Then again, in Bright's disease, I have every reason to remember the value of opium owing to the very general and widespread fear of its use. I believe those who are considered authorities have spoken of the great susceptibility of patients suffering from this malady to its influence, and, therefore, without contradicting them, simply state that nothing in my own experience has led me to confirm it. I have, therefore, no hesitation in giving opium or morphine when I find a patient sleepless and restless as is often observed in old cases before the access of the more marked uræmic symptoms. I have given it with the best effects.

My greatest difficulty in the use of opium has been owing to the idiosyncrasy of the patient, rendering some persons remarkably susceptible to its operation, and these have usually been members of the same family. I allude to the action on the heart and the tendency to syncope. On the other hand there are those who may be said to live on opium—a violent neuralgia, sickness, and even want of appetite, are all speedily removed by an opiate. One example will suffice. A lady had been kept awake all night by a violent crushing headache and constant vomiting; she had a dinner party coming off and considered herself, therefore, most unfortunate. When I saw her in the morning I injected a quarter of a grain of morphine in her arm; in ten minutes she was tranquil, then went to sleep, woke to have her tea, and was ready in the evening to receive her guests at dinner as well as ever. I could relate many such instances.

I need not particularise the large number of nervous diseases in which opium constitutes a most valuable remedy, but merely mention a case lately under my care. An old gentleman had fallen into a melancholia, he felt himself a ruined man, would not eat, was constantly moving about and had little rest at night. For the insomnia, chloral, bromides, sulphonal, paraldehyde, etc., had been given. The medical man would not give opium for fear of "locking up the liver." As, however, I did not fear instant death from such a result I persuaded him to give the patient a quarter of a grain of morphine every night. This was done, it quieted the patient's nervous system, and in a few weeks he had recovered.

I have said enough to show to the younger members of the profession that I consider opium has been able to stand the test of experience, and is as valuable a drug as our predecessors thought it to be. There are those readers, no doubt, and I trust they are numerous, who will agree with most which I have said and declare that I have preached nothing new. My object in writing was not to state any novelty, but merely to declare that after a long experience, opium holds its own. The new class of remedies, valuable as they are to relieve pain or produce sleep, cannot supersede opium, seeing they have none of the other properties which render this drug so widely useful.

NOTES OF A CASE PROBABLY REFERABLE TO A RECENTLY DESCRIBED FORM OF SPINAL DISEASE.

By PROFESSOR GRAINGER STEWART, M.D., F.R.S.E.,
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Mr. — was originally brought to me in the summer of 1889 by my friend, Dr. Spalding, of Snebridge. He was 48 years of age, and had lately returned from New Zealand on account of the failure of his health. He had been seen by various neurologists, and a variety of opinions had been expressed as to the nature of his case. The patient was a thin, wiry man, who had led an active life, and lived somewhat freely in the Colonies, although he had never been intemperate; had never been addicted to sexual excesses, or suffered from syphilis. He stated that he had always been very healthy till the middle of January, 1889, when he noticed a slight tingling in the tips of the fingers of both hands. This sensation increased till it became distinctly painful, and after exertion, such as writing, he had to give it up on account of feeling his wrist and forearm painfully tired. If he made a wrong step in walking, or struck his foot against any impediment, he felt a tingle both in legs and arms, which he likened to a feeling

produced by a stroke on the ulnar nerve. Gradually these symptoms increased, the sensitiveness of hands and feet becoming very marked, his writing becoming shaky, and walking difficult. He complained of various peculiar sensations in his limbs, such as coldness, tingling, numbness, and abnormal enlargement; and he found that muscular movement increased the discomfort in his extremities. If, for example, he raised his hands to brush his hair, the uneasiness markedly increased. All his symptoms were aggravated in cold weather, or if he from any cause got chilled; but his sensibility was little, if at all, impaired, even in the parts in which the sensations were most pronounced. There was no abnormality of the special senses nor of the muscular sense.

As to the motor functions the organic reflexes were natural, as were also the skin reflexes. The knee-jerk was exaggerated, but there was no ankle-clonus. Voluntary motion was somewhat impaired, especially for finer movements. Writing had become difficult, and he felt a certain awkwardness of gait, but he could walk along a straight line pretty well, and turn round without much difficulty, and closing his eyes did not aggravate his symptoms. There was no special interference with co-ordination. There was no vasomotor or trophic change in bones, joints, or skin, but he tended to become thin and anæmic, and his muscles wasted to some extent. His cerebral and mental functions were normal, as were also the spine and cranium.

The case did not distinctly conform to any recognised type of nervous disease, but it appeared more nearly to approach certain forms of peripheral neuritis than any other. Accepting this as our provisional diagnosis, we agreed to recommend rest, good diet, careful massage, and localised electrification with nerve tonics, particularly strychnine. Under this treatment he improved for some time until he was tempted to take a long and fatiguing walk on a hot evening, and this effort induced considerable exhaustion, and was followed by an aggravation of all his symptoms. When seen again late in the autumn of the same year the symptoms had become aggravated, although not altered in character, only there was a distinct degree of diminution of sensibility in the hands and feet, and he showed more awkwardness than before when he attempted to walk along a straight line. Still he did not sway about like an ordinary ataxic patient when his eyes were closed, and his knee-jerks persisted, and, on the whole, his case was not to be diagnosed otherwise than before. At that time the treatment by suspension was being tried in locomotor ataxy and other nervous diseases, and Dr. Spalding and I agreed to try it with him. It was repeated on five or six occasions but without benefit, and on the last occasion it was followed by a degree of faintness which led to our discontinuing the treatment.

During the colder part of the winter of 1889-90, he went to the Riviera, and was under the care of my friend Dr. Rendall, of Mentone. He improved considerably, and in July, 1890, Dr. Rendall reported that the patient had been so well as to require little medical attendance during the winter. On leaving Mentone he had resorted to Aix-les-Bains and tried some hydropathic treatment there. He then felt himself distinctly better than he had been during the autumn, but the legs and hands remained weak, and the peculiar sensations persisted. After a short stay in Aix, he came on to London, and there, having fallen in with some old friends, he seems to have over-fatigued himself considerably. A further aggravation of all his symptoms followed, and when he came to Scotland he was much disheartened, feeling himself in all respects worse.

In the autumn (1890) I found him thinner, weaker, and more anæmic than before, but careful examination gave no further evidence either of locomotor ataxy or of antero-lateral sclerosis, and his symptoms simply showed an increase of all the features which we had at first recognised. He complained bitterly of the coldness of our climate and wished to return to New Zealand, but he had become so weak that Dr. Spalding and I dissuaded him from attempting so long a journey, and advised him to go again to the Riviera and winter in Mentone. When he left us he was pale and thin, complained much of the various morbid sensations in his legs and arms and also in his head. Sensibility was diminished, but by no means lost; the motor powers were considerably weaker, but he was not paralysed, neither was there special

failure of co-ordination, although in walking it was observed that he occasionally knocked his heels together and tended to stumble.

He caught cold in London, and had a bad journey through France, and, on reaching Mentone, was quite unfit for exertion. He was confined to his room most part of the winter, and suffered much from diarrhoea and increasing debility. In the month of April I had the opportunity of seeing him in Mentone along with Dr. Rendall, and found him in all respects much worse. He was emaciated and anæmic, and his weakness was such that he could scarcely walk across his room. He was even unable to stand without assistance. When in bed he was able to move his feet about, although not vigorously, and he could write, although with effort and with but a poor and tremulous result. No satisfactory explanation of his diarrhoea was discovered, and there was no disease superadded, but the condition of the nervous system showed again an increase of the earlier symptoms.

It is clear that the history and features of this case do not conform to those of any well-recognised type of nervous disease. I have never seen a case of peripheral neuritis in which an increase of the patellar reflex existed, and the course of the case did not correspond to any example of neuritis that I have seen. The same remark applies to the suggestion which might be made that the case is one of locomotor ataxy; and in addition to the difficulty of the knee-jerk in such a diagnosis we have to recognise the absence of marked failure of co-ordination and of all that series of early symptoms which have been so familiar to the profession since the days of Trousseau. Neither is it referable to the category of Dr. Gowers's cases of ataxic paraplegia, in which the symptoms proper to locomotor ataxy are modified by the results of sclerosis of the antero-lateral columns of the cord. There is, however, a condition which has been described by Drs. Putnam and Dana—the former writing in March, 1889, the latter in April of the present year—which seems to correspond pretty closely to the symptoms met with in my patient.

Dr. Dana summarises the symptoms of the cases which he watched somewhat in the following way: The disease exhibited at its onset a numbness of the extremities, attended and followed by progressive enfeeblement: the enfeeblement was not attended by paralysis of any special groups of muscles, but culminates at last in paraplegia. In some cases there were ataxic symptoms, but spastic phenomena, with exaggerated knee-jerk and ankle-clonus, were more common. Anæsthesia was met with in some cases; girdle and lancinating pains were very rare. The arms were less affected than the legs. The vision and other special senses and the speech were not disturbed. Mental symptoms approaching dementia were observed in the terminal stage in one case, and the patient usually suffered from great emaciation; and anæmia, often attended by obstinate diarrhoea, was among the marked features. The general course was that of a rapidly progressive affection—rapid as compared with the ordinary system-diseases of the cord. It was more common among women than men, and was more apt to occur after middle life. The cause was not certainly determined. It did not seem, in the cases observed, to be due to syphilis or alcoholism. The pathological changes met with consisted in a combined sclerosis of the lateral and posterior column, ultimately associated with a softening at certain levels. Treatment had only been followed by temporary improvement, and the remedies which Putnam and Dana have found most useful were iron and other tonics.

The case which I have sketched manifestly corresponds in many of its features with those mentioned by the American authors whom I have quoted, and I publish these notes in the hope of drawing the attention of physicians in this country to this little-known form of disease.

AN anonymous donor has presented to the county of Surrey a convalescent home for male patients, at Seaford, Sussex. It has been erected at a cost of £25,000, including £10,000 set aside as an endowment, and will accommodate fifty patients. The President is the Duke of Cambridge; the Vice-Presidents, the Duke of Connaught and the Duke of Teck.

THE Hungarian Prime Minister has expressed himself in favour of the proposal to hold the International Hygienic Congress of 1893 in Buda-Pesth.

ON THE TREATMENT OF ANEURYSM OF THE AORTA BY IODIDE OF POTASSIUM.

By GEORGE W. BALFOUR, M.D., LL.D., F.R.C.P.E.
Physician to Chalmers' Hospital.

IN March, 1887, a clergyman entered my consulting room with the words: "I have been perfectly well for over a year; I have been doing half duty for the last three months, and, with your permission, I intend doing full duty henceforth." His history was as follows: On December 24, 1885, the Rev. W. A. called upon me, and gave me the following account of his case, written out by his own medical attendant, Dr. Gorman, of Rutherglen:

"On several occasions during the last few years, and at intervals usually of many months, the Rev. W. A. has been attacked with sudden disturbance of the heart's action. Generally this has occurred without any evident cause, and under various circumstances. When out visiting, when reading quietly at home, or when lying in bed, the heart would begin to beat more rapidly and forcibly, and this would go on increasing till the pulse rose to 140, and a jarring impulse was communicated to the whole body. This condition was accompanied by a distressing tight feeling in the chest, but there was no marked difficulty of breathing or feeling of suffocation. This would continue for a short time, and then subside so quickly that at the end of an hour not a trace of any disturbance was discoverable. Inhalation of nitrite of amyl gave no relief, but brandy always speedily brought the attack to a close whenever it was tried. When I saw him after the attack there was no unusual murmur, nor anything abnormal to be detected. Rather more than two months ago—October, 1885—had a cold with a raw throat and a slight cough, and for this he kept indoors for two days. Then early one morning he awoke—about 3 A.M.—with a feeling of suffocation, and a strong desire to cough; but the attempt to cough brought on a violent laryngeal spasm, under which he struggled for fully ten minutes, as I was informed, before he got relief. By the time I arrived the spasm was gone, his voice was a little rough, his pulse quick, and his whole body and bedclothes soaked with excessive perspiration. Early in the morning of the seventh day following this attack, Mr. A. had another and a more severe paroxysm of a similar character. During the interval he had been out of bed, but not out of his bedroom, and had been troubled with a little cough, which was, however, soft and loose. Eight days subsequently Mr. A. had a third attack, lasting longer and more severe than ever. After this there was more cough, and at the end of each cough an attempt at laryngeal stridor. At this time a child in the house began to cough suspiciously like whooping cough, and it was suspected that Mr. A. might have whooping cough. I heard him cough several times; there was no true whoop, not even a repeated coughing, but after one or two harsh expiratory sounds, a slight—not croupy—stridor was heard. I consulted with Dr. Joseph Coats, the pathologist, who is also an expert laryngoscopist. He only found slight increased vascularity of the larynx and of the rima glottidis. On getting out of bed to be examined by Dr. Coats, Mr. A. was seized with a fourth attack, slight and short in comparison to his previous paroxysms, as we were told. To me it seemed like a fit of whooping cough, the cough ending in laryngeal stridor, exactly like what is popularly termed a "dumb kink." Dr. Coats did not think the appearances in the larynx sufficient to account for the attacks; he thought there was slight dulness on percussion over the first rib on the left side close to the sternum, and was inclined to suspect a commencing aneurysm of the aorta pressing on the recurrent laryngeal nerve. The pulsation behind the left sterno-clavicular articulation seemed to him to be abnormally increased. No *bruit* of any kind could be detected, nor was the systolic sound at the cardiac apex markedly prolonged. Dr. Coats thought that the action of the vocal cords during inspiration was insufficient. I examined Mr. A.'s larynx on several occasions, both before and after this, but I never could detect paralysis of either of the abductors. The neck was swollen and puffy, the thyroid body large but soft. Fomentations were applied and iodine liniment painted on, which somewhat reduced this swelling.