thirteen or fourteen months earlier he had suddenly lost speech and hearing, and that a doctor put something in his ears, and "blod" (*sic*) for about ten minutes, when he as suddenly and completely recovered.

Wishing to observe the patient's gait more closely than I had done at first, I asked him (in writing) to walk away from me, and when he was a little more than half way across the messroom, I called loudly, "Now come back!" expecting that one of his mates would turn him back; but to my surprise he turned of his own accord; and another order, loudly and clearly uttered, was promptly obeyed. I now remarked in a loudish tone, "You hear me now?" He nodded. "Tell me your name." He shook his head. "Say One, two, three." He opened his mouth and made two or three feeble and utterly soundless efforts, then shook his head again. "Say Ah!" After an apparent effort, he got out a whispered and only just audible "Ah." "Say Eee." Again a whispered but correct sound. "Say your name." [Brown.] A sort of whispered stutter, getting as far as B-r—, was the only response.

Being doubtful of the true diagnosis, I asked the captain to have the boy sent up next day to my office for more searching examination; and in the meantime ordered him some iodide of potassium (which I found in a medicine chest on board), on the vague possibility that some form of incipient cerebral syphilis might be at the bottom of the symptoms. I admit that this was unscientific procedure, but under the circumstances it seemed better than doing absolutely nothing. Before leaving the ship, and while conversing with the captain in the saloon, I was informed that the patient had asked audibly for a cup of tea.

The next day, at 2 P.M., the lad came to my office (accompanied by a sailor), hearing and speaking as well as ever in his life. Nothing abnormal (except slight exaggeration of the right knee-jerk) was to be found anywhere, not even by ophthalmoscopic examination. The statements of the evening before as to a previous attack were repeated *vivâ voce*. That attack, he said, occurred at his home in Southampton, but I carelessly neglected to ascertain the name of the physician who cured him by "blowing into his ears." The diagnosis of functional deaf-mutism was made, and the patient dismissed with a prescription for sodium bromide and ammoniated tincture of valerian, to be taken for a week, together with the application of a blister to the nape of the neck; and with some plain speaking as to the abuse of tobacco and coffee, to both of which he was addicted, and as to the dangers of sexual excess. The latter he denied, though one of his comrades was convinced that he had abused himself in this respect, and one of the officers told me he was sure the boy masturbated habitually; he certainly looked as if he did.

This case agrees closely with that reported by Dr. Ransom in the BRITISH MEDICAL JOURNAL of March 2nd, in several particulars, notably in the absence of features or circumstances suggestive of conscious fraud, and in the fact that the deafness was not absolute, and that both aphasia and aphonia were for a time complete. The chief point of difference lies in the more speedy but gradual recovery of my case.

I do not know whether Sir William Dalby would admit this case as one of true functional deafness, but in the absence of evidence of organic disease or deception, voluntary or involuntary, I do not know what else to call it.

I regret that the departure of the patient for Southampton the day after my second examination makes it impossible for me to follow up the case and report the subsequent history.

SULPHIDE OF CALCIUM AS A PROPHYLACTIC OF INFLUENZA.

By W. E. GREEN, M.R.C.S.,
Surgeon to the Isle of Wight Railway.

DR. J. SINCLAIR COGHILL has contributed a valuable paper on the prophylaxis of influenza by means of a large daily dose of quinine, which is undoubtedly one of the most valuable methods of treatment, but knowing that it is not everyone who can take quinine I resolved, when the first epidemic

visited us, to try a daily dose of 1 grain of sulphide of calcium. All my household took it with the exception of two servants, who for some reason or other did not, the result being that all escaped but those two exceptions.

The next year, when the epidemic again broke out, I asked the authorities of the Isle of Wight Railway to supply all their *employés* with the pills, and all who took them regularly escaped. The manager of the Central Railway also asked me to supply his men with them, and he afterwards informed me that as far as he could ascertain none of the men who had taken the pills regularly had had influenza.

During the next outbreak the pills were again given with like results, but on the Isle of Wight Railway they were not given out to each workman as formerly, consequently but few took them, and the result was that a large number of influenza cases occurred amongst those who had not used the remedy.

During this epidemic I also had an attack from having neglected to take the medicine until a day or two after the symptoms appeared.

I can certainly speak from much experience of the efficacy of this remedy, having ordered it to numerous patients with the most satisfactory results.

It takes about three days before the system becomes sufficiently saturated with the drug to prevent infection, therefore it is rarely of use to those who have already been exposed to it, though even then it appears to modify the attack. When a case appears, I believe the 5-grain dose of quinine to be more rapid in its action than the sulphide of calcium, and therefore safer to give, but should afterwards carry on the effect with the sulphide of calcium, which I feel sure is equally efficacious and much easier for many to take, as it never appears to disagree in any way, although continued regularly for many weeks.

I had a case of influenza a few days ago in a patient who had been taking 12 grains of quinine regularly every day for some weeks, and I have also seen it occur in others who have been taking daily doses of simple sulphur, with the idea of preventing influenza. I believe its *modus operandi* to be that it renders the blood unfit to receive and support the influenza bacillus.

CASTRATION FOR ENLARGED PROSTATE.

By A. G. FAULDS, M.B. GLASG.,
Assistant to the Professor of Surgery, St. Mungo's College, Glasgow.

I HAVE read with great interest the articles on castration as a treatment for enlarged prostate in recent numbers of the BRITISH MEDICAL JOURNAL.

My object is to draw the attention of surgeons to a certain contingency, always grave and often (in my experience) fatal, which should be taken into account before deciding on what is surgically a simple operation. I am indeed surprised at the published statements of Dr. J. W. White, of Philadelphia, and of Dr. E. Hurry Fenwick. The first-named cites thirty cases, all successful; the latter gentleman nine cases, of which number seven are reported as successful, that is, where benefit resulted without mishap. Would it not be educative and equally important to give the details of non-successful cases? With this object I give the following black list:

CASE I.—J. N., aged 66, had endured a catheter life of three years. When examined the residual urine drawn off was nearly 12 ounces, mixed with pus and blood. The prostate was very large, so that its upper limit could scarcely be reached through the rectum. With the assistance of two resident medical officers of the Glasgow Royal Infirmary I operated on December 24th, 1894. Healing, etc., were most satisfactory, but though about a week after dysuria was mitigated on January 19th hemiplegia occurred, with death on the day following.

CASE II.—J. M., aged 71, was castrated by me on January 3rd. Six days later he presented the signs of acute mania, and on January 13th died.

CASE III.—I was asked by a medical friend on January 12th to see a case of enlarged prostate. The patient had been abroad, and for six years had suffered dysuria, with the passage of pus and blood. I ascertained these to be the consequences of enlarged prostate, and operated. A week after

operation the patient became somewhat childish, mania appeared, and death occurred on the twelfth day after castration.

CASE IV.—About this time my attention was called to a case in one of the large Glasgow hospitals. It had been decided to perform orchectomy for enlarged prostate with consequent distress. The operator was a surgeon of large experience, for whose skill I have the highest admiration. A few days after castration the patient exhibited acute mania and died.

CASE V.—A. M., pensioner, had suffered all the distress attending an enlarged prostate for four years, for which he had undergone much unsuccessful treatment at various hospitals. I proposed castration, explaining the dangers such an operation would incur. I castrated, and though I have noted no psychical phenomena as in former cases, thirty days have passed without appreciable mitigation of the urinary trouble.

CASE VI.—My friend and teacher Mr. H. E. Clark, of the Glasgow Royal Infirmary, having taken into account the foregoing cases, determined to try a single orchectomy on the next case that presented, to the end that he might get such partial atrophy as would alleviate symptoms at a minimum risk. The patient died, however, in a few days in a state of mental aberration.

Moreover, I am permitted to refer to a private case of Mr. Clark in which perineal section had been performed to ensure rest and drainage for the bladder. The removal of one testicle was followed by distinct mental weakness and death.

Now in all these cases the patients had been brought to the best possible state of health; some had been relieved, so far, of bladder and kidney disturbance by perineal section, all with the object of minimising the immediate and remote effects of the operation.

I know that in operations other than castration the manical condition may supervene, as, for instance, in a debilitated patient with disordered kidneys after undergoing oöphorectomy. I acknowledge what was known years ago that in some animals castration was followed by prostatic atrophy, but the subjects of such experiments were young and sex not matured. I have good reason for saying that the result—that is, dwindling of the prostate, in part or general—does not invariably follow castration. I have castrated young men for tuberculous disease of the testicle. One case I can recall in which the second testicle was removed one year after the first. This case resulted neither in prostatic atrophy nor in psychical change. Nay, but a few days since a *post-mortem* examination was held in the Glasgow Royal Infirmary on the body of a man who had been castrated five years ago; the prostate was that of unchecked virility.

Now, I consider that in the present state of our knowledge we are not justified in removing the testicles at the risk of precipitating mania or dotage. To my mind, the *post-mortem* appearances of some of the prostates have been more of a cirrhosis than a true glandular enlargement, and this would explain how the muscular fibres could not contract during micturition, and therefore failed to assist the detrusor at the end of micturition. Thus residual urine accumulated. Until the physiologists can more accurately explain the relation between prostate and testicle, show, in fact, wherein their functions become common or most nearly approximate, and until they can show the relationship between the functional group and the higher and lower nervous centres, we are not, in my opinion, justified in operating thus.

ON THE FREQUENCY OF MOVABLE KIDNEY.

By STUART TIDEY, M.D.LOND., M.R.C.P.LOND.,
Florence.

I HAVE read with much interest the successive records of the operative treatment for movable kidney. That the condition is frequently overlooked I infer from the fact that several of my cases had sought advice repeatedly for the associated symptoms and had been treated for intestinal or nervous disorders. I can call to mind 7 cases of movable kidney, of which 1 only had been previously recognised. Of the 7 cases, 1 was a male, the remainder female patients.

The male patient was 33 years of age. He was a keen otter hunter, and had been subject to frequent and prolonged immersion in water, and had also done a good deal of rough pony riding. The symptoms were mental depression and languor, flatulence, and tendency to diarrhoea. The urine contained a small quantity of albumen, varying from $\frac{1}{4}$ to $\frac{1}{5}$. The left kidney descended considerably below its normal position, and slid away in the characteristic manner when the lower end was compressed between the fingers of the two hands. The question naturally arose whether this was a case of incipient Bright's disease or of mechanically-produced albuminuria. An eminent London authority on renal (and many other) diseases decided in favour of the second alternative, and advised the continuance of the pad and belt which the patient was wearing. The symptoms generally improved; albumen was frequently absent from the urine, and the patient was mentally relieved by the knowledge that the indefinite symptoms were due to a mechanical condition and not to some mysterious disease. It is now three years and a-half since I first saw him, and I gather from his letters that the mental and bodily conditions are both more satisfactory now than then.

My first female case was an ayah travelling in Europe. She was seized with renal colic, and the attack was followed by a copious discharge of gravel. She had had one or two similar attacks previously, and the kidney was very movable. I attributed the accumulation of gravel and consequent colic to dislocation of the kidney. A pad was applied, but I have no further record of the patient. I met with another case in a young lady travelling with a trusted maid as companion. The maid had been instructed to pay as little attention as possible to the young lady's complaints. The latter called on me one day complaining of pain in the right iliac region. She had a history of recent gastric catarrh. I examined the abdomen thinking there might be some chronic perityphlitis, but instead of this I found a movable right kidney. I explained the state of things, and here again the knowledge of a mechanical cause for the train of symptoms was a source of great relief to the patient.

Recently I have met with two cases of movable kidney, both in young women and both associated with localised pain, neuralgia, and derangement of bowels. One patient has a strong family history of malignant disease, and was much relieved when I explained the cause of her symptoms. The second had vague ideas of incipient something, and was glad to know that even if the symptoms were progressive there was a fairly certain means of permanent cure.

The following considerations seem to me worthy of attention: 1. That though the individual symptoms, namely, localised pain, mental depression, neuralgia, and intestinal irregularity are indefinite, yet, when associated, they form a fairly characteristic clinical picture. 2. That the pain is often not in the kidney itself, but in the structures irritated by its abnormal mobility, of which the genito-crural nerve appears to be an important one, and may possibly be the afferent tract where reflex neuralgia is a prominent symptom. 3. All my female cases (possibly excepting the ayah) were nulliparous women, and I have been unable to trace any causal relationship with tight lacing. On the other hand, four of the cases occurred in patients who had indulged in violent exercise, such as running down the Righi to Viznau, donkey-riding, pony-riding, and pedestrianism generally. 4. What treatment short of operative interference is likely to lead to permanent relief or cure? The prospect of wearing a pad indefinitely is not satisfactory; to forbid exercise is paving the way to troubles innumerable, and to treat symptoms is to beg the question of treatment altogether. Recently, I have prescribed exercises with a view to strengthening the lumbar and abdominal muscles, together with a liberal diet and appropriate treatment of the digestive organs.

PRESENTATION.—Dr. Tomory has been presented with a purse of sovereigns as a mark of the great respect and esteem in which he is held as a medical officer in Halkirk and the surrounding districts.

A LABORATORY for the preparation of antitoxin is being fitted up in the Willard Parker Hospital by the New York City Board of Health at a cost of 5,000 dollars (£1,000).