ing it, the tubes passed through the mouth might be used, even in the latter case, to gain time to allow an operative surgeon to be called.

The tubes must necessarily be of various sizes, so as to suit the various larynges into which they may be introduced. At present, a tube of a better shape and form than that now in use, and one which will present other advantages, is being prepared for me.

It must be obvious that the time during which the tubes are retained must depend on the case. In some, a few hours might be sufficient to dispel the oedema; in others, a much longer period is necessary.

How to recognise that the Instrument is in the Trachea.—How would one recognise the presence of the instrument in the trachea? 1. By finding the instrument pass over the first ring or two of the trachea; 2. By finding that the air flows into the tube during inspiration and out during expiration—the opposite being the case if it be in the oesophagus; 3. By the mucous expectoration being expelled from it; 4. By the negative signs that it is not in the oesophagus or stomach—i.e., blowing up the stomach through the tube, etc. Before introducing the tubes, an examination by the laryngoscope ought to be made to ascertain the precise state of the parts.

Deductions.—The practical deductions which may be drawn, tentatively at least, from these cases are as follows.

1. Tubes may be passed through the mouth into the trachea not only in chronic, but also in acute affections—such as oedema glottidis.
2. They can be introduced without placing the patient under an anæsthetic.
3. The respirations can be perfectly carried on through them.
4. The expectoration can be expelled through them.
5. Deglutition can be carried on during the time the tube is in the trachea.
6. Though the patient at first suffers from a painful sensation, yet this passes off, and the parts soon become tolerant of the presence of the tube.
7. The patient can sleep with the tube *in situ*.
8. The tubes, in these cases at least, were harmless.
9. The ultimate results were rapid, complete, and satisfactory.
10. Such tubes may be introduced in operations on the face and mouth, in order to prevent blood from gaining access to the trachea, and for the purpose of administering the anæsthetic; and they answer this purpose admirably.

NOTE ON HOMICIDAL MANIA.

By JAMES RUSSELL, M.D., Senior Physician to the Birmingham General Hospital.

THE following particulars given me by the mother of an out-patient at the Birmingham General Hospital, and by the patient himself, explain themselves. In a forcible manner, they tell the tale of what passes in the mind of many an epileptic when driven by his disease to sudden acts of violence; and explain the homicidal tendency which sometimes springs up under such circumstances.

A young man, aged twenty-nine, has been under me, at times, for several years, a confirmed epileptic, and the son of a father equally confirmed in the same disease. His fits were kept under by moderate doses of bromide of potassium, but, after the 31st of last January, his medicine was suspended in consequence of the want of an out-patient ticket. The fits then returned with frequency; about two severe ones, with tongue-biting, occurring in a week, but very numerous slighter ones. In March, the first attack of the mental disorder, to which this communication refers, took place: it lasted for a fortnight, and yielded to medical treatment. The patient was violent for three days, and then fell into a condition of melancholy, "as though a cloud were on his brain". In a week after his recovery of mental health, the fits returned—they had been absent during the period of mental disorder (of course, I speak only from the mother's report)—but again, at the end of eight weeks, the mental affection returned, and again yielded to treatment at the termination of about a week. As before, the recovery of sanity was followed by recurrence of the epileptic fits, mostly in a slight form; and for the third time the mental disorder attacked him (May 19th), and yielded to remedies in ten days.

The mother gave the following description of the mental disorder. He had a constant fear of being dared to hang himself; he told her that, if she did not take every care of him, he would be obliged to do it; he did not like to be considered a coward by people standing before him (in imagination); they kept showing him how to do it; and he thought that if his mother took him to a doctor, he would drive the figures away. This "thought over him" lasted all the time. He wandered about, sensible in other respects, but with a sort of pitiful expression, more child-like, and with a tendency to cry. "It is ridiculous," he said, "to talk of anything else, for I have got it in my mind, but it never

comes when I am right." He dared not sleep; for, if he closed his eyes, "he saw so many".

The patient himself told me that it was like a man before him; there was like a scaffold and a rope, and they kept showing him the way to do it. They said, "You dare not do it! you dare not do it!" Something felt very heavy on his forehead, and all was dark about him. "I could not bear the thought of hanging myself; but nothing else would come into my mind." When these "feelings" were passing off, something passed from the forehead, over the face, then down the arms, out at the fingers, and then he became himself again, and could think of other things.

This young man has been more or less epileptic from infancy, but he has only suffered once before from any mental derangement. He then had an idea that his mother loved his brother best, and that seemed to work on his mind. He thought he must get rid of his brother. One day his mother heard him threaten his brother, and open his knife; he was easily induced to part with the knife, observing that he thought he had better do it to himself instead.

The patient's attestation to the compulsory nature of this suggestion, and to the impracticability of his varying it by any effort of his will, and at the same time his half-consciousness of the unreality of the whole, are worthy of notice. What if this countercheck be weakened or removed?

COLOUR-BLINDNESS AMONGST THE MEDICAL PROFESSION.

By B. JOY JEFFRIES, M.D., Boston, U.S.A.

IN the JOURNAL for October 25th, 1879, Mr. Herbert W. Page published an article on "Colour-blindness: its Examination and Prevalence". I have commented at some length on this subject in a previous communication, and would now merely report in reference to a suggestion he then made. He proposed that the members of the British Medical Association should be most carefully tested at the Cambridge meeting in August next, to ascertain the proportion who are colour-blind "among those who neither lack education, observation, or cultivation".

To partly answer this suggestion, I have recently tested 465 of the members of the American Medical Association at the New York meeting, and of the members of the Massachusetts Medical Society, at the annual meeting here in Boston. I found, among these 465 physicians, 22 colour-blind. Of them, 14 were red blind, 2 green blind, and 6 incompletely colour-blind, using the standard of Professor Holmgren. The whole number of males I have so far tested is 17,327. Of these, 724 were colour-blind in a degree to be included in the classes proposed by Holmgren. I have also tested 13,813 females, finding only 10 colour-blind.

Unless the whole of a large number of people are tested, the ratio, we find, may be quite above or below 4 per cent., which seems to be the true average for males. For instance, in New York I found but 6 out of 195; here in Boston, 16 out of 270. As a general thing, perhaps, as many colour-blind, from various reasons, stay away as apply to be tested. Here in Boston none of my professional brethren whom I knew to be colour-blind came to me. Could I have tested the other 2,000 of the medical profession attending these two meetings, I am quite convinced that the whole would have given me the usual 4 per cent. average. If the members of the British Medical Association are tested at Cambridge, the proportion found colour-blind will depend on the number examined, and whether those thus defective apply or stay away. If 1,500 be present, they can all be tested in three days by one person working six hours each day, provided it could be so arranged as to have a steady stream before the examiner.

Now what method of testing could accomplish this with certainty and accuracy? A pretty extended experience, theoretically and practically, convinces me that such investigations can be carried out only by Holmgren's method, with which none other compares. Certainly with it, as with all methods, it depends largely on the examiner, who must be all eyes in watching the face, fingers, and look of the examined. The latter had far better not speak, or at least confine this to a question of what is asked of him to do. The examiner can explain what is needed, and one after another sees what is done by those before him. It is also a test of mental and physical quickness.

In a previous communication to the JOURNAL I have defended the accuracy of my published results. In these tests of my medical brethren, I of course had the advantage of their being desirous to appear the best, and also do as nearly as they could just what was asked of them. The bystanders constantly wondered that I did not mark as defective many who seemed so to them. This test of my friend, Professor Holmgren, when the right worsteds are used (a most important point), and the

examiner is practically familiar with its use and the laws of the colour-blind, yields results in no way inferior in certainty and scientific accuracy to any other method. For readiness of application none of course are comparable.

Mr. Page said, "Because uneducated and unlearned men cannot sort Holmgren's skeins is, to my mind, the very poorest evidence of their being colour-blind." Now my experience has been with children of four years of age upwards to adults and old people; and with *all classes*, from the highest to the lowest, socially and educationally, I have never found a person who could not do what is required in Holmgren's test, viz., "pick out from the bundles of worsteds all lighter or darker of the colour of the test" presented, unless they were colour-blind. I am assured Mr. Page would agree with me, could he follow my work *de visu*. I am forced to say that educated people have proved themselves as stupid in performing the task as the uneducated, and often as stupid about colours; hence the immense value of the simplicity of Holmgren's test. Almost invariably, the writer who speaks of it in opposition or in doubtful tones, shows most conclusively from what he says that he has not learned it either from Professor Holmgren's description, or *de visu* from a practised examiner. Professor Holmgren himself does not pretend that it is as easy as it looks to the bystanders, whether of the profession or the laity. But what he holds, and what my own experience fully sustains him in, is, that this means of detecting colour-blindness is most practical and very certain, when conducted properly and understandingly. His long and minute description of the manner of applying the test must be studied, and his directions put in practice. When this is done with large numbers of males, I mean thousands, the result will be a ratio of 4 per cent. with defective chromatic sense, not colour-careless or colour-stupid. These we must call colour-blind, and they are dangerous as railroad *employés* or as mariners. Whether we class them by the Young-Helmholtz theory or by Baring's, does not change their defect or alter its relation to the community.

CLINICAL MEMORANDA.

CASE OF ACUTE INTUSSUSCEPTION, TERMINATING IN RECOVERY.

L. G. C., AGED eight months, was first seen on Monday, April 26th, 1880, at 5 P.M. The mother stated that the child seemed perfectly well on Saturday morning, but that on Saturday afternoon it was seized with sudden sickness, and appeared very ill and in pain. She, therefore, gave a dose of castor-oil; but the sickness continued. On Sunday, at 2 P.M., the bowels acted slightly; but blood passed. When seen on Monday, the child was semicomatose, with sanguinolent discharge from the bowel, with occasional great straining and retching. A little chalk mixture, with aromatic spirits of ammonia, was ordered. At 10 P.M., the child was again visited; the symptoms being much the same. On examining *per rectum* with the finger, a protruded invaginated portion of the bowel could be just reached, and the diagnosis of intussusception was complete. The nozzle of a small pair of bellows was introduced, and an attempt made to inflate well the bowels; but from some cause the inflation did not go on very successfully, although a considerable quantity of air seemed to enter the canal. The tube of a stomach-pump was then passed carefully up the bowel, and carried firmly but cautiously against the invaginated mass—desisting during the violent fits of straining which the passage of the tube seemed to cause. At last, after passing at least one foot of tube, air was heard to issue through it, bringing with it a little bloody mucus. The tube was withdrawn, and, on feeling again with the finger, no protruding portion of bowel could be felt. On the following morning, there was a slight decrease in the sickness. The child still lay in a listless state, occasionally twisting about as if in pain, but with no action of the bowels. No medicine was given; but on Wednesday a gruel injection, administered in the morning, came back directly, causing much straining. In the evening, another injection was administered, and brought away a small quantity of fecal matter; and on Thursday, as the symptoms seemed to warrant it, there being no vomiting, some carbonate of magnesia with aromatic spirits of ammonia were ordered; and, on the evening of Thursday, the bowels acted, and the child progressed, without a bad symptom, and is now well. No portion of the intestine ever came away, as the motions were carefully watched.

The interest in the case lies in the intussusception being so fortunately placed as to be within something like reach, and in its early detection before any very serious adhesions had formed to cause peritonitis. Brandy was allowed all through, and apparently with benefit.

SAMUEL PRALL, M.D.

THERAPEUTIC MEMORANDA.

ON A NEW METHOD OF ARRESTING GONORRHOEA.

I READ with great pleasure the article headed as above by Mr. Cheyne, and wish to state that I have adopted his method of passing medicated bougies up the urethra for acute and chronic gonorrhoea. The bougies I used were made by Kirby and Co., 14, Newman Street, Oxford Street. The other day, I thought I would use iodoform in the shape of a bougie; I therefore ordered some containing five grains in each, and have been very gratified with the result, which has quite come up to my expectation. I have been in the habit of using iodoform, both in the form of ointment and of powder, for some years, and with marked success, in the treatment of indolent varicose ulcer of the leg, soft chancres, etc.

The method I adopt in the treatment of gonorrhoea is this: I first order the patient an injection containing ten minims of liquor plumbi and two grains of sulphate of zinc to an ounce of water; to be used frequently, until the acute symptoms have subsided. I then pass a No. 9 bougie up the urethra as far as the ulcerated spot. I then apply a piece of lint over the orifice of the urethra, under the prepuce; and tell him not to pass his urine for some hours afterwards. I order him to take as little liquid as possible, and no stimulants. I generally pass one or two bougies a day. My patients generally get rid of the gonorrhoea in a week. The only constitutional treatment I adopt is a brisk purgative, followed by tonics.

J. BRINDLEY JAMES, M.R.C.S. Eng., 47, Jamaica Road, S.E.

SURGICAL MEMORANDA.

AMPUTATION FOR DISEASE OF THE FEMUR.

I HAVE read with interest a contribution by Mr. Holmes, in the JOURNAL of the 17th instant, in which early amputation is advocated in malignant disease of the femur. There is a case now in the wards of St. Thomas's Hospital, where the thigh has been amputated at the upper third for rapidly growing sarcoma of twelve weeks' duration. The growth involved the lower third of the femur, and probably originated centrally, although upon section the expanded shell of bone, usually found in these cases, was imperceptible, this having been absorbed. The circumference of the knee exceeded that of the opposite by eleven inches; and the entire vertical measurement of the growth was eleven inches and a quarter.

When admitted, the child, who was six years of age, was suffering most acutely; the skin over the tumour was tense, red, and shining; and, although suggesting the presence of a huge abscess in connection with the knee, the nature of the disease was at once recognised. Amputation was performed on July 10th by Mr. Croft, three days after admission; since which, the patient, in spite of the severity of the operation, has recovered in her general health to a degree beyond expectation.

It is early to speculate upon the ultimate recovery of the patient; but this and other similar cases which have come under my observation, where the patient has been worn out with pain, and the growth encroaching upon or involving surrounding structures with rapid strides, would indicate that early amputation is necessary and often followed by the best results.

H. PERCY POTTER, F.R.C.S., Surgical Registrar.

RUPTURED LIGAMENTUM PATELLÆ.

A SHORT account of this, as far as I know, extremely rare accident may be of interest to readers of the JOURNAL.

On December 20th, 1878, I was called to see J. J. D—, aged 39, a builder, of spare habit, who, while superintending some work on a building, fell through a scaffolding six feet high. The accident was due to a beam, which was being raised into position, falling and breaking down the scaffolding on which the man was standing. He sustained a punctured wound of the forehead, with a depressed fracture of the outer table of the frontal bone over the left frontal sinus; a lacerated wound of the left cheek; and complete rupture of the ligamentum patellæ. The rupture was transverse at the apex of the patella, but did not involve that bone in the least. The force which tore the patella from the ligament was exerted from below upwards, the knee having been firmly and tightly grasped between two or more pieces of wood as the man fell downward through the scaffolding. Although there was some swelling, the diagnosis was very easy. All possibility of doubt or error, were there any at the time, was cleared up in a week afterwards, when all effusion was absorbed. The patella was readily and easily pushed up on the femur, until its apex was on a level with the