a simultaneous equal relaxation of both internal recti. This complex action is controlled by a definite nervous mechanism, and the loss of power means an innervational disturbance and not a muscular defect. This mechanism is probably controlled by a centre situated close to the sixth nerve nucleus. This would explain the fact that these cases are often followed by convergent strabismus due to a sixth nerve lesion. In making a diagnosis, paralysis of divergence is easily confused with paresis of one of the internal or external recti muscles, but can be differentiated by observing that the diplopia does not increase in the direction of action of these muscles, and that the separation between the true and false images remains unaltered so long as the distance between the eyes and the object is kept constant.

REFERENCES.

¹ Dunnington: *Arch. of Ophthalmol.*, vol. lli. ² Holden: *Ibid.*, vol. I.
³ Duane: *Ibid.*, vol. xxviii.

PAROXYSMAL TACHYCARDIA IN AN INFANT.

BY

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IT will be of interest to record this case of paroxysmal tachycardia on account of the very early age of the patient, and because it is an outstanding example of the vast amount of distress a young child's heart will stand.

The patient was a female child, aged 8 months, and the attack lasted for eight days without cessation. The heart could at no time be counted, but was roughly estimated at somewhere about 200 to 300 beats to the minute. The onset of hepatic pulsation, Cheyne-Stokes breathing, and severe bronchitis during the illness all had apparently no detrimental effects on the recovery. The child is the youngest of a family of three, having been born quite normally and fed on the breast, and the breast alone, up to the time of the illness. She had been examined at the local clinic at about the age of 6 months, and was found to be a perfectly healthy, contented, and exceptionally well nourished baby. The mother and the other children are all quite healthy, and the former undoubtedly makes an ideal mother.

I was called to see the baby on a Thursday afternoon because the mother had become anxious about its condition during the previous night on account of vomiting and restlessness. The child had been ill the whole night, but the mother had concluded that she was tired by a journey into Cardiff and a long day out in the sun the day previous. The mother noticed that the urine had become scanty, the evacuations a trifle loose and green, and that there had been no desire for food; this was most unusual in a child who had been accustomed to be most hearty.

The baby, when I first saw it, was apparently in no serious condition; its cheeks were rosy, its breathing was natural, and it had all the appearances of a child who was in perfect health but who was apparently somewhat restless and irritable as the result possibly of an irritable tooth. The temperature was just 96°, but no pulse could be felt at the wrists. There was nothing to be discovered in its abdomen nor on rectal examination. The chest, as far as the lungs were concerned, was devoid of physical signs. The nervous system was normal, all the reflexes being present and