the house for a day or two should, I need scarcely remark, be insisted on, whenever practicable. The warm or hot air-bath (or 'packing'), as suggested by Dr. G. Johnson, is a valuable adjuvant to the treatment, if had recourse to on the day of seizure; and, in severe cases, I generally recommend one or the other, if obtainable, and an immediate retirement to bed in a warm room.—Believe me, yours very truly,

"Sir Thomas Watson, M.D., Bart." "JUKES STYRAP.

R Liq. morphie (P.B.) mxl; vini antimon. mxxx: potasse citratis Div; syr. aurantii 3ij; aquæ ad 3iv. Misce et fiat mistura, cujus sumat cochlearia magna ij quâqua tertiâ vel quartâ horâ.

R Liq. morphie mxl; vin. antimon. mxxx; liq. ammon. citrat. 3j; potasse citratis Div; sp. chloroformi 3j; aquæ ad 3iv. M. Ft. mist., cujus capiat cochlearia magna ii quâqua tertiâ vel quartâ horâ.

My attention was originally directed to the value of small doses of morphia in catarrh under the following circumstances. Many years ago, I was confined to my room by a very severe catarrhal attack and bronchitis, for which antimony, etc., were prescribed by a friend with but trifling relief. For some reason or other, I was induced to add the twelfth part of a grain of morphia to a dose I was about to take, and in half an hour or so the sneezing and defluxion had considerably abated. The next few doses were taken without the morphia, and the coryza, etc., returned, and the cough became troublesome; in consequence of which, I repeated the morphia, and again the sneezing, etc., ceased. In every subsequent attack of catarrh (to which I was, at one period, very subject), I combined the antimony with morphia; and, having tested their value on myself, prescribed them for others with a like satisfactory result. In what way the morphia effects the speedy relief from discomfort which almost invariably follows its administration, I am not prepared to say. Probably, as Dr. G. Johnson suggests, it is due to some direct influence on the nerves and vessels of the inflamed mucous membrane, rather than to any diaphoretic action. Be that as it may, I would strongly advise such of you as are subject to "colds" just to try the medicine; and I entertain little doubt that the effect of its first trial will be such as to induce you eventually to thank me for the suggestion of so simple a remedy.

The antimony, in addition to its special effect on the inflamed mucous membrane, tends to counteract the usual constipating action of the morphia; and the citrate or bicarbonate of potass relieves the thirst and itching not infrequently produced (in my own case at least) by the opiate. I would also remark that, by giving the morphia in small and repeated doses of one-twelfth of a grain, combined with correspondingly small doses of antimony, it can be safely administered to persons otherwise intolerant of opiates, without suffering from the headache, nausea, and other distressing symptoms which so often follow a full dose of opium.

Mayhap some of you will mentally exclaim, "Oh! the principle of treatment has been known from time immemorial." Possibly so. Nevertheless, simple and efficacious as the treatment by morphia and antimony in small doses really is, I can truly assert that, during the not few years in which I have been in the profession, I have never seen it alluded to in any work on medicine, or practised by others than myself; which fact will, I trust, be deemed a sufficient apology for soliciting your attention to it.

In regard to the hot-air bath, I need scarcely remind you that such may be readily extemporised—the chief essential being a capacious spirit-lamp, with a large wick, usually kept in stock for the purpose by surgical instrument makers; and, being made of tin, the cost is trifling. The following will be found a simple and effective plan. Let the patient be seated, undressed, in a suitable armchair in his bedroom, and carefully enveloped in two or three folds of blankets extending from above the shoulders to the floor, but *outside* the chair (or, still better, a hoop affixed thereto), so as to allow a free circulation of the hot air round the body. A Mackintosh cape thrown over the blankets will enhance the effect. The best position for the lamp, according to Dr. G. Johnson, is, with due precautions, between the legs, rather than underneath the chair; and it should be kept burning for twenty or thirty minutes, or until free perspiration be established. The patient should get into a warm bed between the blankets. Nervous people are apt to object to a hot-air bath so constructed, from an absurd fear of the flame of the lamp. The difficulty may be obviated by placing a wire guard over it.

In the absence of the means for providing a hot air or water bath, an effective action of the skin may be induced by wrapping the patient in a sheet or thin blanket (to which latter patients offer less objection than to a wet sheet, on account of the relative warmth-imparting feel), wrung out of moderately hot water, and enveloping him in a couple of warm dry blankets; in other words, "packing" him, as it is termed, for an hour or more, until free perspiration takes place: a plan of

treatment which, I venture to affirm, you will find highly beneficial in renal and other forms of disease, notes of which I reserve for a future paper, with "Gleanings from Hospital Practice".

SOME CASES OF CATALEPSY.

By GEORGE H. SAVAGE, M.D.,

Assistant Medical Officer to Bethlem Royal Hospital; Lecturer on Mental Diseases at Guy's Hospital; etc.

ONE reads in text-books that catalepsy is a disease allied to hysteria and to epilepsy; that it is very rare, and that its onset is sudden; that the state lasts only a short period and then passes off, the patient being unconscious of what has transpired. What I have to describe differs from this. In our cases, the state was persistent. Catalepsy is an undoubted neurosis, and, therefore, allied to hysteria and epilepsy; but in the following cases the relationship was nearer to insanity. In many cases of melancholy with stupor, one sees a more or less cataleptic state, but with memory and knowledge of what was going on around. I am convinced that many of the so-called cases of catalepsy are the result of mental disease that has been of so slight intensity or of such short duration that it has been passed by unobserved.

I publish the following cases, with the permission of my colleague Dr. Rhys Williams.

All the cases were males; all were young; in one only was there distinct family taint; all suffered from melancholy, and were at times dirty; and all will pass into dementia and cease to be cataleptic. I cannot explain why in this process of decay, for a time, persistent muscular action is seen. In the insane, we may have insane organs and insane muscles; that is, organs or muscles that are not controlled by the nerves, or in which the nerves are discovered. Thus, we have had lately a series of cases of torticollis in melancholic patients.

The first case was one of catalepsy following melancholia. The patient was Alexander C. B., a letter-sorter, single, aged 23. He inherited no neurosis; had been sober and industrious. He received injuries seven years ago from being run over, but the effects passed off. The cause of his present illness was supposed to be worry; he fancied that he would be accused of theft; he became more and more nervous, and gave up his work. He gradually seemed to shrink into himself. I first saw him at the Westminster Hospital with Dr. Sturges, whence he was transferred to Bethlem. On admission, he was thin, sallow-looking, with cold moist skin; pulse small, rapid, and weak. He ate fairly, and slept well. In whatever position he was put, there he remained; and on several occasions he maintained the outstretched position of his arm for two hours together. He could be made to stand on one foot, the other being outstretched in front. He did not flinch if slightly pinched, but did if pricked or severely pinched. Everything had to be done for him. At first, he was wet and dirty. We used the continuous current through his head daily; and for a time were able to get some movements following a word of command. The interrupted current produced more pain and more results. He was induced to follow another patient; and, as long as this patient walked slowly and steadily, the cataleptic followed like his shadow, not eighteen inches from him. No power of initiation was obtained; and, after three months, he was discharged uncured.

The next case was that of Frederick M., bank clerk, aged 27. One of his brothers was insane. He had had no previous attack. He was first restless and uneasy; gave up his situation, and left England. He still felt miserable; and at length attempted suicide by dividing the skin and muscles of his left arm down to the bone, at New York. On the wound healing, he was brought to England. On admission, he was in a similar state to the last patient. As his limbs were left after one meal, so they would be found at the next. The appetite was voracious; and the patient slept well. The damaged arm was galvanised; and the wounds over the knuckles and in the palm healed. This patient would maintain the same position for hours together. He was wet and dirty. As he is now (November 30th) steadily losing what was left of his mental powers, so is he losing this cataleptic state, and will, no doubt, soon simply be a dement.

The last case I shall give is that of Thomas H. F., aged 20, a clerk. He had no insane relatives. The supposed cause of his illness was family and pecuniary troubles. He was naturally cheerful and industrious. Seven months before admission, he lost his interest in his work and surroundings, and complained of "feelings in his head". He was suicidal, and had hallucinations of hearing. He ate his food, if fed with it; and slept fairly well. On admission, he was typically anæmic and will-less. He was led about by others; and, as they left him, so he remained. Morphia subcutaneously was tried, and galvan-

ism produced no good results. He has now (November 30th) become more demented and less cataleptic; and will undoubtedly sink into weak-mindedness if he do not die sooner of some intercurrent lung-disease.

CLINICAL MEMORANDA.

PARTIAL HERPES FRONTALIS, WITH INFLAMMATION OF THE EYE.

THE patient, a man aged between 50 and 60, attends at St. Mary's Hospital once a week on account of paralysis agitans, affecting chiefly the left upper extremity. He has the intolerable restlessness, and experiences the subjective sensation of heat, characteristic of paralysis agitans; and the tremors can be controlled for a time by effort when the hand is held out. He had been taking arsenic for several weeks, when, on November 10th, herpes broke out on the left side of the brow and forehead, and the eye became inflamed. On Wednesday, November 15th, it was seen that there were only three patches of herpes: one on the eyebrow, on the supraorbital foramen, which was in the vesicular stage; another rather more than halfway up the forehead, close to the middle line, further advanced, and showing a group of small, shallow, irregular ulcerations; the third higher on the head, about an inch from the middle line, smaller, and healing. There was no distinct herpes on the nose; but, on examination, an abrasion, apparently left by a single vesicle, was found at the tip of the left side. The interior of this nostril was very sore, and the patient said there had been pain and small red spots on the left side of the nose. Both conjunctiva and the intraocular structure were inflamed, but not severely.

There are several points of interest in this observation. One is, the occurrence of herpes during the administration of arsenic, which is so common that, as Mr. Jonathan Hutchinson has suggested, arsenic must be capable of provoking this affection. But it seems also to show that the nasal division of the fifth is more closely related with the internal division of the supraorbital nerve than with the other branches. I have several times seen herpes along single branches of the supraorbital at a distance from the middle line, and always without implication of the nasal division or eye. Cases such as this, again, in which herpes follows one or two twigs of a large nerve, throw light on the causation of the eruption. It is almost universally admitted that herpes is due to disturbing influence exercised on the nutrition of the skin by a nerve; but it is not a settled point whence the irritation starts. An opinion largely held is, that the ganglion on the posterior root is the origin of the disturbing influence. My own conclusion is, that injury of or disease in a nerve-trunk or branch—i. e., affecting fibres only, and not cells—is adequate to the production of herpes. It seems to me improbable that inflammation in a ganglion could produce trophic consequences along only one small branch, bound up, perhaps, for a great part of its course, in the trunk of the nerve. More conclusive, however, on this question, are cases such as the following. An elderly man received a severe bruise on the right side of the chest, at about the posterior axillary line. He suffered much pain; and, in a few days, severe herpes came out along two intercostal spaces from the seat of injury nearly to the sternum, the vesicles closely aggregated, forming a continuous band over the two spaces and the intervening rib, while none are found behind the bruised point.

It is worthy of note that, in herpes, the trophic influence travels towards the periphery, and therefore against the direction of the usual functional impressions, which are centripetal, the nerves being sensory. (This is excluding, of course, the hypothesis of special trophic fibres, which I do not accept.) If this is the case with sensory nerves, it may be the case also with motor nerves, and peripheral lesions may react upon the nerve-cells of the cord.

W. H. BROADBENT, M.D., F.R.C.P., Physician to St. Mary's Hospital.

CHLORAL-HYDRATE AND CONGESTION OF THE KIDNEYS.

As deaths from doses of this drug are common, and I fear the habit of patients taking it without the authority of medical men is increasing, I beg to call attention to the fact, or what I believe to be a fact, that this drug causes congestion of the kidneys; and, if it do so, it must be injurious if taken when the individual is already suffering from congestion of these regions. My attention to this point was attracted by two cases; one, a medical friend of mine, who was found dead in his bed about half-past ten o'clock at night. Death was attributed to a dose of chloral, presumably an overdose. It was stated that he was suffering from con-

gestion of the kidneys, and at the *post mortem* examination they were found much congested.

The second case had been considered one of hydrophobia, and had been taking large and repeated doses of chloral. At the *post mortem* examination, we found hæmorrhage into the spinal canal and intense congestion of the kidneys, to which two causes the death was attributed.

Many experiments on animals have convinced me that congestion of the kidneys may and does almost invariably follow the use of chloral; and I therefore write this in the hope that some one more experienced in this line of research may clear up my opinions on the subject.

CHARLES ORTON, L.R.C.P.Ed., Medical Officer to the North Staffordshire Infirmary, Newcastle-under-Lyme.

A CASE OF THORACENTESIS.

WM. SHERWOOD, a coalheaver, aged about 36, was admitted into the Ealing Cottage Hospital on May 25th, 1876. He was suffering from urgent dyspnoea, and there was evidently a large accumulation of fluid in the left pleural cavity. He stated that he had been ill for about a month.

On the following day, the fluid was withdrawn by the aspirator, and was found to measure over eight and a half pints; it was of an albuminous character, and somewhat turbid from a small admixture of pus. The effusion again formed, and in about a fortnight was again withdrawn, amounting to five pints. This was done twice subsequently. The fluid became more purulent, and on the last occasion was thick and foetid; and he now coughed up a quantity of similar matter, showing that a communication was established between the bronchial tubes and the pleural cavity. I now determined to insert a drainage-tube, and accordingly did so on July 15th. A pint of a weak tepid solution of iodine was injected daily into the pleural sac. The quantity of pus daily secreted was for the first week about eight ounces; it gradually diminished, and now (September 11th) averages one ounce daily. The patient's general health has much improved, and, in fact, he seems perfectly well. Since the drainage-tube was inserted, his weight has increased from 10 st. 3 lbs. to 11 st. 8 lbs. The left side of the thorax has somewhat contracted, and now measures seventeen inches, the right being eighteen. Respiration of a healthy character is heard over the whole left lung, excepting a very small portion at the base.

GEORGE D. BROWN, M.R.C.S.

OSSIFICATION OR CALCIFICATION OF THE HEART.

EDWARD M., aged 21, of dark complexion, middle height, spare, but muscular, was taken suddenly ill in the street, and died whilst being removed to hospital. On a *post mortem* examination, death was found to have resulted from disease of the heart of unusual character. The organ was enlarged and congested, weighing seventeen ounces one drachm. It measured eleven inches around the base and seven inches from the base to the apex. In the hand, it felt dense and unyielding, especially posteriorly, where, in its substance and on the surface, was observed a quantity of hard white concrete deposit. The right auricle and ventricle were greatly distended, but healthy in fibre. The anterior wall of the latter was four lines in thickness; the valves were sound. The septum cordis was thickened, hard, and solid at the upper part, seemingly occupied by a foreign body, causing it to encroach more than naturally on the right chamber of the heart. The left auricle did not collapse, but maintained its full outline from the presence of deposit in its interior, being lined irregularly with a thick incrustation, which was much aggregated about the opening of the pulmonary veins. From the outside, the auricle communicated to the touch a sensation as though it were full of cracked nutshells adherent to the walls. The left ventricle was, as to its posterior and left side, almost entirely converted into a solid bony calcareous mass, so dense and firm as to require considerable force with a strong knife to cut through it. The interior of the septum was in a similar condition, but not to the same extent. The tendinous zones, the foundations of the heart, were changed into a hard structure. In this situation, most probably the diseased action originally commenced. The columnæ carneæ were large and healthy; but in many of them were found embedded particles and patches of the deposit. The mitral valves were free and sound, while those of the aorta were thickly incrustated; but, beyond their immediate vicinity, the vessel itself appeared healthy. The wall of the left ventricle was one inch in thickness.

The deceased man was one of four sons, all of whom died about the same age (21), some of them suddenly, save this, the last of the four. The parents are living—strong healthy persons, advanced in life. They stated that their son was never sick; never complained, except that, one Sunday, some months ago, he fainted in church. On the day of his death, deceased left home, some miles distant from the city,