prove a direct cause of convulsive action; and the carefully recorded statistics of Dr. Murphy show that the mortality in this disease is much greater when labour has been artificially accelerated than when it has been left to the natural efforts.

In conclusion, I need scarcely say that I have given but an imperfect and incomplete account of a very comprehensive subject. Enough, however, I would fain hope, has been said to furnish ample scope for an interesting and instructive discussion on a question of much importance to obstetricians.

RESTRAINT IN INSANITY.*

By STANLEY HAYNES, M.D., Malvern.

THE propriety of mechanical restriction has lately attracted some attention; it was questioned in the treatment of patients becoming maniacal during variola, and, quite recently, with regard to the treatment of otherwise unmanageable, suicidal, violent, or destructive insane persons.

As this topic is now brought forward for the purpose of eliciting discussion, and the expression of medical opinion upon a *questio vexata* in our profession, I abstain from here noticing the excesses to which mechanical restraint used to be subject and is now carried, or from recording the judgments of authorities in favour of or against it.

As medical men, we must put aside all mere sentimentality in the consideration of this subject, and confine our attention to the inquiry whether our patients will be benefited or injured by the imposition of corporal restriction. To avoid irrelevant discussion, perhaps it will be well to define the meaning of restraint, as applied to our treatment of patients. Restraint is moral, intellectual, medicinal, or corporeal. Moral and intellectual I propose to exclude from this investigation. By medicinal restraint I understand the conditions in which patients can be placed by the administration of narcotics, sedatives, or nauseants. Corporeal restriction is of two kinds—by seclusion, and by mechanical appliances. Seclusion, as a form of restraint, is solitary, undesired confinement; when patients request to be kept apart from others, it is unfair to consider them as restrained. Restraint by some appliance, *i.e.*, restriction of motion in any desired direction by some kind of garment, is effected by means of sheets, camisole (or "strait waistcoat") or glove.

It is to be assumed that all practitioners will agree in the propriety of restraint—other means failing—in surgical cases (*e.g.* when a person has a self-inflicted wound and is striving to pull it open); and it will probably be at once conceded that in some of the maniacal conditions consequent on variola, typhus, and other febrile states, we are justified in mechanically repressing our patients from injuring themselves and others, by fastening a sheet across the patients and under the sides of the beds; such patients are too weak to be kept in bed by the hands of nurses, however careful and gentle. There will be more difference of opinion concerning the restraint of insane persons, the lunacy authorities being, naturally, antagonistic to the principle, and the majority of British asylum superintendents condemning it; their example is being followed by some of the German alienists, and it is to be sincerely hoped mechanical restrictions will soon be as rare in America and on the European continent as here.

As the question now stands, mechanical restraint is the bugbear of lunacy practice; we have rushed from too much restraint to too little, if we are never to use it under any circumstances, as some extremists uphold. We can no more advocate prevalence of physical control than we can of depressing procedures; but there can be no doubt there are some very exceptional cases in which the employment of mechanical restraint is the most advisable method we can adopt, and, therefore, our duty as physicians and men. The system of non-restraint is in fashion, but is it not abused by being pushed too far? How long will it be before we have the inevitable reaction? When a patient is prevented from injuring himself or others by being forcibly held by anyone, he usually has the spirit of opposition raised within him and struggles to be free; the then necessary pressure upon his arms may cause bruises, easily produced and tardy to disappear, but he is restrained quite as much as, or more than, if he had worn some special garment; still, it is not "restraint" requiring to be entered in the Case Book and Medical Journal, and so manual restriction is preferred to mechanical, by which a patient cannot injure himself or others if he be guarded by an attendant.

Some persons appear to entertain a morbid aversion to the use of any mechanical restraint; it used to be so much abused that they seem to dread it could be again, notwithstanding the close inspection the autho-

rities exercise so carefully, and the absence now of all privacy concerning the treatment of the insane. Those who advocate non-restraint at any cost err most needlessly, if they imagine mechanical restraint can be again abused; the honesty, humanity, skill, and watchfulness of British asylum superintendents are sufficient guarantees against so sad a relapse, even if the supervision of the authorities, central and local, were relaxed, and if the importance of medical and public opinion, as expressed by the press, ceased to be duly estimated.

In no case where it can be avoided without harm to the patient should restraint be resorted to; but in some few and otherwise unmanageable cases of suicidal melancholia, of excessive and dangerous violence, it is better to employ some appliance than frequent manual, antimonial, or narcotic means. The "moral" effect produced on a wilfully aggressive or destructive patient by the use of gloves or the camisole is often most salutary and valuable; he finds he can do no harm, and ceases to be a source of apprehension and danger; he feels he is conquered, and is reduced to the similitude of a thrashed bully.

With regard to the curability of the patients, is it not infinitely preferable to see an occasional, but only when really necessary, use of mechanical restriction than to find sedatives, or nauseating doses of antimony, given for the purpose of quieting the patients? By the use of the latter, it may be charmingly easy to keep the obnoxious word "restraint" out of Case-Books and Reports, and the patients can be very much less troublesome, noisy, and expensive; but they are also more incurable. It is better to have curable patients with the censure, if such must be, than incurable ones with the commendation of the authorities and journalists. The medical Commissioners in Lunacy are practical men, experienced in the difficulties met with in the treatment of exceptional cases, and, although adverse to the principle of corporeal restraint, are just, and tolerate it when its necessity and circumstances have been indicated and duly reported. Every physician treating an insane person must consider, "What is best for the patient?" and answer the question in accordance with his resources, and conscientiously; otherwise, he fails in his manifest duty.

NECROSIS OF THE CLAVICLE IN A CHILD.*

By JAMES THOMPSON, M.B., Leamington.

IN April of the present year, I was called to see a child aged 4 years—the last surviving child of a family of six children—of delicate appearance, and with evident constitutional taint. There was no history of any injury. The child complained of pain referred to the sternal end of the clavicle; the joint was swollen and red, and had been so for twenty-four hours before I was called to see it. Movement of the head caused much pain, but the child freely moved the arm herself; the whole clavicle was tender to the touch, and the swelling spread towards the acromial end. The diagnosis given at the time was fracture of the clavicle, with some laceration of the sterno-clavicular joint. It seemed most likely that by some slight and unrecorded injury the bone had been fractured in a child with a scrofulous diathesis and history. The ordinary bandage was applied, and a cold lotion over the seat of injury. This appeared to cause much discomfort, and the child wriggled off the bandage, and moved the arm freely. The swelling and tenderness continued, and three days afterwards there was a severe rigor, with subsequent high temperature (106 deg. in axilla), which pointed to the formation of matter. An abscess formed, which was opened when ripe, and a large quantity of pus evacuated. The child was so restless that it was quite impossible to pass a probe into the abscess to investigate the cause of the formation. Dr. Carter saw the case with me, and after consultation we agreed to poultice and support the child's health, and wait the issue. The general health of the child improved greatly, but the local tenderness continued, and a guarded prognosis was given, stating that under the circumstances it was quite impossible to say what was the actually injured part. The abscess continued to discharge for nearly three weeks, during which time the child could not be induced to keep the arm quiet. I had now quite made up my mind that it was diseased bone with which I had to deal, and I requested permission from the parents to use chloroform, but this was refused; palliatives, stimulants, and support were all that was left. Another week passed over, and then another rigor took place, and another abscess formed one-and-a-half inches below the sterno-clavicular joint. This was opened, and another quantity of matter was evacuated with relief to the general symptoms; three days afterwards I fancied I felt loose bone (with

* Read before the Psychological Section at the Annual Meeting of the British Medical Association in Birmingham, August 1872.

* Read before the Surgical Section at the Annual Meeting of the British Medical Association in Birmingham, August 1872.

the sponge), and then I confidently called on the friends to permit its immediate removal, to which they reluctantly consented. I made an incision over the course of the movable piece of bone, and easily drew it out, when, to my surprise, I found it was at least two-thirds of the whole clavicle. It seems to have died in mass. Near the sternal articulation, there was a well marked pit of the spotted ulceration of scrofula. The opening healed up almost immediately; every effort was made to keep the arm immovable, but without much benefit. The final result is now, that the child has perfect use of the arm, and the distance between the point of the shoulder and the middle of the sternum is only one-half inch less than that of the sound side. There is a ridge of bony matter forming along the site of the former clavicle. I congratulated myself on the successful issue of the case; but I fear that another centre of mischief is now forming in the lower third of the femur of the same side.

CASE OF SPASMODIC CONVULSIONS RESEMBLING TETANUS, OCCURRING PERIODICALLY.*

By S. SPRATLY, M.D., Rock Ferry;
Associate of King's College, London.

I AM induced to bring this case before the Medical Section of this Association; first, because it is one that is very rare; secondly, in order to obtain an expression of opinion from the members present, who from their large experience may be able to throw some light upon it, as hitherto it has resisted all treatment. I shall endeavour to relate the case to you in as few words as possible.

In the early part of April last year, I was sent for to see a young lady about 23 to 24 years of age, who was suffering from cough and general debility. On inquiring into the family history, I found that the mother had died of phthisis about fourteen years previously. On examination of the chest, there were puerile breathing at the apices of both lungs, a very short irritable cough, and slight expectoration. After being under careful treatment for three months, the cough subsided; the breathing became perfectly natural; she could walk without distress, gained flesh, and expressed herself as feeling much stronger and better.

Early in September, a feeling came on of soreness in the stomach, accompanied by a thorough loathing for food. Twelve hours after this, a violent spasm occurred, accompanied with great pain and extreme muscular rigidity; the feeling being, as she expressed it, as if all her inside were being drawn up and tied in a knot in the middle. This lasted two to three minutes, then gradually subsided, to be followed in a quarter of an hour by another, and so on for eight or ten in succession. I was from home at the time, and did not arrive at the house until all was over. After the spasms had ceased, she fell asleep, and awoke early in the morning much exhausted, but perfectly free from pain; she became cheerful, was able to run about the house, go into society, and appeared as if nothing ailed her.

At the end of four weeks from the first attack, another came on, with the same warning—soreness at the pit of the stomach, a loathing for food, and great depression of spirits. At eight o'clock in the evening, the same time as before, the spasms commenced. I was then present. The first appearance was muscular rigidity of the hands and arms; the fingers were stretched out perfectly rigid, and separated from each other; the hands were thrown back, with the palms upwards; the elbows drawn down to the sides; the body writhed to and fro; the face assumed a sardonic appearance; the muscles were thrown into rigid contractions, especially the depressors of the angles of the mouth; the jaws were firmly set; the colour of the skin was slightly livid; the eyelids partly closed; the eyeballs depressed, so that only the sclerotic could be seen. Then opisthotonos came on; the head was thrown completely back; the body was perfectly arched, the feet and the back of the head touching the bed only, the back being raised about six to eight inches from it; the other muscles of the body were in a state of rigid contraction; the abdomen was hard and tense. These symptoms lasted for two or three minutes, then gradually subsided, to come on again in a quarter of an hour, and to be repeated ten or twelve times in succession, and in precisely the same manner. During the paroxysms, the breathing was little if at all affected; the pulse was not increased in frequency, and remained steadily at 74; the temperature was not increased or diminished. These attacks have continued from that time to the present; but the interval has become less and less, and for the last three months they have come on regularly every Wednesday, and always

at 8 P.M., lasting generally until one in the morning; the patient generally having twelve or thirteen convulsions during the attack. They have been latterly much more severe; and more so if the spine be touched, however lightly, during the attack, at the junction of the eleventh and twelfth dorsal vertebrae. This part of the spine, within the last two months, has become very tender, and rather prominent and angular, as if the bodies of the two vertebrae in question were diseased: this feature has only shown itself lately. The patient always has the usual premonitory symptoms, and can predict the time of the paroxysms to a minute.

Such is a short history of the case during the paroxysms. All treatment hitherto used to arrest them has been of no avail. Antispasmodics of all kinds at the time of the attack, and tonics and antiperiodics during the intervals, have been perseveringly tried. The only thing that seemed in any way to moderate the intensity of the symptoms was the subcutaneous injection of the extract of Calabar bean along the spine where the tenderness exists, which slightly modified the intensity of the spasms; and since its use only during the last two attacks, the interval has increased from seven to eleven days. Chloroform, while she is under its influence, relieves all symptoms, but the moment sensibility returns the symptoms are as bad as ever. Menstruation is quite normal; and there is no hysterical history.

CLINICAL MEMORANDA.

SPONTANEOUS DISLOCATION OF THE JAW THROUGH "TONGUE-SUCKING".

ON Thursday, August 15th, at midnight, a young lady aged 15, a patient of mine, while on a visit at a friend's house, was awakened from her sleep with pain under the ears and inability to close the jaws, or to articulate plainly. She aroused her friends, who, feeling alarmed, sent for their medical attendant, who arrived about three in the morning, when he at once declared the jaw to be dislocated, and quickly reduced it. I went to see her on the Saturday following, and found her well, but much alarmed at going to bed, fearing that the accident would again occur during sleep.

I am anxious to place on record this remarkable case, inasmuch as I am persuaded that the habit of tongue-sucking, which the young lady has always done from her infancy, and so audibly during sleep as to be heard in any part of the sleeping-room, was the true cause of this distressing accident. The action of the pterygoid muscles (which are inserted, the one "into the inner surface of the angle and ramus of the jaw as high as the dental foramen," the other "into the neck of the lower jaw and into the interarticular fibro-cartilage") together brings the jaw downwards and forwards, projecting the lower teeth beyond the upper. The continued action of the above muscles during sleep, I have no doubt, had so preternaturally loosened the ligaments and muscular structures supporting the joint, as to render them unable to resist the violent action of them during sleep.

EDWIN MORRIS, M.D., F.R.C.S., Spalding.

SELECTIONS FROM JOURNALS.

SURGERY.

FOREIGN BODIES IN STRICTURED OESOPHAGUS.—Dr. Menzel relates, in the *Archiv für Klin. Chirurgie* (Band xiii, p. 678), two cases of stricture of the oesophagus complicated with the presence of foreign bodies. Both were children, and were under Dr. Billroth's care in the Vienna General Hospital. The first was a boy aged 6, who was reported to have drunk some strong alkaline lye by mistake about a year previously. Narrowing of the oesophagus followed, which was treated by bougies; none, however, larger than a quill could be introduced. Three days before admission, he swallowed a breeches-button. When he was admitted, a bougie could not be made to reach the stomach, but was arrested opposite the upper part of the sternum. All attempts to remove the foreign body by instruments and by emetics were fruitless. Accordingly, on the next day, Dr. Billroth performed oesophagotomy, and removed the button by means of forceps. The progress of the case was favourable; the incision in the oesophagus was healed on the sixteenth day and the external wound on the twenty-fifth day. The child was fed throughout by the mouth; slight pressure on the oesophagus being sufficient (after the removal of the sutures on the third day) to prevent the escape of food. The second case was that of a female child, who, at the age of a year and a half, had swallowed some nitric acid. On her admission, an oesophageal tube of the size

* Read before the Medical Section at the Annual Meeting of the British Medical Association in Birmingham, August 1872.