is loss of some of the most "delicate" movements, with, at the same time, the retention of many "coarser" movements. Unable to button his shirt, the patient may be able to grasp strongly, or to strike a heavy blow. In some cases there is, if possible, further demonstration. An arm is permanently partially paralysed all over, loss of some movements of the whole of the limb; and yet that other movements of the whole of the limb remain emphasised by the occurrence of severe convulsion of it, which is nothing other than a sudden excessive development of the movements remaining. Any adequate doctrine of localisation has to account for this. In chorea we find persisting paralysis, with over movements of the same parts; what has been called loss or defect of voluntary co-ordination in this disease is indirect evidence of some paralysis; the involuntary disorder of co-ordination is owing to over activity of movements left.

I contend that there is no difficulty whatever in conceiving, whatever difficulty there may be in believing, that the exhaustion of the highest layer, first depth, which defect of consciousness implies, is causative of a slight degree of paralysis "spread out thin" all over the body (called "weakness"); that exhaustion of two layers, second depth, which loss of consciousness implies, is paralysis spread out more "thickly" all over the body, notwithstanding that, from the raised activity of the third layer, other movements of all parts of the body may be in great excess; and that the immobility in post-epileptic coma is paralysis spread more thickly still all over the body.

Since I say (1) that the highest centres are sensorimotor; (2) that negative affections of consciousness imply negative conditions of parts of the highest centres; and (3) that there is some defect of consciousness in every case of insanity, I ought to hold the opinion that, in every case of insanity, there is some degree, however slight, of universal or widely distributed paralysis—sensory, or motor, or both. So I do. That I could not demonstrate its existence in many cases, I admit. I should expect there to be the least degree of negative affection of consciousness, and correspondingly the least paralysis, in cases of insanity where the accompanying positive element was very elaborate, that is, on the physical side, when the dissolution was very shallow and the level of evolution remaining was very high. In cases of dementia, the patient's "lethargy" might be put down to his negative mental state—a metaphysical explanation. I should call dementia the chronic analogue of what acutely is post-epileptic coma, and attribute the lethargy to the negative condition of more or less of the patient's highest centres, implied by his negative mental state, and call the lethargy paralysis.

Paralysis is indirectly admitted in some cases of insanity (when its existence might be denied directly) in the assertions that there is loss of facial expression, difficulty of articulation, tremor of the limbs (indirect evidence of some paralysis), and shambling gait. Taking but one of these, surely loss of expression implies either loss of the most special or "delicate" facial movements, or continuous development of them (rigidity), or both. There is no abstraction "expression" to be lost. What we know of any healthy person's conduct is from his movements. Such symptoms as I have enumerated are just those I should expect from chronic negative lesions of parts of the highest motor centres. They exist in many cases of general paresis, which Crichton Browne has shown to be owing especially to disease extending from the front backwards in the brain, from highest motor centres towards middle.

Now for the "serious qualification" I spoke of. The following difficulty, taking the case of the fisherman, has to be met. There was so-called loss of consciousness, implying a deep dissolution, and yet his very elaborate doings implied a very high level of evolution remaining. I hold that in post-epileptic states there are local dissolutions, meaning that the post-epileptic exhaustion is in, or preponderates in, one cerebral hemisphere. Thus, whilst there is a low level of evolution in the highest centres of one half of the brain, there is a perfect or very high level in those of the opposite half. If so, the discrepancy disappears.

[The lecturer then variously illustrated the assertion that all elaborate (positive) mental states in cases of insanity of every kind were the outcome of activities of healthy nervous arrangements on the lower level of evolution remaining. He believed that the patient suffering from delirium tremens saw rats, mice, etc., by agency of nervous arrangements which the pathological process had spared; he did not believe that a patient "heard voices" (words spoken), nor that a melancholic man framed the delusion that he was going to hell, during the activity of nervous elements touched by any pathological process. He thought that in Anstie's principle lay the explanation, not only of these positive mental symptoms, but of the necessarily co-existing negative mental symptoms also].

He then spoke of the several factors in cases of insanity. (1) There

are different depths of dissolution, both of uniform and local dissolutions of the highest centres. This has just been illustrated by cases of local dissolutions, and might no doubt be illustrated by a parallel series of chronic cases of insanity—by cases from those with very complex delusions, down to cases of dementia, if the duplex symptomatology of each were noted. (2) The person undergoing the dissolution, young or old, educated or uneducated, intelligent or unintelligent. (3) The rate at which dissolution was effected. He believed that the more rapidly control was removed, the greater was the activity on the lower level of evolution remaining—contrasting, in illustration, the furious delirium of the epileptic maniac, who had undergone dissolution in a minute or so, with the quiescence of the senile dement, who had undergone dissolution some thousand times more slowly. (Similarly for different cases of epilepsy.) (4) The influence of external circumstances and local bodily states. Examples of the induction of very elaborate states of the highest centres (in the lower level of evolution remaining) by simple peripheral excitations were given by all writers on dreams. The lower level of evolution, then, in hyperphysiological activity, allowed a wider irradiation to simple stimuli coming to it. "Hearing voices" might not necessarily imply any disease of part of any centres especially concerned with sounds or words. That particular mental abnormality might be determined, in a patient reduced to a lower level of evolution, uniform or local, by some morbid state in the ear or auditory nerve, or in its nucleus acting on the lower level of evolution remaining.]

THREE CASES OF PLEURAL EFFUSION WITH VERY FEW SUBJECTIVE SYMPTOMS.

By W. M. BEAUMONT, M.R.C.S., Oxford.

THE following cases, which have recently come under my notice, are of interest from the fact that in each the patient was unaware that there was anything serious the matter with the chest. In neither was there any dyspnoea, and inability to lie on the sound side was conspicuous by its absence.

J. D., aged 42, a nervous, hysterical woman, and one who, *prima facie*, would have been expected to exaggerate every little ache and pain, complained of pains in the abdomen and epigastrium, a feeling of *malaise* and depression of spirits, although not sufficiently severe to confine her to bed. She had been continuously occupied nursing her husband through a long, and finally fatal illness. There was neither pain in the chest nor cough; she ate well, and could sleep when lying on either side.

On examining the chest, as a matter of routine, I found skodaic resonance below the left clavicle as far as the second rib; below that absolute dullness (flatness) extending to the base. There was also dullness in the axillary and infra-axillary regions. Posteriorly, there was high-pitched resonance in the left interscapular area as low as the sixth rib; dullness in the infraspinous and infrascapular regions, taking the italic *f*-shaped curve first pointed out by Dr. Ellis.¹ There was ægophony, and in one spot at the left base posteriorly there was tubular breathing. The heart's impulse was imperceptible, but apparently in the epigastrium. I had great difficulty in persuading her to submit to treatment. On aspirating at the sixth interspace in the infra-axillary region, I drew off thirty-four ounces of clear blood-coloured serum.

W. H., aged 12, an errand-boy, had not been very robust, although he had never been laid up in bed, nor prevented from working. He complained of occasional pains in the left side, which had been felt during the last twelve months. Night-sweats supervened, but there was no cough nor hæmoptysis. He had been under medical treatment for debility.

On examination, the chest was found to be flattened somewhat under the clavicles, and there was very little respiratory motion on the left side. The semicircumference of the chest at the nipple-level measured half an inch more on the left than on the right side. The breath was very fetid. There was skodaic resonance under the left clavicle downwards to the second rib, and dullness below. The percussion-note over the manubrium was duller than normal in the upper half, and the dullness then deepened in intensity to the ensiform cartilage. Posteriorly, the dullness in the suprascapular and supraspinous areas was

¹ "Clinical Lectures On Cases of Pleuritic Effusion," by Dr. R. Douglas Powell (*Medical Times and Gazette*, 1882). In connection with this, it is curious to notice that such a careful observer as Professor Frerichs states that "the line of dullness in hydatids of the liver is at a lower level close to the vertebral column and the sternum than it is in the axilla," "but," he continues, "this does not hold good with pleuritic effusions." "Clinical Treatise on Diseases of the Liver," by F. T. Frerichs, *Transactions of the Sydenham Society*, Vol. II, p. 247. See also Dr. Stephen Ward *On Some Affections of the Liver*, 1872, p. 55.

wooden in character, below it became stony. Vocal fremitus was entirely absent. The heart's impulse could be felt in the epigastrium. On aspirating, twenty ounces of clear straw-coloured serum were evacuated.

J. W., aged 24, a labourer, had always had good health before the present attack, which began with a slight, but troublesome cough. He had not shivered. There was tenderness over the spinous processes of the second, third, and fourth dorsal vertebrae. When I first saw him the cough had subsided, but the tenderness of the spinous processes remained, otherwise he made no complaint. The tongue was clean and moist, the appetite good, and the urine normal. There was slight dulness at the left base posteriorly. In a few days rapid effusion into the left pleura occurred, manifesting itself clearly enough objectively, but without subjective symptoms. There was neither pain, nor cough, nor difficulty of breathing. Temperature 98.4°, respirations 28, pulse 76. The heart's impulse was visible in the fifth interspace, just within the nipple-line. I aspirated his chest at the angle of the scapula, and drew off forty-eight ounces of yellow alkaline serum, with a specific gravity of 1020, and which did not gelatinise.

The absence of any very marked subjective symptoms in these three asthenic cases may explain why we so often find in the dead-house old pleuritic adhesions, although there is no history of the subjects having ever suffered from pleurisy; for if these three patients could go about without knowing that there was anything very wrong with their chests (whilst in each there was a considerable quantity of fluid), it can be readily understood how a slight pleurisy, with a very moderate effusion, may cause adhesions to be formed without the subject of them giving up work, or consulting a medical man.

CLINICAL MEMORANDA.

THE INCUBATION OF MEASLES.

Six or seven months ago, J. H., aged about 20, residing in a neighbouring village, where there was not at the time (nor had been for a long time previously) a single case of measles, travelled by train to Brackley, a distance of about eight miles. On looking around the carriage, she found among her fellow-passengers a woman with some children—one an infant in arms, which had a very red face. On getting into conversation with the mother, she discovered to her horror (being of somewhat nervous temperament) that the said infant "had 'fell' with the measles" (*alias*, the rash had come out) at Bletchley Junction; *i.e.*, about half-an-hour before my patient entered the carriage—the other children having recently recovered from the same disorder. Just a fortnight afterwards J. H. returned home, feeling on that day "out of sorts," with coryza, and sent for me the following morning, when I found her with the rash well out all over her face, neck, and shoulders. The complaint ran a mild course. A fortnight exactly after this, her youngest sister (who had not seen her for some time until her return home) caught the infection; the general feeling of *malaise*, etc., occurring on one day, and the rash coming out very freely the day following. In this second case the complaint also ran a mild course, and no other case has occurred in the village up to the present date (March, 1884).

W. L'HEUREUX BLENKARNE, M.R.C.S., Buckingham.

THERAPEUTIC MEMORANDA.

A NOTE UPON A LOCAL METHOD OF TREATING PHTHISICAL COUGH.

THE merits of mullein, taken by the stomach, are now well established as a weight-increaser and general palliative in pulmonary consumption. I am anxious to call attention to a simple and apparently effectual method of using this drug for the relief of phthisical cough, which was lately suggested to me simultaneously by two sources, by a hospital patient and by a paragraph in the *Philadelphia Medical and Surgical Reporter* of February last.

Richard F., aged 30, an engine-driver in the office of the *Freeman's Journal*, was admitted into St. Vincent's Hospital on February 29th last, suffering from chronic phthisical disease of the apices of both lungs; and was treated in the usual way, and with the usual results, with the milk-decoction of mullein (see BRITISH MEDICAL JOURNAL, January 27th, 1883). His principal trouble had been a constant racking cough, which, however, he informed me, he had now in complete control by smoking the dried leaves of the mullein-plant in an ordinary tobacco-pipe. Whenever he was attacked by this cough, he used to fill his pipe with these dried leaves, broken up into a kind of

coarse snuff, and, by the time he had finished, the cough would be relieved. After he had been a few days in hospital, he told me that he suffered severely from the cough at about 3 A.M. every morning; but that he was afraid to smoke, as it would be a violation of hospital rule. I told him that this only applied to tobacco-smoking, and that he was free to smoke his mullein, provided he was careful not to set his bed on fire. His cough was at once relieved, and he is now up and talking of going back to work. A remarkable feature in his case is that he does not use tobacco in any form.

I have since seen a very favourable notice in the American journal already mentioned, of this method of using mullein. The extreme simplicity of the procedure renders it worth a trial; and the flavour of the leaf, when smoked, is not disagreeable. It can be used either in an ordinary pipe, or in paper cigarettes, and might be found useful in asthma and spasmodic coughs in general.

F. J. B. QUINLAN, M.D., F.K.Q.C.P.

Dublin, March 25th, 1884.

OBSTETRIC MEMORANDA.

UNUSUAL WEIGHT OF FŒTUS AT FULL TERM.

ON March 16th, a lady, aged 35, primipara, tall, healthy, and well built, gave birth to a well formed female child, weighing eighteen pounds and measuring twenty-six inches in length. Delivery was effected by forceps, and presented no unusual difficulty till after the head was born, when the shoulders wedged between the coccyx and the pubic arch; by bringing out each arm they were released. The pelvis now lodged in the same place as the shoulders, and was only liberated after a severe struggle by compressing the iliac bones of the fœtus. The passage, even of the thorax and abdomen, was effected only by great effort. There was just a twitching of the nose and lips of the child after birth. The placenta was expelled in ten minutes afterwards. A binder was applied and one drachm of ergot administered. The pulse was 80. The patient seemed exhausted, but fully conscious. Artificial respiration, warm bath, brandy, etc., failed to resuscitate the child, although persevered in for half an hour. Unfortunately, the patient, on asking if the child were dead, was answered in the affirmative by an attendant, and at once threw up her hand, exclaiming, "Then I shall die too." She died two hours and a half after the extraction of the fœtus. The immediate cause of death seemed to be syncope from shock by the news of the death of the child after such a severe and laborious extraction.

Perhaps the extraordinary size of the child may be, in some measure, accounted for by the inordinate appetite of the mother. She herself informed me, during the labour, that she had often eaten a pound of raw meat at a time, took little or no exercise during the last six weeks, often lying in bed till eleven o'clock, and again lying down at three in the afternoon till six. I am informed by a relative that, on one occasion, she ate three pounds of pork at one meal during the latter part of her pregnancy. The lady had made a note of the date since the last menses were seen, which made the fetus exactly nine months on March 16th.

P.S.—The weight and length were given me by the father, an intelligent business-man.

EDWARD GORDON, M.R.C.S., L.S.A., Stockport.

PATHOLOGICAL MEMORANDA.

A CASE OF CONGENITAL EPULIS.

THE following case, being exceedingly rare, if not unique, is, I think, worth recording. Mrs. M. J. McC., aged 30, primipara, wife of a trooper, 5th Lancers, was admitted into the hospital for soldiers' wives and children, Dublin, on March 5th, at 7 A.M., and confined at 3.15 P.M. There was a considerable flooding from a placenta partially attached to the fundus uteri and a rent in the cervix. Having removed the placenta and checked the immediate hæmorrhage, I found, on examining the baby, that the mouth was filled by a bluish-red tumour, which projected between the lips, and was firmly adherent to the lower gum immediately to the right of the mesial line. It had a very peculiar appearance, and precluded all attempts at sucking, but not of swallowing, when a little milk and water were introduced on the left side by means of a spoon. On March 8th, I passed a double carbolised silk ligature, from within outwards, through the middle of the tumour, tying it tightly at either side. It came away in two days. A second smaller growth, to the right of the first, was treated in a similar manner on March 17th. When this last came away,