Some apparatuses are simply stays with supports added to them; but the important thing that should first be attended to in such cases is to see that a girl has plenty of room in her clothes. Make a girl unbutton her clothes and fill her chest by a deep inspiration. You will then often find two inches between the buttons and the button holes. When the dress is fastened it is impossible for her to fill her chest with air, and the first thing is to get rid of this hindrance to expansion. The best method to adopt with such cases in order to secure the filling of the chest with air is to have a rope put up in some convenient place with knots on it. Let the girl, with as little on as may be, try to climb up the rope until she is on tiptoe, then take three deep breaths and let herself down again gradually, and presently repeat the proceeding three times. I am accustomed to write the directions down on paper, and make her keep it in her bedroom. It is well to write these things down with every formality as if it were a prescription. The patients may not carry out your prescription, but they are more likely to do so if you go through the formality.

Next, it is most important that the patient should avoid any habit tending to throw work on one shoulder more than on the other. Too much work should not be thrown upon the muscles of the back. In piano playing, for instance, it is well that the back should have a firm support behind it, and when children play the piano take care that the feet are always upon a stool and not dangling down. Take care also that all writing and drawing is done at a sloping desk, the girl sitting on a chair that is not too high.

With regard to exercise in these cases, if the patient can ride a horse or a pony it is a good thing, but a girl should not always ride with the crutch of the saddle on the same side. Small side saddles are made for children with a crutch that can be shifted.

Shall the girl be made to lie down or not? I believe that lying down is not of the slightest use in these cases. The practice is an old one, and it unquestionably rests the muscles, and it is wise to make a girl lie down for an hour after a ride or walk, but simply to rest the muscles, and not with the view of acting on the spine.

Such is the general treatment of these cases. As far as you can avoid special stays. There are some severe cases which require instrumental supports, especially cases in which bony deformity has resulted from rickets; but you should assure the parents that they are not to cure the disfigurement, but simply to prevent it becoming worse.

Some years ago I served on a committee appointed by the Clinical Society to consider the question of the treatment of lateral curvature of the spine, and I will read to you some of the conclusions we came to.¹

"Cases without Osseous Deformity."—The Committee feel that while gymnastic exercises prove very useful in a great many cases of pronounced lateral curvature by improving the muscular power and relieving pain, yet that it is essentially in cases without osseous deformity, and when the curvature depends on flaccid muscles, relaxed ligaments, and on a general want of tone of the system, that this plan is indicated, and most likely to prove beneficial and even curative. Moreover it seems not improbable that the use of mechanical supports in such cases tends to maintain the curvature by preventing or limiting voluntary muscular action, and thus withdrawing from the muscles their natural stimulus to action and healthy tone. On the other hand, there are cases of lateral curvature in children too young to appreciate the dangers of faulty positions, and too weakly to keep themselves in improved positions after drilling without some extraneous aid. In such cases some means additional to exercises may be necessary to prevent the assumption of these faulty positions.

"Cases with Osseous Deformity."—For cases in which there is more or less well-marked osseous deformity treatment must necessarily vary according to the special needs of the case, a cure of the deformity, or even much alleviation, being quite impossible. In many of these cases the patient complains of pain, which pain is relieved by the use of a well-adjusted support, a fact to which the Committee can testify from personal observation. On the other hand, the Committee have seen great relief to pain afforded by gymnastic

exercises without the use of mechanical supports. It seems very doubtful whether any real or lasting improvement is procurable by any method of treatment whatever in the later stages of such cases."

HYSTERICAL (SO-CALLED) AND FUNCTIONAL DEAFNESS.

By SIR WILLIAM B. DALBY, F.R.C.S.,
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THE "Case of Functional Deaf-Mutism" related by Dr. W. B. Ransom in the BRITISH MEDICAL JOURNAL of March 2nd induces me to offer a few remarks on a class of cases for which I suggest no name for the present, except to say that any definition hitherto in use is not strictly accurate. They are generally spoken of as hysterical deafness, sometimes as functional deafness. I do not for one moment venture to criticise Dr. Ransom's definition of his particular case, but those to which I refer present so many points of similarity that they may usefully be laid side by side with his case in order to elucidate their precise nature. I am sure that Dr. Ransom would not object to this use being made of his case under any circumstances, but it becomes especially valuable for the reason that he adopted probably the only method which would have instantaneously cured his patient, or, speaking more accurately, would have at once put an end to both the mutism and deafness, as indeed it did.

To illustrate my meaning I will briefly relate a similar case so far as the so-termed hysterical deafness is concerned.

Some years ago a young lady, aged 17, in every way healthy, and exceedingly good-looking, was found one morning by her friends to be absolutely deaf to all sound. All communications had to be written, and she replied to them as usual. Her voice was not affected as to tone. After a week or so, she was brought to me by her medical attendant and her mother. The external and middle ear were quite healthy. A great many attempts had been made to try if she could hear anything, on both sides, in front of her, and behind her. But do what they would, she never evinced the slightest perception or gave the slightest start, and they were one and all quite certain as to the complete deafness. I was tolerably familiar with the demeanour and voice of persons who, with good hearing to start with, had suddenly lost all perception to sound, and I was quite certain that this girl could hear as well as ever she did; so I was exceedingly careful not to let her know that I had the least suspicion she could hear, and I explained (in consultation) to the medical attendant what I believed was the state of the case. I suggested that with his consent and her mother's I should arrange that she should suddenly apparently regain what had really not been lost. My plan was simple enough—that she should walk through two rooms into a third, and that as she entered the third room, from a point where she could not see, a gun should be fired. Without any doubt she would then have been so startled that she would have displayed to us all that she heard. From that instant she would no longer have been deaf. For reasons which may have been quite good, my friend objected to this, and especially on the grounds that her mother would never consent to it, so certain was she that her daughter was actually quite deaf. I then said it would be best to apparently accept the deafness as an incurable affection, with the perfect confidence that one day she would appear with the hearing as completely and suddenly restored as it had been completely and suddenly lost. So I saw her no more, but some months afterwards I saw a relative of hers who I happened to know, and he informed me that about six months after my examination she came down to breakfast hearing quite well.

Now, surely this case would be very inaccurately described as "hysterical" deafness. So far as I understand, if a young woman has hysterical paralysis of a limb she firmly believes that she cannot move it, and she cannot until some strong emotional influence has demonstrated to her that she can do so. In the case of a special sense like hearing, the girl cannot be under the impression that she does not hear. She cannot help hearing; it is not a question of loss of power

¹ *Clinical Soc. Trans.*, XXI.

over volition; the function is involuntary; moreover, the function is perfectly performed, so it is just as inaccurate to speak of "functional deafness."

Let me give an example of true functional deafness: A child, who had become intensely deaf without any disease of the middle ear, recovered completely after the evacuation of a large number of lumbrici; the function of hearing had been suspended and restored. I have constantly known hearing suspended under a violent emotional influence, and under many other conditions which I need not mention here. This deafness would be accurately described as functional. What happened with this girl and others like her must surely come under the head of mental. A great mental strain must always have been going on lest inadvertently she should be surprised into evincing some perception to sound, and especially when it proceeded from behind or out of sight. I was much struck by a remark of Dr. Ransom, or rather a footnote, in which he draws attention to the fact of the demeanour not being like a malingerer. This applies remarkably to the girl whose case I mention and to others I have seen.

I have seen malingerers who had a very strong motive to induce people to believe them deaf, and their demeanour was quite different to these girls. Probably she had no motive, or, at least, could not say what it was if she wished to do so, but the fact remains that, unlike the person who really suddenly loses hearing, she retained the most perfect modulation of her voice. From the moment that these girls unconsciously display to the bystander that they hear, the deafness goes. What interested me, therefore, so much in Dr. Ransom's case of the deaf-mute was that when he felt the faradic current through the larynx, and gave the "yell," his voice and hearing, like the girl's, returned so soon as his voice was displayed to the bystanders. There was another point of strong resemblance. In the case of the girl (as I mentioned) the voice retained its perfect modulation; for how should she know that this would have become altered if she suddenly lost all hearing? Whilst in the case of the boy who became the deaf-mute, he was unable to emit any sound—surely the oddest kind of deaf-mute; but how should he know that deaf-mutes, whilst unable to articulate, are most noisy, and emit all sorts of inarticulate sounds? Another odd point of resemblance in all these cases is this: They are all right the night before, and always discover themselves to be deaf in the morning, when they awake and are alone. The persons who really suddenly lose all perception to sound do so at all sorts of times, and often in the presence of other people.

Dr. Ransom says, "although the deafness was not absolute when the patient came to the hospital, yet severe tests, such as the cannon, showed it to be real," and, previously, "he gave no sign of hearing a cannon let off close to him on November 5th." In reference to this, I must say that in the cases of which I have made mention the subjects who heard well would also have given no sign of hearing a cannon if they knew it was going to be fired and could see it. But if they saw no cannon (or gun, as the case might be), and the explosion was quite unexpected and near to them, they would have displayed unmistakably to the bystanders that they heard it.

The position, therefore, resolves itself into one of two, and I am prepared to accept Dr. Ransom's opinion in either case. First, he heard the cannon and showed no sign of hearing it. Then his case comes at once into the same category as my cases. Or, secondly, he did not hear the cannon. The function of hearing had been lost, and was restored instantly by the electric shock through his larynx. In the latter case it is a unique instance, and the like of which I have hitherto regarded as impossible to bring about.

Cases of this kind are sufficiently rare to make it most important that each one should be recorded, as every fresh one not only throws new light on the subject, but in those instances where the hearing is really lost either for a time or permanently they help to show what I have for long maintained, that the sense of hearing is often apt to be lost from emotional causes, although I am quite unable to offer any reasonable explanation, and have strictly limited myself to suggestions for the consideration of others. They also help to show that there can be no true hysterical loss of hearing any more than there can be a hysterical loss of smell or of any other special sense.

REMARKS

ON A

SERIES OF THIRTY CASES OF MOVABLE KIDNEY TREATED BY OPERATION, WITH THEIR RESULTS.¹

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THE completion of a series of thirty cases of nephrorrhaphy seems to me to be worthy of record. The value of the operation has sometimes been called in question. I am anxious, therefore, to record with their after-history, so far as I have been able to learn it, the ultimate results of these thirty operations.

Very nearly two years ago, in a paper which I had the honour of reading before the Fellows of the Royal Medical and Chirurgical Society, I drew attention to a class of cases of movable kidney which had hitherto attracted but scanty notice in this country, and in which very severe pain was one of the prominent features. From the pain and other acute symptoms which determine these attacks, it seemed all but certain that a sudden displacement of the kidney from its natural bed must be their determining cause, and that the term "acute renal dislocation" would best describe what took place, and what indeed was essential to the production of the symptoms in question.

Such cases form only one variety of floating kidney, though a further and more extended experience of what may be described as the more common variety of this condition has forced on me the conclusion that it is rare to come across any case of the kind in which pain has been completely absent throughout; and of the reality of these attacks of pain, when once they are witnessed, there can be no possible doubt. The question to be determined is what is the probability of a successful result if an operation be performed. The immediate result in all my cases was a successful one, and, so far as I have been able to learn, every one of my patients is alive at the present moment.

In by far the great majority of these cases pain has been the prominent feature, and the severity of the pain has led to the demand for its relief. The special character of the pain was described at some length in my previous paper before alluded to. Suffice it here to say that the pain usually begins without any warning, sometimes in consequence of a strain or some severe exertion occasionally after injury. It is often attended by vomiting, and later on usually gives rise to local abdominal tenderness. The duration varies from a few hours to a day or two, and in some instances it may be cut short by manipulating the affected kidney, in other words, by reducing the dislocation. The condition of the urine during and shortly after the attacks varies greatly. It may be scanty and blood-stained, or almost porter-coloured, like that which is passed in acute Bright's disease, whilst in the less severe cases it is more commonly quite unaltered.

In some of the cases here related the pain was far less acute. It was described by the patients themselves as consisting of a dull ache, which rarely left them free from a sensation of uneasiness in the loin, and was usually aggravated by hard work or exercise of any kind. This class of case in women is almost invariably attended by more severe pain at the monthly periods, but I have never come across any instance in which the urine was blood-stained or much altered in condition in cases of moderate severity. In many of my cases, during the interval between the attacks, the kidney, even when the patient complained of no pain, was unduly tender to palpation.

Several of the cases referred to in the table on page 577 present points of special interest; I will therefore refer to certain of them *seriatim*, and afterwards state briefly the conclusions which seem to be deducible from them.

Cases I and II both occurred at the West London Hospital,

¹ Read before the Medical Society of London, March 11th, 1895.