11 of these cases no attempt at version was made as the pregnancy had only attained the sixth or seventh month, and it was thought that they might safely be left for a little longer. In 14 cephalic version was performed by external manipulation, sometimes by one and on other occasions by two operators. There were 7 cases in which version was found to be so difficult that chloroform had to be administered, with the result that success was obtained in 6. In 3 other cases attempts were abandoned owing to small amount of liquor amnii and close apposition of the uterus to the foetus. In 19 cases spontaneous version occurred. In 2 the patient did not return to the clinic. In this way the 56 cases were accounted for. There were 3 cases of transverse presentation in the 509 patients. Cephalic version was carried out in them all by external manipulation. Towel pads may be used in difficult breech and transverse presentations.

A CASE OF CONVERSION NEUROSIS.

BY

PHILIP C. LIVINGSTON, M.R.C.S., D.P.H.,

MEDICAL OFFICER IN CHARGE OF MEDICAL RESEARCH, R.A.F., INDIA.

WHILE doing the duties of staff surgeon in Ambala, India, I was called out early one morning to see a lady, aged 34, said to be acutely ill. On arrival I gathered that she had been having a series of fits which appeared superficially to resemble epileptic seizures.

When first I saw her she was just coming round from a second fit, and had gained a drowsy consciousness. She had incontinence of urine, rigid muscular contractions, and cyanosis. The temperature was 100° F., pulse full in volume. I learned that the day before, at about 11 a.m., she had gone into the bazaar wearing a very flimsy hat, and had come back with a severe headache which persisted throughout the day and night. A "touch of the sun" naturally suggested itself, particularly as that summer was an exceptionally hot one (about 108° F. early April, shade temperature at noon). I had the room darkened and cooled and a cold pack put to her head. The temperature and her general state did not seem to call for any other treatment. I eliminated malaria by film examinations. She had no more fits, and passed out of my care on departing to a hill station for the rest of the summer.

I was called again to see her in the following September. During her stay at the hill station she had had three severe attacks of a similar nature to the first, each more alarming than the one before, with longer periods of unconsciousness. The present was the fourth in five months. I found her on this occasion practically unconscious, the eyes turned upwards, the lips blue, the teeth still set (tongue not bitten as means to stop this had been employed). She had had a succession of four fits during the night, and was clearly feeling the strain. I admitted her immediately into the family hospital of which I had charge and asked the sisters to watch her closely and to note anything peculiar regarding the attacks. She was kept screened and quiet and put on a strong triple bromide mixture. She had three further fits, each one less severe than its predecessor, and under the influence of the bromides quieted down by the following day. The fits certainly appeared practically identical with those seen during an epileptic seizure. There was no family history of epilepsy or fits of any kind. Another blood film examination proved negative to malaria, and showed nothing abnormal in the differential count. Specific disease was excluded. I examined the central nervous system with extreme care. Nothing could be found beyond a slight increase in the knee-jerks.

Closer examination into her domestic life brought out the fact that her fits always corresponded with periods of worry about her two children during the absence of her husband on tour. The fits came on when he came back or just prior to his return—that is, when the tension of solitude was relieved. My patient passed rather a secluded life and saw very few people, although she lived well inside the cantonment.

Treatment.

The case here assumed a new aspect. I talked with her for a long while in private and led her towards the solution of her problem, which she eventually solved to her own satisfaction. She would never live again without a companion while her husband was away. This was the first step. Next came the consideration of drugs. Bromides I put immediately out of court in view of the fact that the case did not call for depression but healthy stimulation. I therefore put her on a series of injections (twelve in all) of the glycerophosphate compound put up in ampoules by Parke, Davis, and Co. During the full course her husband remained at home. The result was excellent. She felt inwardly much fitter—"never better for years," as she described it—and ceased to worry over her domestic problem.

Her husband went on tour shortly afterwards and returned to find her quite well. A companion stayed with her during his absence. Only once while he was away (she had again elected to live alone on three successive occasions) did she have any signs of recurrence. I was called in and found that she had been alone for

nearly two weeks at a time when the political situation was causing us all some anxiety out here. She had three slight fits, not to be compared in severity with those seen previous to treatment. Again she settled down quickly and has not had any trouble since. I have now lost sight of her.

In a space of about nine months after the above treatment she had only one slight recurrence under great mental provocation.

This case I think is rather exceptional, (a) in virtue of the fact that the weakness caused through exposure to the sun should become by "conversion" the expression of a psychoneurosis and continue as such; (b) the vast improvement in the case after a strong tonic, backed up by the patient's own solution of her problem; (c) the complete lack of previous or family history pointing to any disorders of this nature.

NINETIETH ANNUAL MEETING

OF THE

British Medical Association.

Held at Glasgow, July, 1922.

PROCEEDINGS OF SECTIONS.

SECTION OF DISEASES OF CHILDREN.

Sir HERBERT F. WATERHOUSE, M.D., F.R.C.S., President.

DISCUSSION ON THE ETIOLOGY OF RICKETS.*

OPENING PAPERS.

I.—LEONARD FINDLAY, M.D., D.Sc.,

Visiting Physician, Royal Hospital for Sick Children, Glasgow.

It is an interesting coincidence that on the return of the British Medical Association to Glasgow after a lapse of thirty-four years rickets should again form the subject of discussion by the Section devoted to the study of diseases of children. One appreciates the appropriateness of the choice, since rickets is a disease specially prevalent under industrial conditions, and probably no city in the kingdom possesses these in a more marked degree than does Glasgow. For this very reason the disease has naturally always interested Glasgow's students of medicine. The name of our distinguished President, as you are all aware, is associated not only with one of the most characteristic manifestations of the disease (Macewen's tibial spine) but also with an operation for the rectification of the rachitic deformities. Two important investigations into its presence or absence in India, and the reasons therefor, have been carried out by Glasgow graduates (Huntly¹ and Hutchison²), and it is needless to remind you that within recent years the Glasgow school has earned for itself a certain notoriety on account of the interest which it has evinced in the malady.

Though the two meetings are alike in the choice of subject, the present debate differs from the one of thirty-four years ago in that it is a conjoint one between the physiologists and the pediatricists. This is of course in consequence of the great amount of experimental work which, during the intervening years, has been done to elucidate the pathology of the disease, and the lion's share of this stands to the credit of the physiologist.

Although there is nothing farther from my intention than to belittle animal experimentation, as I appreciate only too well the great benefits which have accrued to medicine in consequence, and indeed much of my own humble energies have been expended in this direction, yet the final battle regarding the etiology of rickets, at least human rickets, must be fought out in the clinical field. It is the admission of this fact, I take it, which is responsible for the onerous and at the same time honourable duty of opening the discussion falling upon me, a clinician.

Clinical Generalizations.

In the life history of human rickets there are several broad facts with which any theory of its origin must be reconciled before it would be justifiable to adopt it as the correct

* Joint Discussion with the Section of Physiology.