to feed by the mouth much severe coughing was produced. He was ordered a nutrient enema every four hours.

On February 13th the wound was dressed and looking very well. His general condition not so good; the pulse was irregular and small; the breathing was good, but there was slight stridor. There were no signs of pneumonia. Hypodermic injection of strychnine was ordered, $\text{m} \times \text{v}$ of a 1 per cent. solution every six hours. He was fed by nasal tube night and morning (milk Oj , brandy 3j , egg i). The rectal feeding was continued every six hours.

On February 14th he was restless, excited, and complained of headache. The temperature 102° ; the pulse 104 and stronger. He was given morphine gr. $\frac{1}{4}$ hypodermically.

On February 15th the wound was dressed; it was looking very well. The tubes were removed. The pulse was 90 , and the general condition much better. The strychnine and rectal feeding were stopped. He swallowed custard and did not cough, and could talk in a whisper.

On February 16th feeding with the tube was stopped; the patient going on well.

On March 11th he was discharged cured from the hospital, the wound having healed by first intention.

I have to thank Mr. Anderson, under whose care the patient was in the hospital, for permission to publish this case.

From a consideration of the matter I think that every case of cut throat should be treated by immediate suture unless the patient is in a dying condition from shock and loss of blood. In such a case it should be done as soon as the patient recovers sufficiently to stand it.

It is very rarely necessary to give chloroform. I have always been struck by the condition of the patient in cases of cut throat. There is great depression of the nervous system, and the patient will allow the wound to be cleaned and sutured without appearing to feel in any way, although perfectly conscious of everything going on around him.

In consequence it is hardly ever necessary to administer chloroform, which must, taking the condition of the patient into consideration, add greatly to the risk. The wound must be very thoroughly cleaned after the air passage has been securely closed; it can be washed out with some strong antiseptic: hydrag. biniodide, i in 500 , or carbolic acid i in 20 .

The suturing should be done carefully layer by layer from the bottom, the air passage completely and tightly closed, and muscles and the fascia taken in order up to the skin. For the buried sutures chromic catgut or silk is best. The skin wound is everted and brought into apposition with horsehair or silkworm gut, and if the wound is deep and extensive a small drainage tube can be put in at each end.

If the cleansing of the wound has been done thoroughly, in most cases the wound will heal by first intention, the period of recovery will be much shortened, and the patient will not run the many secondary risks that occur after the old treatment.

With regard to the use of a tracheotomy tube, it is never, I think, necessary to put in a tracheotomy tube at the time of suturing the wound; should the patient subsequently get oedema and severe dyspnoea, the larynx or trachea should be opened below the wound, and a tracheotomy tube inserted. This will very rarely be necessary, but in any case it must be better to do it when it becomes a necessity, rather than to leave a tube in the wound itself, or to make a fresh opening below at the time of suture. The head should be inclined slightly forward, and fixed in some way to prevent movement, and much depends on good nursing.

In the majority of cases feeding by the mouth is easily accomplished, but in cases in which the epiglottis, pharynx, or oesophagus are involved, it is best to rely for a time on rectal feeding or the nasal tube.

A CASE OF ACUTE PULMONARY GANGRENE.

By T. ARMSTRONG BOWES, M.D. CANTAB.

Herne Bay.

A SAILOR, aged 52, was taken ill at sea, and when removed on shore was delirious for about seven days. The nature of the illness could not be ascertained. There was no history of dysentery or liver disease, but he had "something wrong" with his left lung some years ago when abroad.

When first seen on December 23rd, 1896, immediately after the delirium, he was a sallow-complexioned man, perfectly rational, and quiet by day and night. He complained of slight pain in the left side of the chest, but no abnormal condition could be discovered on this side. On the right side, however, just above the liver dulness in the nipple line,

was a small area of impaired resonance, with a few *râles*, but no bronchial breathing. The heart and remainder of the right lung were natural. Over the sacrum, for the size of half a crown, the skin was abraded.

On December 25th the sputum became a little rusty, and expiration harsh over the area above mentioned.

On December 27th the temperature rose to 100.4° , the area of impairment was slightly increased, the sputum became darker in colour with a grey tinge, and began to smell. From this date to December 31st the temperature remained about 103° F., and rose on the evening of this day to 104.8° F. He was very ill, the sputum copious, very foul, and of a blackish-green colour, containing on microscopical examination pus and elastic tissue. The impairment increased rapidly, reaching to the second rib, and in the second and third interspaces bronchial breathing and coarse *râles* were present.

During the next four days his condition slightly improved, the sputum being less foul, the temperature varying between 101° and 102° F., and from this date onwards to January 29th it never reached normal, being usually about 101° , with extremes of 99° and 102.5° .

On January 10th the discoloration of the sputum was less; three days later it was slightly increased, but it finally disappeared on January 20th, the sputum after this being mucopurulent.

While slowly gaining ground, the signs of consolidation steadily progressed, till on February 7th impairment and bronchial breathing reached from the clavicle to the liver dulness. In the upper three interspaces a tympanitic note and amphoric breathing were present for a few days, but there was no bell sound. The sputum was fairly copious, and mucopurulent, and he periodically coughed up a quantity of it (about 1 ounce) which he felt collect about the second interspace. Great improvement in general condition had occurred during the last week.

On February 14th he complained of a cutting pain running up the junction of the ribs with their cartilages on the right side on drawing a deep inspiration. The condition of his chest was then as follows: On quiet respiration the left chest moved more than the right, and on the latter side expansion was shallow and deficient, the lower intercostal spaces being drawn in on inspiration. Vocal vibrations were increased from the apex to the nipple. There was impairment to percussion from the apex to the third rib from the sternum to the anterior fold of the axilla, and to a less extent below, merging into the liver dulness. The highest pitch of the note was in the third interspace near the sternum. The left lung was resonant everywhere.

On auscultation bronchial breathing and ægophony were heard in the second and third interspaces over an area 3 inches in diameter, the inner edges commencing 2 inches from the right edge of the sternum. Coarse *râles* were general on expiration and inspiration. Behind there was general impairment, with *râles* over the whole of the right lung, with bronchial breathing over the lower half of the scapula. The sputum was less in quantity, mucopurulent, and did not contain tubercle bacilli.

By March 25th the sputum had gradually ceased, and the abnormal signs in the right lung had entirely cleared up, except for harsh inspiration in the region of the right nipple. From this date the patient made an uninterrupted recovery.

DISAPPEARANCE OF A CARDIAC MURMUR.

By C. J. WHITBY, M.D.,

Limpley Stoke.

Mr. W. P., aged 59, came under my care in a hydropathic establishment on March 9th, 1897. He had been subject to persistent colds, usually following an attack of influenza. He complained of pain in the anterior mediastinum, with a feeling of constriction, "as by an iron band," across the chest. He has been an abstainer from alcohol for years, and had never smoked. Seven years ago he had what appears to have been an abortive attack of enterica, and twenty-nine years ago had nephritis after a chill. The pulse was 65, and its tension markedly high. There was no evidence of cardiac hypertrophy, but the second sound, as heard at the apex of the heart, was

accentuated, while in the aortic area there was heard a distinct, blowing, diastolic *bruit*, audible along the sternum, but not at the apex. The urine was normal but for the deposition of a few crystals of uric acid. There was occasional palpitation on exertion, and from this, and the sense of constriction, etc., the patient had suspected the existence of heart disease, although he did not mention this at first.

Considering the chest symptoms of pain and discomfort to be due, in part at least, to the high arterial tension, and its embarrassing effects upon the heart's action, and knowing by experience that such a condition (even when associated with valvular lesions) can be safely and easily relieved by the peripheral vascular dilatation and slight diaphoresis effected by brief exposure to temperatures of 120° F. to 135° F., I prescribed a mild Turkish bath, to be given with due precautions, and followed, of course, by tepid sponging only. This the patient took without the least discomfort, and with apparent benefit, but, unfortunately, was foolish enough to go a short journey in the afternoon, exposing himself to a biting wind, and getting caught in several smart showers. On his return he omitted to change his clothes, which were damp.

Next morning (March 10th) he got up as usual, but felt very ill, and finding his temperature 101° F. I sent him back to bed. Pyrexia (modified by cold packing, cold wet truncal bandages and cold sponging) continued for five days and nights, the maximum temperature being 103° F. There was expectoration, at first of dark blood, then of bloody tenacious mucus (found free from tubercle bacilli), which cleared up with the termination of the fever. There was also intense restlessness (relieved greatly by the cold packs), insomnia, slight delirium, and pain in the splenic region. The urine, at first clear and high-coloured, deposited an abundance of uric acid crystals towards the end of the attack. The diagnosis was influenza. Careful auscultation and percussion revealed no abnormal breath sounds or impaired resonance at any time.

On the second day of this attack on examining the heart I was surprised to find that the aortic *bruit* had entirely disappeared, the pulse now being compressible and remaining so henceforth. On March 31st, when he left the establishment, it had not returned. It is noteworthy that as his appetite returned and he began to eat freely, and to get about the house, the mediastinal pain and constriction returned, though in slighter degree, and would wake him up and keep him awake for an hour or two every night. The exciting cause at this time was probably dyspepsia, and the trouble was relieved by a nocturnal hot wet compress to the epigastrium.

I should be glad to learn whether any of the readers of the BRITISH MEDICAL JOURNAL have observed cases in which what one must consider that functional valvular failures have been relieved by pyrexia or the recumbent position. *Appropos* of the symptoms of aortic regurgitation, Hilton Fagge says that "all the signs just mentioned denote incompetency of the aortic valves; it does not follow, however, that they are diseased, as their want of closure may arise from dilatation of the ascending aorta or disease of its coats. For example, a yielding of the sinuses of Valsalva just above the aortic valves has been proved to interfere with their perfect action." The absence of stenosis (a usual concomitant of aortic regurgitation in organic valvular disease) in this case favours the hypothesis of a temporary dilatation of the aorta.

A CASE OF HYSTERO-EPILEPSY SIMULATING "STATUS EPILEPTICUS."

By H. HYSLOP THOMSON, M.B., C.M.,
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THE following case is of exceptional interest, as it fully illustrates the hysterical condition mentioned by French writers, and known as hystero-epilepsy or hysteria major.

The patient was a young married woman belonging to a highly neurotic family, and having prior to her present illness a definite history of epileptiform seizures. The exciting cause of the present attack was anxiety and sleeplessness, occasioned by the prolonged nursing of a child suffering from

broncho-pneumonia. For a few days prior to the onset of convulsions many of the prodromal symptoms characteristic of this severe form of hysteria were present. The most striking of these were persistent globus hystericus, palpitation of the heart, gastralgia, marked ovarian hyperæsthesia, and severe headache with exquisite tenderness to cranial percussion. Her pulse was rapid and of very low tension, her breathing hurried and sighing, and frequently she gave way to violent paroxysms of weeping. The pupils showed continued dilatation. The tongue on protrusion was very tremulous, and the hands betrayed muscular twitching. Menstruation was suppressed owing to lactation, and the bowels were obstinately confined; her urine, however, was normal in character and quantity. The convulsions which followed, though at first slight and occurring at considerable intervals, increased so rapidly in frequency and intensity as to bear a strong similarity to the severe form of epilepsy the "status epilepticus." Each attack was ushered in with full dilatation and fixation of the pupil, succeeded by conjugate deviation of the head and eyes to the right. No cry, however, was emitted, and on subsequent questioning the patient stated that she was not conscious of any definite aura.

Three stages now followed (1) the tonic stage, (2) the clonic stage, and (3) the stage of emotional excitement. The tonic stage was short but intense, and the convulsions varied in character with each attack. At one time the patient became rigid as she lay; at another, suddenly and with great violence, she would shoot out her closed hands and rigidly assume the crucifixion attitude; or, again, the tonic stage would start with trismus, rigidity of the muscles of the neck, and marked flexion of the forearms. The pulse during this stage increased in tension.

The clonic convulsions which followed were characteristic of an hysterical element; they were most violent and varied in character, yet without exception they showed to a greater or less degree a supervision of volition. At times the head would roll from side to side, followed by rapid flexion and extension of both extremities, or violent lateral and antero-posterior movements of the trunk. Again the patient would suddenly sit up in bed and endeavour to seize with her teeth, or otherwise injure attendants present, failing which she would bend herself forwards in a posture suggestive of emprostotonos, or throw herself back with no inconsiderable violence. During these attacks there was little or no frothing at the mouth, and her face, though pale, was never livid.

Invariably the clonic stage ended with the patient resting on her heels and vertex in the posture of opisthotonos, during which there was great muscular rigidity, with fixation of the chest and laboured breathing. The patient, now thoroughly exhausted, would lie quiet for a brief period, but gradually she passed into the stage of high emotion, in which she would weep bitterly, or point with a look of rapture and expectancy to imaginary forms, and give utterance to the names of friends long since dead. Thus her emotions would sway until she gradually quieted down or passed into another convulsion.

Regarding treatment I first enjoined rest and quietness with the absence of all reference as to the ultimate issue of her child's illness, and along with that useless sympathy. I recommended a light non-stimulating diet, saline laxatives, and put her on hypnotic doses of chloral and potassium bromide, but with little or no effect. On the third day of her illness, owing to the severity and frequency of the convulsions, I determined to administer chloroform. On proceeding to do so, I found that the induction of the first stage of chloroform narcosis was all that was necessary. With the abolition of volition the convulsions ceased, and her pupils, which were previously widely dilated, quickly contracted; her breathing became quiet and natural, previously it was hurried and gasping; her pulse slowed. At no time were the reflexes abolished. Twice she vomited. I thus kept her under the influence of the anæsthetic for the space of an hour, and after she had regained consciousness I inserted gr. ½ morphine suppository in the rectum and left her.

On the following morning I learned that she had passed a good night, with no recurrence. I consequently again prescribed chloral and potassium bromide, with the result that, excepting two slight attacks, she made an excellent recovery.