singular that there was no dyspnoea or distress until the pleuritic attack took place on the right side, when we consider the pressure, if not destruction, to which the recurrent laryngeal nerve was exposed. Dr. Risdon Bennett expresses his belief that, if there be any considerable degree of pressure or irritation of the recurrent laryngeal nerves, there will invariably be a great amount of both dyspnoea and distress: at the same time, he observes that it is somewhat remarkable that symptomatic vomiting or other disturbance of the stomach is not more frequently met with when there is destruction of continuity of one pneumogastric nerve. The experience of this case, then, shows that, even when the recurrent laryngeal nerve is involved, as indicated by the changed and husky voice, dyspnoea and distress may not necessarily be produced.

The normal temperature observed corresponds with the experience of Wunderlich, who says that it is a peculiarity of cancer cases that elevated temperatures are comparatively rare. The absence of pain also corresponds with what has been observed in the majority of cases of cancer of the lung.

I regret I was not at the time acquainted with the valuable sign of tumour in the neck first pointed out by the late Dr. Kilgour of this city, with whose acute powers of observation and diagnostic skill many of us are well acquainted. I cannot, therefore, say whether the glands were affected or not; but I think, if they had been to any extent, it would have been noticed.

Dr. Cockle, in his able and learned work on *Intrathoracic Cancers*, lays great stress upon the importance of external tumour; but one of his cases, in which the diagnosis was difficult, illustrates also the necessity of ascertaining the *duration* of the tumour when present, as the patient in question had had three sebaceous tumours on his neck for many years, while other tumours, cancerous in nature, appeared on the abdomen only shortly before death. Primary cancer of the lungs is said by Walshe to give rise very seldom to secondary deposits elsewhere, although the lungs themselves are frequently affected as a sequel of disease in other organs. The case of Mackie is, therefore, interesting, on account of the secondary cerebral complication connected with it.

(To be continued.)

REMOVAL OF THIRD METATARSAL BONE: ANÆSTHESIA BY CHLORAL-HYDRATE.

By G. J. S. NAIRNE, Surgeon, and ALEX. NAIRNE, Physician,
Glasgow.

ON April 1st, 1875, Christina D., aged 3½, a delicate looking girl, was put under the influence of chloral, and had the third metatarsal bone of her left foot removed for disease. The operation had nothing special to note, but the narration of the administration of the chloral may be interesting.

An aqueous solution was prepared, of the strength of twelve grains to twenty minims. A solution of strychnine (two grains to the ounce), was also prepared. At 10.30 A.M., ten minims of the chloral solution were injected subcutaneously into the right lower leg. At 10.38, there was no perceptible effect; the child cried continuously. At 10.40, ten minims more were injected subcutaneously into the lower part of the left leg, and the child was given to its mother to carry about. At 10.45, the patient was drowsy, but easily roused; she started and cried whenever the mother would lay her down. At 10.55, ten minims more were injected; at 11, she was sleeping apparently soundly. There was no flushed face, but the pulse was rather quick. She awoke and cried. At 11.5, ten minims were administered by the mouth. She dropped off to sleep in a few seconds, and began to snore. Pinching made her cry, but she fell asleep immediately. At 11.18, ten minims more were administered by the mouth. At 11.20, she was in a deep sleep.

The operation was now performed. During its performance she began to cry, but made no struggling to speak of; the eyes remained nearly shut, and the crying seemed that of a dreaming child. Immediately she fell asleep again as sound as ever. Strong tea was prepared, of which she was made to drink a cupful. Her pulse was quick but firm, so we let her alone. She slept deeply for over two hours. More strong tea and milk were then given her, and, in another three-quarters of an hour, she sat up dazed, looking quite unterrified, and apparently oblivious to any pain. Next morning, she took her porridge and milk with quite a good appetite.

Altogether, the administration of chloral seemed better than that of chloroform—in this instance, at least. There was no convulsion, nor apoplectic appearance, and no unnatural disturbance of the breathing. There was no subsequent sickness nor any apparent ill effects. We

conceive that chloral would be much safer and better than chloroforming in ophthalmic operations.

We were glad we had no cause to use the strychnine, but would not have hesitated to inject it subcutaneously if there had appeared any necessity. We have administered strychnine frequently after chloroforming, and generally found an immediate good effect in brightening up the patient and preventing sickness. Subcutaneous injection would, therefore, very likely be successful in restoring animation in cases of chloroform poisoning.

Next time we use chloral we intend to have a much more dilute solution, and a larger syringe, and to inject it into a vein. By these means, we hope to avoid the pain caused by the injection, provide as far as possible against phlebitis, prevent the formation of painful swellings or ecchymoses, and secure the more immediate introduction of the fluid into the circulation. Total unconsciousness does not seem at all necessary to produce anæsthesia, as, although the girl woke up and cried during the operation, she made no struggling, and was asleep before her cry was finished.

CLINICAL MEMORANDA.

RAPID PULSE.

I HAVE read an article in the JOURNAL of this date (June 12th) by Dr. Robert Farquharson of St. Mary's Hospital, on Rapid Cardiac Pulse, and I feel particular interest in the cases which he has recorded, having at the present time a patient under my care whose pulse at the wrist it was difficult to count. I happened to be called to this gentleman, a foreigner, aged 65 to 70, fond of alcoholic drinks, and of bilious temperament. I found him at two o'clock in the morning scarcely able to breathe, and sitting on the side of his bed, surrounded by his relatives, who were in the greatest alarm. The pulse at the wrist was irregular, and 140. There was the same rapid irregular "to-and-fro" action of the heart, apparently caused by aortic insufficiency; but, as in Dr. Farquharson's case, no *bruit* could be detected. As it turned out afterwards, it was the beginning of an attack of bronchitis, and, when free expectoration took place, there was a marked improvement in the circulation, the pulse coming down to 130, then to 120, where it has remained. The urine was scanty, high coloured, acid, and of specific gravity 1010. No albumen could be detected by the heat and nitric acid test. The patient is still under treatment, and relieved as regards the bronchial attack, though still suffering from what would be considered a very rapid pulse (120 to 130), yet not coming up to the abnormal rapid pulse recorded by Dr. Farquharson.

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NOTES ON A CASE OF INSANITY INDIRECTLY CAUSED BY PHIMOSIS.

A. J. K., aged 26, had been formerly a schoolmaster, but now devoted himself exclusively to the study of music, practising on the piano or organ eight hours daily. On inquiry, it was found that he was obliged to give up the school, as he found he could not exercise sufficient authority or control over the boys. There was a slight loss of memory, and he had some difficulty in remembering his age. He stated that the symptoms first noticed were pains in the back, but was unable to say when they commenced. He had lately suffered from a sensation in the occipital region as if the skull were being depressed. He was a seven months' child, and did not walk until he was three years old. When an infant, he suffered from constant diarrhoea and prolapsus ani. He was always very excitable, but his excessive mental and bodily weakness prevented his following any regular occupation. He is passionately fond of music, and has overtaxed his strength by his studies. He had for the last six months been under the delusion that certain people had been following him about and making indecent gestures at him. He could not speak of these facts without bursting into tears and becoming hysterical. He believed that these people had done their best to prevent his getting a living. On inquiry, it was found that he was addicted to masturbation. This habit he attributed entirely to a state of irritation and itching which were constantly present in the penis. On examination, it was found that there was a condition of congenital phimosis, the secretion from the glandula Tysonii never having been cleared away. The case was treated temporarily with bromide of potassium and aperients, and partial circumcision was recommended. The operation was successfully performed; and, from a letter subsequently received, it appears that the habit has