On the night of August 18th—the last night of the present series of attacks—she wrote a short letter to her

in the waking condition. In this respect, the case differs from many of the instances of hysterical somnambulism

music teacher together with the following essay, putting it into an envelope and addressing it correctly, as she afterwards informed us:

SONATA FORM.

Sonata Form is divided into three forms:

1. Introduction.
2. Development.
3. Recapitulation.

(Here follow two lines crossed out.) The Introduction consists of two simple themes both written out shortly (? strictly) on the Tonic. The Development is sometimes very long and in it both themes are worked out thoroughly at great length. The Development is always written in the Dominant. Recapitulation is a brief summary of the whole piece which is written again in the Tonic. Some sonatas also contain a short Introductory Theme, and snatches of this Theme will be found are generally found running all through the Sonata. A good instance is the "Pathétique" of Beethoven.

This essay, as well as the accompanying letter, was written quite clearly in pencil, and was indited in the dim light in which, in her waking state, she had previously been unable to write with any degree of legibility.

From this time onwards there was no recurrence of the sleep-walking, and the patient was discharged a week or two later in good health. Her doctor has recently informed me that "she is much better and earning her living as a typewriter, but has occasional night wanderings."

The physical examination showed little of importance. The chest, heart, and abdomen were normal, nutrition and digestion were good, the urine was free from albumen and sugar, and there was only a slight degree of constipation. The superficial and deep reflexes were, if anything, a little exaggerated. I could myself detect no areas of altered tactile sensibility; but Mr. Jameson Evans, who kindly made the examination of the fields of vision here recorded, discovered a small patch of anaesthesia just above and to the outer side of each upper eyelid. The accompanying figures show the fields of vision in each eye and the colour field in the right eye. These were taken on August 29th, and Mr. Jameson Evans informs me that they give practically normal results, though the colour fields are perhaps a little small.

I think that there is evidence in this case of the existence of abnormal acuity of vision during the somnambulist state. It is of course possible that, after coming to herself on the night of August 17th, the patient might have recognized the object of the test to which she was subjected, and that a desire to arouse interest might have led her to voluntarily make the unsuccessful attempt at writing shown in the second illustration. The house-physician and the nurses, however, were fully convinced that the light in the ward was quite insufficient to allow of any writing or work to be carried out by any normal individual, and I believe that the results of the test may be accepted as reliable. It is worthy of note that the events which apparently occupied her mind during the sleep-walking were not forgotten when awake. Her father's death, the circumstances of the relation to whom she wrote, and the musical interest, were all fully realized

recorded, especially in France, in which the ideas present during the somnambulism have been entirely forgotten in the waking state.

A CASE OF MERYCISM.

By H. F. LECHMERE TAYLOR, M.A., M.B., D.P.H. ED.

IN view of Dr. Brockbank's paper of February 23rd, 1907, it may be of interest to record the following case of merycism in a boy seen recently as an out-patient at the Mission Hospital, Jalalpur Jattan, Punjab.

A boy of the village farming class, said to be 14 years of age, but hardly looking so much, was brought by his mother for pains in the arms. She herself is a leper, showing a perfect clinical picture of the unmixed nervous form of the disease, from which she says she has suffered for twenty-five years. She was afraid that her son might be developing the same condition and wished to have him examined. In the course of the investigation it came to light that he was a habitual ruminant. He and his mother, though questioned and cross-questioned in various ways, both gave a perfectly consistent account of the condition.

About four years ago he began to have return of food into his mouth immediately after meals. This seems to have begun when he was attending school and was in the habit of running home and eating a meal hurriedly during school hours. What came back was slightly bitter in taste, and at first he used to spit it out, with the result that he had a great feeling of nausea and his mouth became "as bitter as poison," to use his own words. Soon he learned that by swallowing the mouthfuls as they came up he could escape the unpleasant symptoms, and the habit of doing so was speedily established. He attended school for only a few months, and then went back to work on the farm, having a good deal to do with cattle; "imitation," however, does not seem to afford a sufficient explanation of the habit.

His present condition is that his food, which he now chews well and eats at the usual rate, begins to regurgitate in mouthfuls as soon as the meal is finished; he does not re-chew it as it comes up quite soft; it is still slightly bitter in taste, but not enough so to be unpleasant; on the other hand, he derives no great pleasure from the process. If, however, he spits out a mouthful, he still suffers from a very bad taste in his mouth, associated with so much nausea and giddiness that he says he is unable to stand without support. The action is quite automatic, and goes on regularly till he begins to feel hungry for his next meal, when it ceases. He has no control over it whatever, nor has he any power of producing emesis at will. He does not suffer in the least from dyspepsia, but is usually somewhat constipated, a very common complaint in the Punjab.

His food, taken twice a day according to the custom of the country, is that of the men of his class, consisting chiefly of thin unleavened cakes of wheat or barley flour

(*chapatties*) along with a little lentil pottage (*dal*) or stewed green vegetables or butter; raw vegetables, such as carrots, turnips, and radishes, are probably freely indulged in; meat is a very occasional luxury. Milk and *lassi* (sour butter milk) are the only drinks except water. Fluids "return" even more markedly than solids.

There is nothing of interest in the family history, with the exception of the mother's condition. There were three other children; two boys died in infancy of small-pox, and a sister in adult age after childbirth. The mother knows of no one else in the family connexion who was in the habit of chewing the cud, and she has never heard of any other person who exhibited the peculiarity.

There is nothing else of importance in the condition of the boy himself. The pain from which he suffers seems to be rheumatic. Careful examination failed to discover any patches of anaesthesia or nervous disorder, suggestive of incipient leprosy or other general disease.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL.

EXCESSIVE PATELLAR REFLEX OF NERVOUS ORIGIN.

The following cases may be of interest in connexion with different points in Dr. Parkes Weber's valuable paper and Dr. Hobhouse's letter.

1. A man, suffering apparently from acute alcoholic insanity, showed Babinski's sign, but no other symptom of organic disease. As his mental state improved the extensor response gradually gave place to one of flexion. After this the mental improvement stopped, and signs of general paralysis began to appear. It may be held that the Babinski sign was due to early general paralysis, but against this are the facts that it disappeared as the effects of the alcohol wore off, and was absent when the general paralysis became manifest.

2. A woman, aged about 45, suffering from melancholia, showed Babinski's sign and a very marked wrist-jerk. She was under observation for some months, during which time her mental condition improved greatly, but recovery was not complete. The wrist-jerk diminished considerably, but the extensor plantar reflex was still present when she was last seen. In this case, of course, the Babinski sign may have been an early symptom of some organic change that had not become manifest when I last saw the patient.

If the extensor response is of functional origin in infants—as presumably it is—why may it not sometimes be so in adults too?

3. A young girl with acute mania, from which she recovered in a few months, showed exaggerated knee-jerks when first seen. Some time later both knee-jerks were absent. Methods of reinforcement were not practicable. Later still, one knee-jerk was present, the other absent. On recovery both were present.

4. A woman with syphilitic disease of the brain came under observation with ankle clonus. This disappeared later without any obvious change having occurred in the organic disease.

A slight degree of ankle clonus is well known to be common in functional disease and slight patellar clonus may occur.

It is not uncommon (so far as my experience goes) for the insane to show contraction of certain individual muscles when they are lightly tapped, like that displayed, only more universally, by some emaciated patients and by those in the lethargic stage of hypnotism. The muscle most frequently affected seems to be the vastus externus, sometimes of one side only; others that I have seen are the deltoid, the pectoralis major, the triceps, the biceps, and the muscles of the hypothenar eminence. The patients who exhibit this phenomenon are mostly general paralytics or chronic alcoholics, in either case having organic changes in the brain; but I have seen it in a case of acute alcoholic insanity that recovered in less than a month, and in a case of simple melancholia which became chronic. This association with cases that are probably free from organic change, and the similarity of the phenomenon to that occurring in emaciation and the hypnotic state, point to its being due to a functional disorder of the cortex, just as is the exaggerated patellar reflex, in Dr. Parkes Weber's

opinion. Perhaps Dr. Weber might have added absence of the knee-jerk to the conditions that may sometimes depend on functional cortical disturbance. The theory that it is necessarily due to the cutting off of inhibitive currents that pass down the pyramidal tract is hard to reconcile with its occurrence in deep sleep, in old age, in hypochondriasis, in emaciated persons, and even in the healthy. The results of Jendrassik's method of reinforcement are also hard to reconcile with the arrest of inhibition theory. No doubt it is said that this method acts by distracting the attention, and so cutting off the inhibiting currents; but, in the first place, the method may still prove successful (in cases where the reflex is not obtainable without it), even if the patient deliberately directs his attention to the knee while pulling on his hands; and, secondly, it was shown by the late Dr. Ch. Félé that the action of one set of muscles does not diminish, but actually increases, the energy of the cerebral cortex in other directions.

Tunbridge Wells.

P. C. SMITH, M.D. Durh.

MIDDLE MENINGEAL HAEMORRHAGE: TREPHINING: RECOVERY.

THE statistics of von Bergmann, giving 16 recoveries out of 99 cases of middle meningeal haemorrhage, are an excuse for recording the following case:

A young man, aged 22, fell off a coal cart on to his head at 5.30 p.m. on June 1st; he was unconscious for ten minutes; he was then given sixpennyworth of brandy by an onlooker, and proceeded home by train. He then had some tea and bread-and-butter. At 8.15 p.m. he began to vomit, and complained of pain in his head; a medical man saw him, and at 9.30 p.m. he became drowsy; during the night his breathing was noisy, and he began to throw his arms and legs about. There were occasional intervals when he was conscious, and he spoke several times; he became quite unconscious during the early morning. At 8.30 p.m. on June 2nd—over twenty-four hours after the accident—he was admitted into hospital completely unconscious; breathing stertorous; pulse 52; pupils markedly unequal, the right fully dilated and the left of a natural size; both were insensible to light, and there was no conjunctival reflex; both arms and legs were in a constant state of movement; a slight boggy feeling was detected over the right temporal area. About 9 p.m., after consultation with my colleague, Dr. Bell (to whom I am much indebted for his help), a trephine was applied over the site of the right middle meningeal artery and at once blood clot was exposed; on enlarging the opening a large extravasation of blood was visible, which was washed away with saline solution; as no bleeding point was seen, the opening was further enlarged with Hoffman's forceps towards the zygoma; a bleeding vessel was finally found low down and this was under-run; the flap was replaced and a drainage tube left in the wound, as the brain did not readily expand.

At 5.30 next morning patient could answer questions, although still drowsy. He gradually made a good recovery and has been in full work for three months. There was total paralysis of the third nerve on the right side for a time, but this gradually disappeared.

In this case there was no history as to which side was injured, and both arms and legs were in a constant state of movement; the slight bogginess over the right temporal region and the marked dilatation of the right pupil determined the site for operation. With regard to this dilatation of the pupil on the affected side Jacobson says: "It is a rare but most valuable sign; taken with other evidence of middle meningeal extravasation, this condition of pupil points to a large clot reaching down into the base and pressing forwards on the sphenoidal fissure and thus compressing the third nerve." This was proved at the operation and also by the third nerve paralysis.

There was a well-marked lucid interval of four hours. Miles and Thompson say the prognosis is grave when operation is delayed beyond twelve to eighteen hours; in this case twenty-seven hours elapsed before the man came into hospital.

I am indebted to the late House-Surgeon, Dr. Mactavish, for notes of the case and for his care in the after-treatment.

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Lowestoft.