muscles; but their loss appears to occasion only trifling inconvenience.

Since the above was written two further articles on the subject have appeared in the BRITISH MEDICAL JOURNAL for January 16th, 1904, by Dr. Distin and Dr. Charles. The latter points out the frequency of brachial neuritis among miners, and confirms my own impressions that a confined posture at work is an important factor in etiology.

REFERENCES.

¹ BRITISH MEDICAL JOURNAL, July 11th, 1903, p. 71. ² Ibid., October 24th, 1903, p. 1035. ³ Loc. cit.

DEEP ULNAR NERVE PARALYSIS AND FUNCTIONAL POWERS.

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It is rarely that we see isolated paralysis limited to the deep palmar branch of the ulnar nerve, hence the following is interesting:

J. H., aged about 27, a carpenter, was struck by a heavy hammer over the left lower radial region, whilst the ulnar edge of the hand sustained a counter-blow through being forced against some hard body. There was a wound over the pisiform and unciform bones.

He worked from the date of accident (September 17th, 1903) at his trade for about three months, just managing to do his work with difficulty. About two weeks after the accident he noticed that his two inner fingers were commencing to become "bent." About the beginning of December he found it impossible to continue his work properly, because, although he could grasp all larger objects, such as saw-handles, hammers, chisels, etc., with his left hand, he could not hold small objects, such as nails, brads, screws, etc.

On January 6th, 1904, I saw him in connexion with his claim under the Workmen's Compensation Act, and I found the following condition: The left hand was markedly smaller than the right, and the intermetacarpal spaces distinctly hollow; there was the usual wasting of thumb and small finger muscles, but it was more pronounced than usual. The two inner fingers were markedly "clawed," overextended at the metacarpo-phalangeal joint, and flexed at the more distal joints. The mid-finger was just commencing to show the same deformity. It was interesting to observe that, when I asked him to try to extend the deformed fingers "properly," he said, "I can, sir, if you just place your finger there," indicating the back of the first phalangeal joints, showing how he missed the steady support of the lumbricales at those joints. He had complete sensation in "ulnar" portions of the hand and fingers. The usual absence of adduction and abduction of the fingers was observed. He had strong grasp for any large object, but for pins and pens and pencils the co-ordination and power of grasp was undecided and so weak as to be relaxed by slight force on my part. In fact, he had no fine adjustment of fingers and thumb.

The following struck me as most interesting; although he had his proper thumb adductors quite paralysed and wasted, and showing marked reaction of degeneration, still I found he could adduct his thumb powerfully, so that he held it firmly against the radial border of the index finger. On examining the apparent tenseness of tendons I saw that the extensor ossis secundi internodii was in strong action, and was performing this adductor function, the obliquity of its tendon's direction from inside to outside of radius becoming very evident, and itself demonstrating its mechanical adductor application, the short flexor and the long flexor and the opponens probably helped in this action, but its power was most marked.

The conclusions which struck me most about this instructive case were: With complete deep ulnar paralysis we have still remaining a good rough hand grasp; we have the thumb-opposing powers and flexion powers (derived from median innervation), and we have the lost adductors supplanted to a useful degree by extensor and flexor muscles. Of course, if the damaged nerve is not rehabilitated, and the degenerated muscles regenerated, in time we must look for a very far worse state of things, owing to tendon and joint adhesions; but even then we must remember that we shall have the thumb performing many most valuable duties in all of its five directions. It is important to differentiate "complete" destruction of function from "incomplete," although most serious, destruction of it.

I may add that this case is to be operated on with a hope of recovering the deep ulnar nerve's function.

REFLEX DISTURBANCES ASSOCIATED WITH ADHERENT PREPUCE.

By ROBERT M. SIMON, M.D., F.R.C.P.,
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MALFORMATION and unusual condition of the penis practically never come under the notice of a physician, and it is, therefore, not remarkable that one's attention can only rarely be directed to such conditions as having a possible and an exciting influence in causing widely differing and remote disturbance of functions in other organs.

Within the last few years, however, I have seen three cases in which the symptoms were due to adherent prepuce or a narrowed urethral meatus. In not one of these cases was there any reason to associate the symptoms with any trouble about the penis, nor was such trouble suspected. It was only after every other possible cause had been considered, and the symptoms had been treated without the slightest benefit to the patient that a thorough examination revealed a condition of the penis which, if not the cause of the symptoms complained of, was, at any rate, so far from normal as to render local treatment desirable.

CASE I.

A boy, aged 18 months, well made and growing rapidly, suddenly became unable to walk. He dragged one leg, and complained of pain in the hip. Any attempt to make him walk caused severe pain, and, at any rate, was resisted with screams. He was under the care of one of the best known practitioners of this city who suspected, despite the absence of many signs, incipient hip mischief. One of our leading surgeons examined the child, and gave a positive opinion against the existence of hip disease but was not able to do or suggest anything which helped to restore the child's walking power or relieve the symptoms. When called in to see the child I thus had the advantage of the opinion of two doctors more familiar with the subject of hip disease than myself, and of their assurance that hip disease was not present, so *faute de mieux* I tried to find some cause of reflex irritation, and after irritation by worms had been considered and negatived we examined the penis.

The prepuce was found to be long and adherent. The child was circumcized and recovery was immediate and complete.

CASE II.

A boy, aged 14, was sent to me from a neighbouring town on account of obstinate and severe intestinal colic. No medicines had relieved him, and I advised that he should be treated as though the colic had been due to lead poisoning. More thorough examination, after this plan had been tried and failed, revealed an adherent prepuce. This was treated, no medicines being given, with complete disappearance of all symptoms.

CASE III.

A boy, aged 3, had been perfectly well during infancy, but when developing from an infant into a well-grown little boy, began to wake up at night screaming and complaining of pain in the abdomen. This occurred night after night with a regularity which resulted in great disturbance to the household, and loss of sleep to the little boy whose health began to suffer. I saw him several times and treated him unsuccessfully for night terrors and indigestion.

I found that advantage was taken of his being awake to get him to pass water, but though he went to sleep afterwards I failed to associate the fact with his symptoms. It was only after all efforts to help him had been futile that I examined the penis. The prepuce was found to be adherent and the meatus narrow. These conditions were treated surgically and immediate and permanent cessation of symptoms followed.

It is probable that in the third case the need to empty the bladder was the starting-point of the symptoms, and that the call to micturate was associated with some erection of the penis, any turgescence of which would be rendered painful by the adhesion of the prepuce. The boy was not old enough to describe his condition accurately, or locate the pain with certainty, so that both by his parents and myself he was considered to be suffering from indigestion. This explanation will not apply to the second case, which like the first must have been due to some reflex disturbance of the nervous system.

In the first case, that of inability to move the leg, it would appear that there must have been inhibition of spinal nerves, due to the peripheral irritation of an adherent prepuce. It is, of course, a truism that we ought to examine our patients thoroughly, but these cases show how great is the necessity to do so when the symptoms complained of are anomalous, and inconsistent with those generally accepted causes which underlie similar disturbances of function.