tions in this place. Farther forward still, corresponding with section 2, the softening was limited to the surface of the island of Reil, which was, however, still affected throughout its whole extent on the section. The claustrum could still be easily distinguished, but it was not so sharply marked off from the convolutions of the Insula by the white band as upon the opposite side. The external capsule appeared perfectly intact throughout. Broca's convolution had entirely escaped. The posterior limits were rather more difficult to define, but here the softening extended rather further superficially than it did deeply. Superficially it reached the bordering convolutions connecting the angular gyrus and occipital lobe, but deeply it did not extend quite so far. The superior temporo-sphenoidal convolution was softened in the deeper part of the Sylvian fissure for the posterior two-thirds of its extent, and for a short distance from the spot posteriorly where the supramarginal and angular convolutions became continuous with it. I have indicated upon the figure, by means of vertical shading, the deeper portions of the convolutions which were affected.

The vessels could not be dissected in the fissure of Sylvius, without destroying the relation of parts, but the destruction produced by the lesion agreed exactly with the distribution of the peripheral branch of the Sylvian artery, and it is fair to conclude that it was caused by plugging (probably embolism) of the vessel, as the accompanying diagram clearly demonstrates. (See previous page.)

The prominent symptoms of the case were aphasia, commencing suddenly, and unaccompanied by loss of consciousness, associated with paresis of the right arm and leg, and of the right side of the face, and with incomplete hemianæsthesia.

Taking the classification of aphasia into the ataxic and the amnesic form, it is clear from the clinical phenomena to which group the case belongs. The motor-centres were not affected. All the movements necessary for the production of speech were possible. Some words the patient still retained, but these, as has been stated, belonged rather to the automatic or emotional class, such as, "Oh, Lord!" "yes," etc. Others, again, were in such common use in his occupation as to have become probably almost automatic, such as "good morning," "corner," "order." At other times, either in response to questions, or when attempting to read, he would give utterance to sounds which, in rhythm and sequence, so closely resembled language that the patient was thought to be speaking Welsh, as he was able to do before his illness, but it turned out to be only gibberish.

It is evident from these facts that the various movements necessary for speech were possible, even of the most complex kind, but that they were not rightly co-ordinated and associated. The case was clearly, therefore, not one of motor or expressive aphasia, but belonged to the amnesic group.

The various receptive or sensory or impressive centres were, however, affected in very varying degrees.

The visual speech-centre was profoundly involved. When an object, such as a pen, was shown to the patient, he was entirely unable to recall its name; though it clearly suggested to him the appropriate idea, for when it was given him he would take it rightly in his hand and make movements, as if for the purpose of writing, although nothing was produced but meaningless scratches. When writing or printing was given him he would turn it the right way up, and look at it as if endeavouring to understand it. He clearly recognised the symbols, though he failed to attach any meaning to them. Sometimes he would proceed to read; but, if words were produced, they would be simply those simple expressions before mentioned, or else an unintelligible gibberish, which had no relation whatever in length or rhythm to the sentences before him.

The auditory-centre was involved, but in a much less degree. The patient understood much that was said to him, as he showed by giving the hand, putting out the tongue, or taking something when told to do so; but the power of response to such orders varied very greatly at different times. Sometimes the patient was capable of imperfect parrot-speech, being able to repeat some simple word or two, when they were spoken to him, but this was unusual; more commonly if he made the attempt, the result was the same as on trying to read, namely, either the set words or gibberish. The state of the patient prevented any detailed examination of other senses, but the condition of hemiparæsthesia was easily made out.

The pathological lesion found, confirmed all the clinical anticipations. The motor speech-centre, that is, the convolution of Broca, had entirely escaped, and the lesion was confined to the region of the brain posterior to the fissure of Rolando. The lesion was most marked in the supramarginal and angular gyri, being here of the widest superficial extent, as well as also of the greatest depth. This is the region where the visual cortical centres are placed.

The supramarginal or superior temporo-sphenoidal convolution was

also involved, but to a much smaller extent, and only in the immediate neighbourhood of the fissure of Sylvius. This is the place where the centre of hearing is localised. Hence we have, as we anticipated, the chief lesion in the centre of vision, and a well marked, but less extensive, lesion in the centre of hearing.

But the lesion is seen below the surface to extend somewhat further.

1. In front it reached into the root of the ascending parietal convolution. Here Ferrier places certain movements of the opposite side of the face and mouth, and we have, in the lesion, an explanation of the loss of power observed in the face. 2. Above, it reached the upper portion of nearly the whole ascending parietal convolution. In the middle portion are placed by Ferrier the centres for the finer movements of the hands and fingers (the prehensile movements), and it was exactly these which were most affected in our patient. In the parietal lobule, or upper part, are placed centres for some of the movements of the leg, and we have, in this lesion, an explanation of the loss of power in the leg.

The cortical lesions thus explain, most satisfactorily, both the aphasia and the hemiplegia. The sense of touch is placed by Ferrier in the uncinate gyrus and in the hippocampus major. Considering the close proximity of these convolutions to the fissure of Sylvius, it is possible that we have, in a lesion of these parts, the explanation of the hemianæsthesia, for the internal capsule had completely escaped. The objection to this view lies in the fact that their blood-supply is derived, it is stated, from the posterior and not from the middle cerebral artery. Moreover, if these parts were involved, it must be to a very slight extent, for they appeared quite natural to the naked eye. Hemianæsthesia is a not uncommon symptom in aphasia when the internal capsule is uninjured, whatever explanation of its causation be given.

The last point of interest is the extensive lesion of the island of Reil; but the functions of this part of the brain are very obscure, and it is impossible, at present, to associate with this lesion its appropriate clinical symptoms. The case, in its entirety, affords very interesting confirmation of some of the present doctrines of cerebral localisation.

ONE THOUSAND MIDWIFERY CASES WITHOUT A MATERNAL DEATH.

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THERE is nothing wonderful in a thousand midwifery cases without a maternal death, but there are some interesting points in the complications I have tabulated.

1. Forceps	48
2. Turning	11
3. Placenta prævia (complete)	3
4. Placenta prævia (partial)	2
5. Post Partum Hæmorrhage	5
6. Accidental Hæmorrhage	1
7. Retained Placenta	15
8. Puerperal Convulsions	5
9. Hand Presentation	3
10. Breech Presentation	8
11. Funis Presentation	2
12. Foot Presentation	5
13. Craniotomy	3
14. Puerperal Fever	5
15. Twins	4

1. Many practitioners will think my percentage of *forceps* cases unusually high. According to Dr. Meadows, the percentage in Germany is 1 in 106, in this country 1 in 115. I may say I have never applied the forceps except in cases where I thought it absolutely necessary.

2. *Turning* has in my practice been above the average; 11 in 1,000, against 1 in 124. I turned five times in placenta prævia, three times in hand presentation, twice in funis presentation, and once in puerperal convulsions.

3 and 4. *Placenta Prævia*.—My percentage is high, 5 in 1,000, whereas 2 in 1,000 is about the average. Three of my cases were complete, the other two partial.

5. *Post Partum Hæmorrhage*.—I have only noted those cases which caused me much anxiety; hence my percentage seems low.

6. *Accidental Hæmorrhage*.—I have only had one case.

7. *Retained Placenta* (15 cases).—Five were due to hour-glass con-

traction; the remainder to morbid adhesions. In one of my cases, the placenta was so adherent, that I was obliged to leave quite a third attached to the wall of the uterus, as the force required to remove it would have been more dangerous than allowing it to remain. I syringed the uterus out night and morning for a fortnight. The portion of placenta separated, and the patient passed it on the sixth day, and made a rapid recovery. It is much safer to leave a portion of the placenta, than to use force which is likely to injure the wall of the uterus.

8. *Puerperal Convulsions*.—Five cases have fallen to my lot, and most harassing they have been. Three were due to septicæmia, and two to reflex action. The treatment adopted in all my cases was putting the patient under chloroform, delivering as rapidly as possible (if the os were not dilated, I inserted Barnes's bags); then I gave a hypodermic injection of a fourth of a grain of morphia. I believe morphia is more beneficial than any other drug in eclampsia. This treatment appears unscientific, but the effect this drug has on the convulsions is really marvellous. I have not tried pilocarpin, highly recommended by that careful observer Dr. Murphy, of Sunderland. I can quite imagine it being highly beneficial in eclampsia due to albuminuria.

9, 10, 11, 12.—On the several presentations I need not comment, as I have already alluded to 9 and 11 under Turning.

13. *Craniotomy*.—The three cases were all due to deformity of the pelvis.

14. *Puerperal Fever*.—My treatment is, syringe the uterus out yourself twice or three times a day. Do not depend on the nurse to do it. I give a mixture of quinine (five-grain doses) and sulphuric acid, with a calomel and opium pill with each dose of mixture. If there be much tenderness, I apply turpentine-flannels to the abdomen, and I sometimes give two-drop doses of turpentine suspended in mucilage every hour for twenty-four hours. The latter often gives great relief.

15. *Twins*.—Two of my cases of hour-glass contraction appeared to be due to overdistension of the uterus by twins.

A CASE OF MILKY HYDROCELE.

By SIDNEY DAVIES, M.A., M.B. Oxon., Cairo.

THE case of hydrocele containing milky fluid, reported by Mr. Kendall, of New South Wales, in the *JOURNAL* of April 11th, induces me to report the following analogous case, which was obviously caused by filaria hominis.

Alexander C., aged 23, a Greek, member of the Cairo police, consulted me in November last for a swelling of the left testicle. The swelling had the appearance of hydrocele, which disease is common in this country. Accordingly I tapped it, and drew off two ounces of milky fluid. This fluid coagulated on boiling, and, after standing a day, separated into a thick and thin portion; in fact, it had the ordinary properties of chyle. Under the microscope, it was found to contain fat-granules and granular leucocytes. Among the latter were seen moving three or four embryonic filariæ, of the same appearance and proportions as those I have frequently seen before in the blood of patients with chyluria.

The patient was born in Alexandria, and had lived there until four months previously to my seeing him, when he entered the Cairo police force. He noticed the swelling of the testicle nine months before consulting me. He had thrice suffered from gonorrhœa, and had had a "soft sore," but no other diseases. He had never had chyluria nor hæmaturia.

In three weeks, after tapping, the fluid returned, having the same appearance as before. After consulting with Dr. Grant Bey, I determined, by his advice, to open up the tunica vaginalis, and allow the sac to granulate from the bottom. I accordingly cut down into the hydrocele, and exposed the testicle. The sac was washed with 1 in 20 solution of carbolic acid, and a large drainage-tube inserted. The patient had an attack of hæmaturia, presumably from absorption of carbolic acid, which lasted two or three days. There was free suppuration, with rather severe inflammation of the coverings of the testicle round the wound; but the wound healed completely in three weeks after the operation. Up to this date there has been no return of the disease.

REMARKS.—In the *Medical Times and Gazette*, May, 1882, Dr. Sonsino described two cases of milky hydrocele (*hydrocele laticinoso*), in which filariæ occurred. Similar cases have been reported by Bancroft and others. It has been shown by Dr. Manson that filaria produces disease by causing obstruction in the lymphatic circulation;

hence its passage into the urinary system, and hence the thickened connective tissue and lacunæ of lymphous fluid observed in elephantiasis. The tunica vaginalis is morphologically a large lymph-space. One would therefore expect it to be a frequent seat of accumulation of chyle or lymph, when the lymphatic circulation is obstructed. It is remarkable that the patient, in this case, had never suffered from chyluria. I examined his blood by day and night, but found no filariæ; but this by no means negatives their existence in the blood. A more persevering search would probably have discovered them. The treatment by free incision was adopted in preference to injections, on account of the fear that the latter process would only heal by producing an abscess, which would have caused more protracted suffering than the method adopted. In a future case, however, I should try injecting iodine. *Filaria hominis* being indigenous to Australia, it seems probable that Mr. Kendall's case was also due to this parasite. I think, if he had looked for filariæ, he would very likely have seen them. In this case, as in Dr. Sonsino's two cases, the filariæ were very active; more so than in blood. In urine they are generally found dead, as I have remarked from my own experience. My examination of the blood was not made till after the patient was cured. Dr. Sonsino has suggested to me that this may account for filariæ not having been found, as the adult worm may have escaped unobserved in the discharge from the wound. I have to acknowledge the kind help of Dr. Sonsino in making these notes.

THERAPEUTIC MEMORANDA.

NITRITE OF AMYL AN ELIMINATOR OF URIC ACID.

THE above statement is not supported by any sufficient evidence in the three cases reported by Dr. Macdonald. Cases 1 and 2 were complicated by the administration also of nitro-glycerine, and Case 3 appears to have been improving before the nitrite of amyl was given. Further, no evidence of any value as to the increased or diminished elimination of any urinary product can be obtained without the total quantity of urine passed in the 24 hours being collected and measured, and the sample analysed being taken from the mixture of the whole. In the absence of this, the degree of concentration and the variations in the excretions of the different urinary constituents at different periods of the day introduce serious sources of error. The results in Dr. Macdonald's cases are quite as likely to have been due to concentration of the urine as to an absolute increase in the amount of uric acid eliminated.

When working at the quantitative estimation of uric acid, it was evident to me that the apparent amount of deposit varied greatly with the size of the crystals and the quantity of pigment, and that such an estimate, without careful weighing, must be extremely inaccurate.

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QUININE IN THE TREATMENT OF PNEUMONIA.

IN the report of the proceedings of the medical section of the Academy of Medicine in Ireland which I read in the *BRITISH MEDICAL JOURNAL* (June 6th), I find that several physicians thought quinine useless in the treatment of pneumonia, and that no one seemed to recognise the fact that quinine will abort pneumonia.

In September, 1884, I published an account of 100 cases of pneumonia which had been under my care at the Birmingham Workhouse Infirmary, and I said that I had seen four cases aborted by quinine. Since writing that paper, I have had at least another 100 cases, and have treated them all with quinine. I have notes of 12 cases aborted by this drug.

Where the disease is not at once checked by the drug, still it is, in many cases, very favourably influenced by it, the temperature being lowered, and the general tone maintained through its influence on the nervous system. Quinine and alcohol (when the pulse indicates its use) are the drugs, in my opinion, the most reliable in pneumonia.

The following case shows how splendidly quinine acts in this disease.

D. H., a man, aged 75, was taken ill suddenly on April 30th, with a severe rigor. I saw him the same day, and found that there was fine crepitation at the left base, dyspnoea, respirations 36 per minute, with a temperature of 104° Fahr., flushed face, etc., but no expectoration. There was a trace of albumen in the urine. He was at once ordered 10 grains of quinine, to be repeated every six hours. The next day the temperature had fallen to normal, the crepitation had diminished, and there was no sign of consolidation. On June 4th, the patient was quite well, and up. The only bad symptom I