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

lost half a stone in weight since the beginning of the year. She has no cough, has palpitation of the heart sometimes, dyspnoea only on going up hill; she has had occasional fainting attacks since girlhood, but these have not been worse lately. The appetite is pretty good; seldom any sickness; the bowels are rather constipated, and there are no piles. There is some bladder catarrh, menstruation is regular, and there is some leucorrhoea. She sleeps well.

On examination the hands and fingers are stiff and swollen-looking, covered with a thick, hard, shiny skin of slightly yellow tinge that cannot be pinched up. When kept warm the fingers are red and burning, on exposure they become affected with a local asphyxia. The nose has a pinched look and is cold. The cheeks are pale, glossy, and hard, and the skin is thick and cannot be pinched up; and that on the chin, forehead, temples, over the angles of the lower jaw, lower half of neck, over the manubrium sterni, and in the infraclavicular regions is of a similar character. Over the greater part of the body the skin presents bronzing, or a brown pigmentation, varying in intensity in various parts. There is decided bronzing of those parts of the face and neck not affected by the scleroderma, the parts so affected being much less pigmented and surrounded by a somewhat hyperaemic zone. The patient says her hair has darkened from brown to black during the past two or three years. The conjunctivae are natural in colour. On the lower lip is a brown line where the upper meets it on closing the mouth, as well as one at the junction of the mucous membrane with the skin; and on the buccal mucous membrane inside the lip is a light brown irregular patch the size of a finger-nail. There are no patches on the tongue. The neck and upper part of the chest are markedly browned; the posterior triangles of the neck are very deeply pigmented, and below the left angle of the jaw is a collection of very dark "freckles" on the already pigmented area. The arms are uniformly lightly bronzed, with marked bronzing in the flexures of the elbows and over the olecranon. In the axillae the brown colour is very marked, and especially on the anterior and posterior borders where the friction of the garments is most exercised. From the axillae the deep pigmentation extends down both sides, over the lower part of chest, and the whole abdomen and buttocks and upper third of thighs. Below that the bronzing is light to a little below the knees, being marked in the popliteal spaces, and over the patellae and ligamenta patellae. The skin of the abdomen, sides, groins, and perineum is as dark as a mulatto's, and has the same soft, dry feel. A specially dark band circles the waist to the spine, due to pressure of waist bands. The back is but lightly discoloured, except over two or three of the lumbar vertebral spines, which are darkly pigmented from pressure of the corsets. The breasts are natural in colour, contrasting strangely with the surrounding dusky skin, but the nipples and areolae are dark brown. On the right leg the whole course of the old phlebitis is mapped out by a dark brown broad line of pigment, which shades off gradually to the surrounding colour, and suggests the marking of a range of mountains on a map. This is evidently due to the deposit of pigment during the cutaneous hyperaemia accompanying the phlebitis. The skin of the feet and legs below the knees is not pigmented except for the geographical marking I have just described, and a few little brown areas over little knots of varicose veins. This omission is probably due to the existence of a chronic state of oedema in those parts. The feet go cold and blue easily, but there is no numb feeling or thickening of the skin. A deep scar of an old burn above the left elbow is quite white. The patient is anaemic; the heart asthenic, with some dilatation; and there is nothing abnormal to be found in the lungs or abdomen.

This case is remarkable in several respects: (1) There is scleroderma of the diffuse type affecting the hands, wrists, face, neck, and top of chest; (2) there is associated Raynaud's disease affecting hands, nose, and ears; there is deep bronzing of the skin, in distribution and characteristics typical of Addison's disease, without the typical constitutional symptoms, though there is undoubted debility.

Is this combination a rare clinical entity?

DISQUIETING reports having appeared in the press as to an outbreak of yellow fever in Jamaica, the Governor has telegraphed to the Colonial Secretary that, since the death of an officer from the disease reported on November 19th, 1903, no case has occurred, and that the state of health in the island is most satisfactory.

A MODIFIED OPERATION OF CASTRATION.*

By WILLIAM THORBURN, F.R.C.S.,
Honorary Surgeon, Manchester Royal Infirmary.

I wish to call your attention to certain modifications in the operation of castration which I have practised during the last twelve months and which appear to me to constitute an improvement on the ordinary method. Whether, in so doing, I am following in the footsteps of others, I do not know but I have not found any description of the operation which we now adopt.

You are aware that we encounter special difficulties in procuring strict asepsis in operations upon the scrotum, difficulties due to various factors of which the most important are the folds of skin, the large sebaceous and sweat glands, the proximity of the anus and urethra with consequent risk of soiling dressings, and the absence of resistance to firm scrubbing or firm bandaging.

You are also aware that the lax connective tissue of the scrotum tends to the ready production of oedema, and that its numerous veins are liable to cause oozing of blood into its substance, these factors rendering its tissue a most favourable nidus for infective organisms. It is for these reasons that we take somewhat exceptional precautions in operating through the scrotal skin. In the operation for varicocele we make the incision as high up as possible, and bring it over the pubic region; in the radical cure of hydrocele we do not close the wound completely, but insert a gauze drain to remove the blood and serum which form so exceptional a cultivating medium.

In the operation of castration the difficulty of an aseptic technique is often still further increased by the presence of an open sinus or ulcer due to tuberculous or less commonly to fungating malignant disease. Under these unfavourable circumstances, suppuration after operation is difficult to avoid, and although the ultimate result is probably always, or nearly always, satisfactory, it is not unusual to have convalescence prolonged by the formation of sinuses leading to ligatures which have been placed upon the spermatic cord or by slowly-healing wounds of the scrotum itself.

To a certain extent these difficulties are overcome by making the incision as high as possible, and then dragging the testis upwards, and by this method we can avoid in many cases cutting through the skin of the lower part of the scrotum, but we still have a more or less extensive scrotal wound continuous with that which leads to the ligatured end of the cord. It is thus important to avoid if possible any connexion between the upper part of the cord with its ligatures and its communication with the pelvis on the one hand and the too frequently septic scrotal wound on the other.

It is also important in most cases of tuberculosis and malignant disease to divide the cord at as high a level as possible, and for this purpose the internal oblique muscle often requires to be partially divided, while we do not wish to leave a weakened area which may give exit to a hernia.

The operation which I now describe appears to meet most thoroughly these various indications—namely: (1) To give high access to the cord; (2) to close securely the abdominal wall; and (3) to avoid the danger of suppuration in the upper wound, with tedious convalescence and possible exacerbation of tuberculosis about the upper end of the cord and the vesiculae seminales.

The pubic and scrotal regions having been prepared in the usual manner and the patient placed upon the table with his antiseptic compress *in situ*, the latter is turned off the pubic region only, the genital organs being still covered by it. An oblique incision is then made along the line of the inguinal canal as for the radical cure of hernia, but only about $\frac{1}{2}$ in. in length, the external oblique aponeurosis and the internal oblique muscle are separately divided, and the spermatic cord is traced well down into the pelvis, and clamped there with Spencer Wells's forceps. By means of an aneurysm needle the cord is then transfixed and securely tied with silk immediately above the clamp. A single ligature is next placed on the cord, about $\frac{1}{2}$ in. below the clamp, and the whole cord is cut across close to and on the distal side of the clamp, which is then removed. The spermatic cord is thus doubly ligatured, and is cut across at a high level. To close the abdominal wall the internal oblique muscle is then sutured to Poupart's ligament, the external oblique aponeurosis is sutured, and the skin wound is completely closed. For the deep sutures we use

* Extract from a Clinical Lecture.