about the end of that time another attack supervened, which was ushered in by three deep crowing inspirations. After the third inspiratory sound the child threw its head backwards with its eyes half opened, raised slightly both arms for a few seconds, and then let them drop by its side. The child seemed, suddenly and without further effort, to cease breathing, and became rapidly cyanosed. There was no movement or struggle of any kind except an occasional feeble sobbing gasp. Artificial respiration with oxygen was resorted to, as before, and after some time normal respiration returned without any special manifestation. There were no convulsions, and in the intervals between the attacks the child showed no signs of exhaustion and looked surprisingly placid.

Operation.—It was felt that something ought to be done to relieve or obviate the attacks, and Dr. Campbell was strongly of the opinion that the initial cause lay at the glottis. The crowing sounds at the onset of the seizure, and which seemed to be produced in the larynx, favoured this supposition, but the very feeble respiratory effort that was put forth led one to suspect complications in connexion with the respiratory centre. A view could not be obtained beyond the epiglottis, which was of the usual infantile type, and inspection and palpation with the forefinger negatived any idea of hypertrophy of the faucial or pharyngeal tonsil. It was decided to perform tracheotomy in preference to intubation, and during an interval between the attacks the trachea was opened, after having to draw slightly downwards the isthmus of the thyroid. A small amount of chloroform was used, and there was no difficulty with the breathing during the operation. The result was satisfactory, for all the symptoms disappeared after the tracheotomy tube had been inserted.

Subsequent Progress.—The further history of the case was quite uneventful. The morning following the operation he was found to have passed a good night, taken nourishment freely, his bowels had moved and his temperature was normal. On the 6th, or four days afterwards, I removed the tube and placed a thick pad of gauze over the wound, but in a short time the patient seemed to experience difficulty in breathing, became excited, began to cry, and finally relapsed into an attack similar to those already described. At this time I spent about an hour in accustoming him to breathe by making him inspire by the wound and expire by the larynx. An unsuccessful attempt was also made to get a view of the larynx as I suspected the presence of a loosely attached congenital papilloma. The tube was then reintroduced. The same plan as regards breathing was carried out on the 7th. On the 8th he seemed to have more confidence and to breathe better, so when the usual spasm took place the pad over the wound was retained and after a rather severe struggle the spasm appeared to relax and breathing became natural. A firm pad was put over the wound and retained with a bandage during the day. The tube was replaced that evening and finally removed the following morning or six and a-half days after operation. Five and a-half months afterwards he had had no recurrence of the symptoms.

Can a satisfactory explanation of this respiratory disturbance be given? In some respects it resembles laryngismus stridulus, while in others it offers points allied to the condition described by Thomson¹ under the title of "infantile respiratory spasm," and which is further discussed by Sutherland and Lack² as "congenital laryngeal obstruction." But while possessing features in common with both of these affections it differs in certain particulars from either. The early age of onset and the absence of any known cause or complication correspond with what is noted in infantile respiratory spasms, but in other respects the general character of the attacks differs. It resembles more closely a severe attack of laryngismus, for there is in both a sudden onset with a few inspiratory struggles, which is followed by cessation of breathing. But in laryngismus, except in rare instances after the occurrence of cyanosis, the spasm relaxes and respiration is resumed. Moreover, the severe forms are usually accompanied by spasms of other muscles and general convulsions.

The attacks in the present case differ from these in being free from convulsions or facial spasms, in being prolonged in character, and in following each other in rapid succession without any apparent cause. Further, cessation of breathing, which showed little tendency to pass off, invariably occurred, and the symptoms were instantly relieved and ultimately entirely disappeared after tracheotomy. That the laryngeal spasm was the chief factor is shown by the natural breathing which followed opening of the trachea.

We have here to deal with a powerful stimulus, or a peculiarly hyper-sensitive nervous organization, or a combination of both. Accepting the statement that electrical stimulation of the central end of the superior laryngeal branch of the vagus nerve usually tends to inhibit inspiration, we can well believe that an irritant sufficiently powerful to cause glottic spasm would profoundly affect the highly sensitive respiratory centre, and so bring about such inhibition. It might further be argued, that the respiratory centre being largely automatic in action, this automatism having once been interfered with would not be sufficiently established in

so young a child as to enable it to respond readily to the stimulus from the venous blood.

REFERENCES.

- ¹ *Edinburgh Medical Journal*, September, 1892, p. 205. ² *Lancet*, September 1897, p. 653.

HYSTERICAL PARAPLEGIA IN THE MALE.

By FREDERICK SMITH, D.S.O., L.R.C.P., L.R.C.S.I.,
Major, Royal Army Medical Corps.

HYSTERIA is not generally regarded as a military disorder, and in the advanced form above named it is probably rare in males, whether civilians or soldiers. Two marked cases, however, have come under my care in army practice.

CASE I.—This was a negro soldier of the West India Regiment, aged 23, serving in West Africa. The patient was admitted for malarial fever. The fever subsided in the course of three days' treatment, and it was suggested to the patient that our sympathetic attentions would be no longer required after the morrow—a return to stern duty was imminent. The following morning he complained of a lump in his throat; there was also a pain there. In the evening the pain extended from the throat to the legs. Finally he was unable to move his legs at all. The case was recognized as hysteria throughout, the cue being the initial globus hystericus. The difficulty was to bring it home to the man's mind. Corrigan's buttons applied along the sciatic nerves had no effect except to injure the patient's skin. There was not an electric battery available. For some three months the patient lay on his back, legs fully extended, and bedsores developed on his heels. This last fact caused the diagnosis to be questioned. In the meantime, however, on two occasions when visiting the hospital in the evening I saw that the sleeping patient's legs were doubled up. The attendants most likely told him of this fact. Any way, he informed me one morning that he was much better, and would like to try and walk.

The next day, at my morning visit, the man was clothed and standing by his bed. He was discharged to duty. Two years later he was still soldiering, and displayed to me with some merriment a scar where the buttoning had been a little overdone.

CASE II.—This was a European British soldier, aged 19, at home. His history is taken from the written records, as he came into my hands at a late period in the disorder. He was first admitted for influenza. After a couple of weeks' treatment he was discharged to go on active service in South Africa. The day after embarkation he reported sick, with weakness of the legs. Arrived at Capetown, he was transferred to hospital and at once invalided home. At this time he is said to have had weakness of limbs, exaggerated knee-reflex, some inco-ordination, and great difficulty in walking. When I took over the case in England the man had been some six months in hospital altogether. He had been supplied with a bicycle-wheeled chair to be worked by hand, and in this conveyance he moved about the hospital as quickly as the men on foot. He was allowed as much food and drink as he liked to ask for, being, so to speak, one of the war heroes.

His condition was as follows:—Lower Limbs: Absolute motor paralysis as far as patient's will was concerned. The limbs were invariably fully extended in front of him, but he could sit up in bed. Complete anaesthesia to touch, pinpricks, etc., existed from the toes to about the junction of the upper-third and middle-third of the thigh. The knee reflexes were slightly exaggerated. The rest of the body was normal; the bladder and rectum unaffected; and no pain experienced along spine or anywhere else. There was no wasting of lower limbs; appetite was very good; sleep was normal.

The patient had gone on from bad to worse. At the Cape he could get about a bit. At home, though the picture of health in other respects, he was completely paraplegic, and daily massage caused no improvement. There being a suspicion that the case was one of functional disorder, a reliable nursing sister was asked to observe the man at night. She reported that on two occasions she had seen him move his legs when he was asleep; a definite movement, such as drawing up his knees. Her evidence was confirmed from other sources. A strong battery was then used. To this there was no anaesthesia; the muscles contracted quickly and powerfully, and the patient complained that the current was too strong; that the pain was very severe. There was no change in the symptoms during the next few days.

I then lost sight of the case for six weeks. On my return the patient appeared to be no better. He was invalided as unfit for further service, but remained in hospital. A few days after passing the Board for discharge the man was again examined carefully, and the battery was mentioned. On examination it was surprising to find that he could move the limbs a little. The battery had gone wrong (the current being scarcely perceptible), yet it was noticed that he contracted the extensors of the foot before the electrode touched him. He was inconsistent in some of his statements as to anaesthesia, and as regards perception of heat, etc. Anaesthesia seemed to be patchy, but on going over the ground several times mistakes were made—places were anaesthetic one moment and five minutes later were not so. I should have said that the man was now aware that I thought he was not so helpless as he seemed to be.

Permission to carry out the Weir-Mitchell treatment with this case was refused, but his wheeled chair was taken away. He was given a walking machine, and told that he had to

walk. A week later he was walking fairly well with a stick, though there was still exaggerated knee-jerk. The case then passed out of my hands.

That these cases were both hysteria I have no doubt. As complete recovery of Case II had not taken place when I parted from him, I cannot say for certain that it was purely hysterical. It may be thought that there was a malingering element in both the cases, for both men expressed their wish to be invalidated, thus revealing a sufficient motive; but that Case I, however, could have gone on to bedsores without self-mesmerizing agency is unlikely.

AN UNUSUAL EPILEPTIC CASE.

By W. HENRY LEWIS, M.B., B.Sc. EDIN.,
Llansantffraid.

THE following short note refers to a case of epilepsy of sufficiently unusual character to be worth recording: The patient, a young fellow 25 years of age, a farmer's assistant, first came under my observation on December 26th, 1902, and on that day I had an opportunity of observing a form of fits which was new to me. The patient when I entered the room was in the position of opisthotonos, which was abruptly and violently exchanged for that of emprosthotonos, and then back again, the alternations occurring three, or four times varied with an occasional right pleurothotonos. The subsidence of the fit was followed by a short interval of consciousness, after which I was able to watch the initiation and development of another fit. The first indication of the onset I noticed was a dulling of the intellect, followed by a fixing of the gaze; then came complete suppression of consciousness, extreme extension of the right leg and right arm, with clenching of the right hand, followed by the alternations between opisthotonos and emprosthotonos, with an occasional curious grand convulsion of the body to the right, which threw the patient, if not held, out of bed. A succession of such fits gave opportunity of observing their undoubted peculiarities. Unconsciousness apparently commenced with the fixed look, a decided and obvious dullness preceding it. The convulsions were tonic in character, and not of the ordinary tonic-clonic epileptiform type; there was, in fact, no succession of clonic movements. They were entirely limited to the right side of the body; the left side during the fit being at rest, even while the opisthotonic and emprosthotonic positions were maintained, a lateral deviation to the right in these positions being noticeable. During the subsidence of a fit the face took on an expression of agony, and the left hand, with a slow and deliberate movement, was passed up to the left side of the head; this was a regular sequence, and almost immediately the unconsciousness passed off, and, in a hesitating manner, the patient would converse and respond to questions, and even gave information as to his history, which information was verified on later inquiry, but had no recollection or knowledge of the fit through which he had passed.

While still conversing he would lapse into a state of dullness, the eyes would be fixed, unconsciousness occur, and the details of a fit as I have described them follow. This type of fit continued to occur and recur for about four hours, then, after a period of rest, he became maniacal, and attempted to strangle himself by means of his handkerchief, and, when this was taken from him, by a rolled-up corner of his bed-sheet. Being again interfered with, he violently and with intention threw himself—striking the left side of his head—against the wall of the room which adjoined his bed.

When I saw him next morning I found that the type of fit had altered. It was now much modified, and was of the ordinary epileptiform variety—tonic and clonic—slight in degree, and limited to the right side. The unconsciousness was not so profound, but was still preceded by the dullness, and disappeared with the subsidence of the fit. He would then at once converse and give expression to gloomy forebodings, his mania being decidedly melancholic. He stated that all was up with him, that he would be of no good any more, and asked for a razor that he might kill himself. He complained of pain on the left side of his head, and suddenly, with quick elusive springs, would bang that side of his head against the wall with apparently suicidal intentions. The gravity of the symptoms on the third day had appreciably diminished, and on the fourth day the epileptic state was over, and he was practically well.

I have allowed time to elapse before reporting the case, so that I might be enabled to watch for any recurrence of the attacks, but I have only to record that he has been in all ways

perfectly well since. In character he is a man of singularly fearless disposition, careless of danger and peril, and most distinctly "non-nervous."

His previous history was as follows: About ten years ago he was waylaid by robbers, who knocked him on the head and left him lying unconscious. Since that time he has had occasional fits, the last series having occurred three years previously to the one I describe, but none had the severity of the one under notice.

The family history is good; father and mother are alive, and there are brothers and sisters who have nothing in their history, as far as I have ascertained, which affords any light on the case.

The treatment adopted consisted in large doses of bromides, which drug he still takes; blistering over the left side of the head, and the administration of croton oil, the brisk action of this drug being a determining factor apparently in his recovery from the epileptic state; the probable beneficial action of this oil being suggested by the possible influence of the generous feeding associated with the festal season in inducing the attack.

Certain interesting points in the case seem worth recapitulating: (1) The dullness of the intellect, which was quite obviously the first indication of the approach of a fit; (2) the curious and unusual clearing up of the intellect which at once followed the subsidence of the convulsions; (3) the violence of the fit; (4) the purely tonic character of the "grand convulsions"; (5) the limitation to the right side; (6) the indication of pain on the left side of the head; (7) the prolonged period of the epileptic state; and (8) the long interval between successive periods.

Is this case one to be regarded as of the type described by Hughlings Jackson, or does it partake in any way of the hystero-epileptic form of Charcot's as occurring in the male? Probably the explanation is to be found in regarding it as of the Jacksonian or symptomatic type, the epileptic state being consequent to irritative disturbances in a cortical lesion somewhere in the left central convolutions.

SCLERODERMA ASSOCIATED WITH RAYNAUD'S DISEASE AND ADDISONIAN PIGMENTATION.

By GEORGE C. R. HARBINSON, M.B., B.Ch.,
Matlock.

ON June 10th, 1902, I was consulted by a lady, aged 45, who complained of rheumatic pains flitting about the body, accompanied by some stiffness. Two and a-half years before she had an attack of "influenza," followed by rheumatism, which lasted nine weeks. A year later the rheumatism reappeared, and had since troubled her. I noticed that the skin of the neck and parts of the face looked bronzed, and on inquiry found it had been gradually becoming more pronounced during the past four or five years. The pigmentation began, the patient thinks, on the abdomen and top of the thighs, and then affected the chest and arms, and recently the neck and face. The patient has not felt in good health for five or six years, owing to "worry and bother and trouble." Twelve months ago she noticed, when she stretched her hands and fingers out, or when she went out into the cold, that the fingers became white at the tips, numb, and icy cold, which condition disappeared on warming them thoroughly. Shortly afterwards they broke out at the tips, and continued in this condition all the summer, being treated as "whitlows" by the medical attendant. Now only tiny scars mark the place of ulceration.

During the past six months the condition of the hands has been becoming much worse. The fingers and hands and wrists feel swollen, and the skin has a drawn feeling. On exposure to the least cold the fingers become blue and icy cold and numb, and oftentimes painful, and the tips of the nose and ears become white and cold. There is a peculiar "numb" (not anaesthetic) and tight-drawn feeling in the chin, lower lip, angles of mouth, cheeks, temples, forehead, and over the angles of the lower jaw, so that the patient has difficulty in opening the mouth sufficiently to take solid foods. The skin is dry, the hands and chest alone perspiring in the night. There are varicose veins of twenty years' standing in both legs to the middle of the thigh, and there has been oedema of legs for some years. Five weeks ago the patient was laid up with phlebitis of the right internal saphena vein from above the ankle to the middle of the thigh, and she is now suffering from a similar attack in the left leg. She has