1,261, and of these 662, more than half, were performed under spinal anaesthesia. The first cases were done in October, 1907, so that the method has ceased to be a novelty, and the increase has been a gradual one. Moreover, a large number of these operations were done by assistant surgeons or house-surgeons, who used the anaesthetic they preferred.

To sum up, it is clear that spinal anaesthesia, owing to its limited field, can never replace chloroform. If we are to be limited to one method that must, of course, be general anaesthesia. But, in the ground common to both, there is not a vast difference between the two methods in ease, safety, and effectiveness, if these are taken together over a large number of cases. What there is, is slightly in favour of general anaesthesia. Yet in a number of cases spinal anaesthesia offers advantages which cannot be got in any other way, and its apparatus and technique are so simple that it is worth any surgeon's while to use it whenever there is anything definite to be gained by it. In the large number of cases where there is nothing to choose between the methods, the use of stovaine becomes a matter of taste and convenience.

There seems to be a tendency in England to regard spinal anaesthesia as a dangerous method, and one that can only be employed successfully by a few experts who have devoted their attention to it. As far as my experience goes this is less true than it is of chloroform—the danger of spinal anaesthesia is about the same, and the skill required for its administration less.

In conclusion, I should like to express my especial obligation to Dr. Aly Bey Ibrahim, my assistant surgeon, and my thanks to the English and Egyptian residents, especially Dr. Thom and Dr. Maloney, to my successive house-surgeons, and to Dr. Shahin, recently appointed anaesthetist to the hospital, who have helped me by anaesthetizing cases, by keeping notes, and by making valuable suggestions.

REFERENCE.
1 *Lancet*, October 1st, 1910.

A CASE OF PAROXYSMAL TACHYCARDIA.

BY

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M. K., a tailoress, aged 35, came up to my out-patient department at the Heart Hospital in 1909 complaining of palpitation of the heart and pains in the chest for some years. On feeling the pulse I found it was beating at the rate of 180, but examination of the heart disclosed nothing abnormal beyond the rapidity of the pulse.

She was said to have been delicate from childhood, and began to be subject to these attacks of rapid heart beating and palpitation some fourteen years previously. There was no history of any other illness. The attacks used to come on about every five or six months, beginning quite suddenly and unexpectedly, very often soon after food, but also quite frequently in the night. She herself associated the attack with indigestion. The attack would last any time from four to twenty-four hours and then pass off gradually. As is generally noted in these cases of paroxysmal tachycardia, she was not very much distressed, and would go to her work as usual; she could not, however, lie down during an attack, and therefore when it occurred at night she was a good deal troubled by it. On only one occasion did she complain that she had severe pain in an attack.

I saw her from time to time, when her pulse was usually 76, but I never saw her with the tachycardia again as on the first occasion. She could never be persuaded to come into the hospital, but by treatment of the indigestion she became much better, the attacks very infrequent, and her condition generally improved. In August, 1910, however, she had two attacks lasting seven and ten hours respectively, after which there were no more. I saw her in January, April, and May, 1911; each time she complained of feeling generally weak, but there were no more attacks of tachycardia, and after May 15th I did not see her again. Apparently she had been fairly well till September 2nd, and was at work that day the same as usual, but about midnight she was seized with an attack. The friends with whom she lived were not alarmed, as it appeared to them no different from other attacks; but she soon complained of very severe pain, calling out with the pain, which she had never done before, and saying that she was dying. At 4 a.m. she became very quiet, and died at 4.30. As she had not been to the hospital for four months an inquest was held, and the post-

mortem examination, which was made by Dr. Freyberger, disclosed an unusually large patent foramen ovale, but an otherwise normal heart.

Clinically I had never found any evidence of an organic lesion of the heart, and I looked upon the case as one of simple paroxysmal tachycardia. Had we been able to take her into the hospital, some features pointing to the congenital lesion might have revealed themselves. I have not come across, in the literature on the subject, any other instance of paroxysmal tachycardia being associated with a congenital lesion, and consider that in this instance the association was a purely accidental one. Although the ultimate prognosis in paroxysmal tachycardia is unfavourable, yet I think anything in the nature of sudden death is distinctly rare; as a rule, the attacks become more frequent and last longer, the heart dilates, and we have all the signs and symptoms of cardiac insufficiency with backward pressure.

In my experience, most attacks of paroxysmal tachycardia terminate abruptly, the heart appearing to the patient to be jerked, so to speak, into the right place. However, in this case the patient was quite clear that the symptoms passed off gradually.

LEUCODERMIA UNDERGOING PIGMENTATION ON EXPOSURE TO SUNLIGHT.

BY

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IN view of the interest recently exhibited in certain pathological conditions of the skin, concerned with the comparative absence or excess of pigment in its layers, notes of the following case may be worthy of record.

G. A. L., aged 18, entered the Royal Navy as a youth, in January, 1911, and came under my care for a scalp wound in March of the same year. A few days after his entry on the sick list I saw him stripped to the waist, and the fact that he was subject to leucoderma in a high degree was at once obvious. The condition affected the skin of the neck in front and behind, as well as that of both groins. The usual condition obtained in this case—there was a brownish pigmentation of the skin, and the patches devoid of pigment lay in the coloured portion. There was a yellowish ochreous coloration of the skin of the sides and the front of the neck above the clavicles, and above the vertebra prominens behind, and a much slighter pigmentation of that over both scapulae. On the left side of the neck were two large oval patches of leucoderma about 1½ in. long, and about ¾ in. wide, their long axes being approximately horizontal. In front of these patches and above them was a much smaller one, of about the same shape. On the right side of the neck were two small oval patches. Posteriorly a large butterfly-shaped patch had its head at the vertebra prominens, and extended over both scapulae. In the region of the groins pigmentation and leucodermic patches were less well marked than in the neck.

This youth was of a fair complexion, with blue eyes, and his skin was of the cream-coloured tint that tans a deep brown on exposure to the sun. He was sturdily built, enjoyed general excellent health, and had had the leucoderma ever since he could remember. There was not the slightest suspicion of syphilis in this case, but it is of interest that the distribution is that usually associated with syphilitic leucoderma.

In July I had occasion to look at this youth again, and at once noticed a change in all the leucodermic patches on the sides of the neck which were exposed to light. In all there appeared a reddish blush of inflammation, and in all, but especially in the two largest on the left side of the neck, there had developed numerous oval and rounded areas, 2 or 3 mm. in diameter, and of a brown colour; whilst a pigmentary invasion of the periphery of the patches was also seen to be taking place. At the back of the neck and in the groins, where no light reached the leucoderma, no change in them had taken place.

This youth had previously to his entry into the navy worn a high collar, and had been engaged in an indoor employment. Having to wear the characteristic open collar of a bluejacket, exposed to the light, and particularly the sunlight, portions of his skin which previously had been covered, and the pigmentary invasion of the leucodermic patches was probably the result.

It is stated by many authorities that the pigment increases in these cases during the summer, and particularly at the edges of the leucodermic patches. Stelwagon of Philadelphia, cites a case in which all pigment was