3566. Ephemerides, [1895–] 1897, I–XXII. 1a. 8°. [*Montreal*, 1895–8.]

Notes and comments on cases, contributed to the Montreal Med. Jrnl., vols. 24–7. Nos. I–XVIII are not the original issues but proof-sheets paged consecutively (for a reprint); nos. XIX–XXII are extracted from copies of the Journal.

T title in the Journal
is 'Ephemerides, 1895'

Offprint from Trans. Ind. Grad

throughout
even in
the 1898
initial
work

vol 24, Dec 1895, p. 518, the 'Ephemerides' is
in Gothic, and instead of the name
is 'By William Osler, M.D.

EPHEMERIDES.

I.—Introduction.

With the kind consent of the editors I propose to occupy a few pages of the Journal each month with notes and comments on some of the more interesting cases which came before me in the daily round of consultation work last year.

In looking over my notes I find certain cases in which the visit has been of vital moment to the patient, usually in making a diagnosis, upon which successful treatment directly depended, as in myxœdema or pernicious anæmia. In a very much larger number there has been some important suggestion to make, either in prognosis or in the management of the case; while in others the chief value of the consultation has been in a reasonable talk with the patient about his condition, with assurance that there was nothing serious, and general advice as to mode of life and diet. Coleridge somewhere remarks that when a man is vaguely ill the talk of a doctor about the nature of his malady tones him down and consoles. It is very true, and to tone down and console are important functions of professional advisers.

There is a group of cases in which the physician seeks counsel on account of some special obscurity in the disease, an obscurity which may not be lightened by the consultant after the most careful scrutiny. Not to receive the positive information they seek is often a great disappointment to both doctor and patient, but we must remember that there are—changing slightly Sir Thomas Browne's phraseology—cases indissoluble in physic, and a diagnosis is not possible in every instance. Frankly to confess ignorance is often wiser than to beat about the bush with a hypothetical diagnosis.

A consultant's life is not without unpleasant features, chief among which is the passing of judgment on the unhappy incurables—on the cancerous, ataxics, and paralytics, who wander from one city to another. Few are able to receive the balm of truth, but now and

again one meets with a cheery, brave fellow, who insists upon a plain, unvarnished statement of his prospects. Still more distressing are the instances of hopeless illness in which, usually for the friends' sake, the entire "faculty" is summoned. Can anything be more doleful than a procession of four or five doctors into the sick man's room? Who does not appreciate Matthew Arnold's wish?—

> "Nor bring to see me cease to live
> Some doctor full of phrase and fame,
> To shake his sapient head, and give
> The ill he cannot cure a name."

How often under such circumstances has the bitterness of the last line recurred to me! Oliver Wendell Holmes, in the *Memorial History of Boston*, speaking of two of the leading physicians of the early part of the century, says, "I used often to hear him (Dr. Danforth) spoken of as being called in 'consultation,' as the extreme unction of the healing art is called. If 'old Dr. Danfurt' or 'old Dr. Jeffers' were seen entering a sick man's door it was very likely to mean nothing more nor less than a *nunc dimittis*." 'Tis not pleasant to think that *pallida mors* so often treads upon our heels.

There is nothing new under the sun, and the common practice of friends who, wishing to leave nothing undone, call in a batch of consultants is by no means modern. In the delightful lectures on *Latin Poetry*, delivered in 1893 at the Johns Hopkins University, Professor Tyrrell, of Dublin, quoted a long passage from the "Satyricon" of Petronius. The friends were discussing poor Chrysanthus, who had just "slipped his wind." Seleucus says, "and it is not as if he hadn't tried the fasting cure. For five days neither bit nor sup passed his lips, and yet he's gone. Too many doctors did for him, or else it was to be. A doctor's really no use except to feel you did the right thing." The last sentence might have come from George Eliot or George Meredith.

The value of careful note-taking is recognized by most consultants. I know, however, several men in large practice who have discarded it as altogether too onerous, and as taking up much more time than it is worth. The material which an active consultant may collect in a long life is enormous. The late Dr. Austin Flint's notes cover 16,922 folio pages, all written with his own hand. The late Dr. Howard constantly lamented that the leisure never came in which he could work over the clinical records which he had so faithfully kept for so many years.

A case cannot be satisfactorily examined in less than half an hour, unless the notes have been taken previously by an assistant, a plan

which consultants in very large practice might adopt more widely. A sick man likes to have plenty of time spent over him, and he gets no satisfaction in a hurried, ten or twelve minutes examination If one never saw a patient the second time, notes might be superfluous, but can anything be more embarrassing in a return visit than to have forgotten name, face, malady, everything? At such a moment well indexed notes are worth their weight in gold. Last year I had a notable illustration of the value of memoranda, however slight. Dr. Bray, of Chatham, brought a patient, whom from certain peculiarities I remembered at once, though nearly twelve years had elapsed since I had seen him. In 1883 he had, at Dr. Bray's suggestion, consulted me in Montreal Fortunately I was able to lay my hands at once on the notes of the case. The point of interest in 1883 was whether the impotence was an early tabetic symptom, an opinion favoured by Dr. Jewell, of Chicago, and by a New York specialist whose name I do not remember. In the twelve years the patient's condition had remained unchanged, and many of the symptoms which he thought were of recent origin had been present at his first visit. Neither the patient nor Dr. Bray had any recollection of a previous consultation with me, of the truth of which only my notes convinced them.

The histories may be taken very conveniently on the cards of the Boston Library Bureau, and filed away alphabetically. I have had much comfort since the adoption of this plan. It is a great saving of time and labour to dictate the condition of the patient to a stenographine, who can (if the arrangement of the consulting rooms is not convenient) be secluded behind a screen. She can afterwards add the notes to the card on which the history has been taken.

For several years I have adopted the plan of dictating at odd times abstracts of the histories of special cases and filing them in order ready for publication. In this way, when noting carefully during the session of 1892-93 all the cases of abdominal tumour which came before me for diagnosis, I had, in October, 1893, when I began the series of lectures which have been published, all the cases type-written and ready It has always been a regret to me that I had not learned stenography which Dr. Gowers has found so serviceable, and the use of which in medical work he has advocated so warmly.

II.—Heberden's Nodes.

I thought that the nature of Heberden's nodes had been settled and it was a great surprise to find in that delightful work, *The Senile Heart*, by Dr. Balfour, statements entirely at variance with what I had been taught, and have taught for many years.

Heberden's original description is worth quoting: "What are those little hard knobs, about the size of a small pea, which are frequently seen upon the fingers, particularly a little below the top near the joint? They have no connection with gout, being found in persons who never had it; they continue through life; and being hardly ever attended with pain, or disposed to become sores, are rather unsightly than inconvenient, though they must be some little hindrance to the free use of the fingers.'

All recent authors speak of these *nodi digitorum* as identical with the bony outgrowths of arthritis deformans. Charcot, who gives a very full description of them, states, as a result of numerous observations at the Salpètrière, that, (as in the other forms of chronic arthritis) the cartilages undergo a velvety change, and may even disappear, and leave an eburnated surface. The nodes are exaggerations of the little pisiform nodules which exist normally on either side of the lower extremity of the second phalanges. He expressly states that they are composed of layers of new bone; that there exists no trace of urate of soda, either in the cartilages or in the neighbourhood of the joints, or in the soft parts (*Œuvres Complètes*, J. M. Charcot, VII. p. 255). In Figures 5 and 6 of Plate 1., he gives good illustrations of the nodes.

Balfour expresses an entirely different view. "For diagnosis, however, and certainly for treatment, we have to distinguish between Heberden's *knobs* and Haygarth's *nodosities*. The *knobs* are extravascular deposits in the neighbourhood of the smaller joints, chiefly of the fingers, but they may be found about the toes also, and appear as gouty pearls on the cartilage of the ear. They begin like small peas, or at least are scarcely noticed till they are about this size, but they sometimes attain a considerable size, and produce great and irregular deformity of the hands or other parts affected; they are composed of urate of soda, and are popularly know as chalkstones The *nodosities*, on the other hand, are associated with rheumatoid arthritis, and not with gout; they are really 'exostotic growths, from the margins of the articular surfaces, as well as from the periosteum and bone in the neighbourhood of the diseased joints.'" Either the distinguished Edinburgh physician has been napping, or there are many rash statements on the subject in the text-books.

In an immense majority of all cases these little nodules have surely no connection with gout. They are extremely common in this country, in which gouty arthritis is very rare. Charcot states that in a few instances they do occur with uratic deposits (tophi). I have personally never met with an instance of the kind, and should be glad to

Oplacencia, 1895.

By William Osler

hear of any observations of the existence of Heberden's nodes with tophi.

Of six private patients with Heberden's nodes seen last year not one had had gout. Two of the patients, a woman aged 50 and a man aged 70, had been "high livers," and the former had an eczematous rash. Two of the cases were of special interest. In one, a woman aged 30, the trouble began in her 25th year and involved the index, little and middle fingers of both hands; the ring fingers were spared. The *nodi* were very pronounced. The patient had no rheumatic history and had been very healthy. The other case, Mrs. H., aged 73, illustrates the deforming character of this local arthritis in some instances. They developed gradually many years ago with a little redness and soreness. Only the terminal phalanges of the fingers were involved. Other joints have not been affected. The thumbs were also involved. In three of the fingers anchylosis of the terminal joints had occurred, and in four of the fingers the terminal phalanx was strongly everted to the ulnar side. Only one of these cases consulted me on account of the nodes. The rarity of extension of the arthritis to other joints in these cases is notorious.

III. Geographical Tongue.

Rayer's linguaı pityriasis—eczema of the tongue, exfoliative glossitis, of other writers—is not a very uncommon affection, and rarely of much moment, lasting from a few weeks to a month or two. Occasionally, as in the following cases, it is very protracted and intractable, and a source of great worry.

Mrs. W., aged 65, wife of a physician, seen on several occasions throughout the year. She first came under my observation on March 3rd, 1894, complaining of a peculiar disease of the tongue, associated with a burning sensation. The condition had persisted at intervals since April, 1893. I dictated the following note at her first visit: "The tongue is not enlarged. The dorsum presents a number of irregular, somewhat serpiginous abrasions, the edges, for a couple of millimetres, look whitish and infiltrated. The papillæ, however, are not destroyed, and it is only the superficial layer of epithelium which is removed. About a third of the dorsum is occupied by these patches. She says that sometimes they are entirely covered by the greyish white material. Towards the left side of the tip there are three or four rounded patches with small, red, central depressions which look like the beginning of the trouble. There is no induration. Far back on the left side there is a patch in which there are one or two small hæmorrhagic papillæ, but here, too, there is no induration."

She says that when first noticed the disease was at the tip and was not painful. She had been of late greatly distressed about it, particularly as she has dreaded that it might be the beginning of a cancer. Her husband had taken her to a number of physicians without getting any satisfactory account of its nature, and a surgeon had suggested that it might be the commencement of malignant disease.

As there was evidently a strong nervous element in the case, I assured her that it was not likely to lead to anything more serious. The application of a twenty grain solution of nitrate of silver twice a day gave her great relief, and for several months she thought she was cured. In September of 1895 the burning feeling in the tongue returned, and the patches were again very well marked.

On January 24th, 1895, the tongue was covered with irregular serpiginous patches with depressed, smooth, denuded centres and greyish white margins. The use of the nitrate of silver was resumed. and she was ordered iodide of potassium. She improved very much, and throughout the summer remained well. In October the trouble began again. The burning feeling was very distressing, and hot things and many articles of food caused very unpleasant sensations.

I saw this patient a few weeks ago, and she was still troubled with occasional patches.

The condition has now recurred at intervals for nearly three years.

A few weeks ago I received a letter from a naval surgeon of the Pacific Squadron, asking information about the case of a brother officer. His description is so accurate and careful that I quote part of it, inasmuch as the diagnosis is to be readily made from his account. "The papillæ of the tongue are very prominent ; three longitudinal fissures traverse the organ ; one in the centre ; one on either side, each with lateral fissures. Opaque, whitish patches, linear and semi-circular in shape, begin in the fissures and soon spread over the dorsum, always with semicircular outlines. The patches grow larger, widening as they pass, until they reach the under surface of the tongue, when they disappear. The mucous membrane over which the patches have passed and are about to pass appears perfectly normal. Fresh patches are sure to form again. From four to six days is the natural existence of any one of them. Curiously enough, the patches are limited to the right half of the tongue. There is no pain, but the patient complains of a dry, chipped feeling, especially in the morning, when the white patches are more marked. The suffering is more mental than physical, inasmuch as the patient fears the development of an epithelioma."

The irregular patchy appearance of the surface of the organ gives

a certain resemblance to a map—hence the name "geographical" tongue I have never known an instance in which it was so persistent and the cause of so much suffering as in Mrs. W.

IV. Buccal Leucoplacia.

Buccal psoriasis, or keratosis mucosae oris, offers many perplexing problems to the physician. The two cases I here report illustrate very different types of the disease, the one characterized by much irritation, sometimes swelling, and an extensive patchy leucoplacia; the other represented by a small, opaque white, corn-like thickening.

Lieut. A., U.S.N., aged 45, was referred to me May 10th, 1895, by Dr. Beyer, complaining of a sore tongue of six years duration. The patient first noticed a little 'canker sore' on the right side of the tongue. It soon disappeared, but shortly afterwards the tongue became so painful and swollen that he could scarcely eat.

The patient has always been a vigorous, healthy man. In 1881 he had a primary, syphilitic sore, with very slight eruption after it. He was thoroughly treated; married in 1889; has no children. He has been a smoker for years, but on account of his tongue has had to give it up except at intervals. In the summer of 1892, a moist, patchy eruption came upon the head, and appeared at intervals for nearly two years. With this exception he has had no signs of syphilis since 1881. He has been a temperate man; he has never had the gout. The trouble with the tongue has occurred at intervals since 1889. The condition on examination was as follows:

He is a healthy-looking man of good colour. There are three little nodules on the margin of one ear, not chalky. There are longitudinal ridges on the nails. The mucous membrane of the lips and of the gums is normal. On each side, just within the frœna of the lips the mucous membrane for 1 cm. from the edge is thickened and greyish white in colour. This condition, the patient says, comes and goes with the soreness of the tongue; and these patches may appear at the angle of the mouth before the tongue gets sore. They have extended so as to be visible at the outside. The mucosa covering the cheeks and palate is perfectly normal.

The dorsum of the tongue presents one long central fissure with numerous lateral ravines. On the left half there are three parallel fissures, on the right two longitudinal furrows. Towards the root of the tongue the fissuring is very irregular. The general surface is reddened and the papillæ are well seen, nearly all of the simple form. In the central portion and along the median fissure the mucosa is smooth, glossy, and in places thickened, here and there quite white.

Far back, on the right side there are several well marked patches of leucoplacia, and a small, firm, projecting body, like a wart. The margin of the tongue and the lips are smooth. The mucosa looks a little denuded, but not specially red or raw. At the left margin of the tip there is an opaque, white plaque. On the under surface of the tongue on the left side near the frænum there is a small. slightly projecting, opaque portion of the mucosa.

He says that at present the tongue is nearly well. He gives, however, an account of the remarkable influence of certain substances. Smoking in the present state of the tongue does not appear to irritate it in the slightest. Milk, coffee, whiskey, or any alcoholic drink excites superficial inflammation with a good deal of swelling. In some of these acute attacks the tongue becomes so much swollen that he can scarcely masticate. He has to be particularly careful about his food, taking a very plain diet The influence of milk is, he says, most extraordinary. He has tried it a dozen times within the past four years, and on each occasion it has excited a good deal of swelling and soreness of the tongue. If after an indiscretion the tongue becomes swollen, he takes calomel, from two to four grains for three nights in succession, and the condition of the tongue begins immediately to improve. The present state causes him no anxiety whatever ; his only worry is lest any food should accidentally light up the superficial glossitis, as during the acute attacks the tongue is swollen, red and very painful. He does not think that the white patches have increased much within the past two years.

The following case represents a very different form of leucoplacia, one to which the term lingual corn is more appropriate.

Captain X., of the British Army, aged 41, consulted me March 12th, 1895, about a patch on the dorsum of the tongue, which had been worrying him for six months.

He is a large framed, healthy looking man. He has always been very well and strong. He has been a moderate smoker (pipe); lately he has been smoking cigars, one or two a day.

About twenty years ago he had a soft chancre which was followed by buboes, but there was no secondary rash. About two years ago he had a little raised sore on the under surface of the left side of the tongue, which caused him a good deal of worry. There was some doubt about its nature, but he was given iodide of potasium and it disappeared gradually.

The present trouble began about six months ago, when he noticed the spot about to be described. He does not think it has increased much in extent.

On the right side of the tongue, about 4 cm. from the tip, and 2 cm. from the median line, there is an opaque white spot, exactly 5 mm. in length by 4 mm. in width. It is not raised above the surface and is not ulcerated. Behind and at the sides it passes uniformly into the mucosa ; in front it is separated by a small, narrow groove. It is everywhere opaque white on the surface, perfectly smooth, feels horny, not rough, and on pressing it between the thumb and finger laterally it apparently has no great depth, and it does not feel indurated. It resembles a small, localized spot of leucoplacia. Just behind it there is one little accessory spot about half the size of a pin's head. The other parts of the tongue are perfectly smooth and clean. The glands beneath the jaw of the right side are not enlarged.

A thin shaving, taken from the spot, showed nothing but flattened scales of epithelium. The patient has had, at intervals, for four or five months, pains in his bones, particularly at night. He has been taking iodide of potasium for between two and three months, but without special benefit, and without any change in the local condition.

The patient was given a favourable prognosis, and urged to continue the iodide for three months, and then, if not better, to have the spot excised.

The association of leucoplacia with persistent smoking has long been recognized. (Smoker's tongue.) As in the cases I here report syphilis is a common antecedent, though the relation between the affections is very obscure. One of the most obstinate and extensive instances I have ever seen was in a man who had not used tobacco, and had not had syphilis. The mucous membrane of the cheek on the left side, almost from one alveolar fold to the other, was represented by an opaque white patch of about the appearance and consistence of a 'milky patch' on the pericardium. The condition caused a great deal of mental worry and distress, and the patient consulted several physicians both in this country and London without getting any satisfaction as to the nature of the trouble. After lasting for more than a year it gradually disappeared and he has never had a recurrence.

A very much more serious matter is the relation of these patches to epithelioma. About one in five of Butlin's cases of epithelioma were preceded by leucoplacia. With such a percentage, when the patches are localized, as in the second case I mention, excision should be advised.

V. Acute Gout in the United States.

The comparative infrequency of acute gout in this country is a matter of every-day comment. In hospital statistics, and in bills of mortality the disease is mentioned but rarely; thus, it does not occur among the causes of death in the Report of the Medical Officer of Health of the City of Baltimore for 1894.

During the past year I asked all private patients most particularly about the occurrence of attacks of gout, and have examined in each instance the ears for tophi. There were only three cases in which gouty arthritis had occurred, and in only a single instance were tophi present about the joints or ears. During the session of 1894–95 I had in the wards four cases of gouty arthritis at one time, a unique event in my hospital experience.

Considering how careless Americans are about their diet, and the enormous amount of animal food which they consume *per capita*, and the widespread prevalence of the so-called acid dyspepsia, the absence of the severer manifestations of gout is very remarkable. The average American of the upper classes is a very much more temperate man than his trans-Atlantic cousin. The club man, too, who drinks to excess, prefers as a rule whiskey to the malted liquors or the stronger wines. I have sometimes thought that in the gout of this country the question of alcohol is of minor importance; the three patients referred to who had acute gouty arthritis were quite temperate. In considering the apparent infrequency of gout the failure to recognize the condition must be taken into account. I have known cases to be mistaken for rheumatism, even with well characterized chalk-stones on the knuckles and tophi on the ears.

The importance of asking very specially about the occurrence of gout is well illustrated by the following case:

A physician, aged 44, who had been for fifteen years a very hard-working man in one of the tenement districts of New York, consulted me May 21st, 1895, complaining of shortness of breath on exertion, which had first developed in October, 1894. In his family and personal history there were apparently no etiological factors of any great importance. He had never had syphilis or rheumatism. He had been an abstemious man, but had worked very hard. He presented all the features of advanced arterio-sclerosis, with hypertrophy of the heart, and the usual accompanying changes in the urine. There was no retinitis.

I had finished the examination, and, as he knew quite well the serious nature of the trouble, was discussing with him the possible

cause of his kidney and arterial changes. I had forgotten for the moment to feel his ears, but on doing so found on one ear three small white nodules on the edge of the helix, towards the tip, most suggestive of commencing tophi. I then asked him particularly about attacks of arthritis, and he said that five years before he had had a furious attack of acute gout in the big toe, which had laid him up for a week. He had entirely forgotten about it, and did not regard it as of any momemt in his history.

The tophi and the history of an acute attack of gout leave no room for doubt as to the cause of the renal and arterial changes.

One sees here occasionally families in which gout is hereditary, and even quite young members may have severe attacks which lay the foundation of serious renal and arterial changes. During the past two years I saw at intervals with Dr. Hollyday, Miss X, aged about thirty-five, unmarried, in whose family on the father's side gout was very pronounced. When I first saw her she had all the features of advanced gouty kidney; the urine was of large amount and low specific gravity; the arteries were sclerotic; the pulse of high tension, and the left ventricle greatly hypertrophied. She had been a very abstemious woman, in easy circumstances, who had done a great deal of church and charity work. She had had three attacks of acute gout, the first when she was about twenty-seveny ears of age, which began in the big toe of the right foot. In the second attack, three years later, the tarsus was involved as well as the big toe. The third attack, last year, was in the same situation. She never had involvement of any other joints. The big toe joints on both sides were somewhat thickened. There were no deformities of the hands; no tophi on the ears. She had very extensive albuminuric retinitis. She died in uraemic coma in June, 1895.

While gouty kidney, either as a sequence of acute attacks, or as an event in chronic, irregular gout, is certainly less common in this country than in England or Germany, cases such as the two I have just given occur more frequently, I think, than has been suspected, or than we might gather from the writings of authors in this country.

VI. Calcification of the Auricle.

Tophi along the margin of the helix, or in fact anywhere on the auricle, are distinctive of gout. Has calcification of the cartilage of the ear the same significance?

Within six months three patients were seen with calcification of

part of the auricle of one ear; without the presence of tophi, without arthritis, and in each instance without any history of acute gout.

The first case was a vigorous, muscular man aged 64, who had angina pectoris. He had been accustomed to take stimulants in moderation, chiefly French wines. The heart apex was outside the nipple line; the arteries were stiff; the pulse tension was a little increased. The upper half of the right pinna was unusually stiff and firm, and the cartilage quite hard and calcified. The skin was not in any way affected, and there were no tophi along the margin of the helix. The patient had never had gout.

The second case was a man aged 55, strong and vigorous, who came, for the purpose, as he expressed it, of a 'general overhauling.' He had been a very healthy man, and for years had had large and important interests to control. He had not had syphilis. There was no special increase of tension, and the superficial arteries were not sclerotic. There were no tophi and no enlargement of the joints. The cartilage of the upper third of the left ear was completely calcified.

The third case was a man aged 63, who complained of dyspepsia. He had never had symptoms of gout or of rheumatism. He had been a vigorous healthy man, accustomed to take a good deal of exercise. The pulse tension was not increased. The apex beat of the heart was a little outside the nipple line, and he had a soft but well marked diastolic murmur at the second right costal cartilage, which was propagated down the sternum. There was one small Heberden's node on the ring finger of the left hand. The cartilage in the upper third of the pinna of the left ear was calcified. In the right ear the cartilage of the tip of the helix was calcified, and there were several small nodular bodies along its upper edge, which did not, however, look like ordinary tophi.

Whether calcification of the cartilage of the auricle is due to the deposit of urate of soda I cannot say. I can find but scant references in the literature, and my attention has not been previously called to the subject.

VII. Arthritis Deformans in Childhood.

Of this rare condition I saw a case in Montreal with Dr. Howard, a case at the University Hospital in Philadelphia, and during the past six years two patients have been at the Johns Hopkins Hospital; all these were in children above ten years of age. The following very advanced case came under observation in December:

E. P. K., aged seven years, the third child, was brought by his father for a condition of chronic swelling of the joints, with wasting. There was no history of rheumatism or of any joint troubles in either

the father's or the mother's family. The father had not had syphilis. The child was strong and well until about three and a half years of age, when the ankles began to swell. He had not had scarlet fever or rheumatism. From the onset to the present the swelling of the joints has been progressive. He has never been laid up in bed, but he has had in the past three years many "spells" in which he has had fever, and in which the joints would be a little tender. At times he has had at nights very heavy sweats. For months he would be better and suffer but slight inconvenience; then for weeks he would with difficulty be able to get about the house.

The child is a small, feebly developed, intelligent looking boy. The colour is a little yellowish. The head is held to the left and the chin cannot be moved to the middle line. The neck is completely fixed and moves with the head and trunk. He can neither nod nor rotate the head from side to side. From behind, it is seen that the cervical vertebræ present a solid immobile mass, and there is much thickening about the spines and lateral processes. The temporo-maxillary joints are not affected. The left arm is semi-flexed and cannot be fully extended. The elbow-joint is uniformly enlarged and the tissues about it much thickened. The head of the radius seems involved, and the movements of pronation and supination are very limited. Any attempt at motion in this joint causes pain. The right elbow is not affected. The left wrist is enlarged, flexion and extension are very limited; there is no fluctuation. As he stands he looks knock-kneed from the marked eversion of the right leg. The right knee-joint is greatly enlarged. The movement is limited; the patella is fixed; there is much ligamentous thickening, and the end of the femur seems to be expanded.

The feet are most affected. Both are freely movable at the ankle, and the malleoli are not expanded. The tarsal and metatarsal bones are, however, greatly enlarged and their ligaments are thickened; the skin over them is raised, but natural looking. The tendons can be felt, but there appears to be uniform involvement of the bones. The joints of the toes and of the fingers are not affected.

The temperature was normal. The reflexes were not increased; there were no disturbances of sensation and no trophic changes about the nails or skin. The heart sounds were clear. The edge of the spleen was just palpable; the liver was a little enlarged. There was albumin in the urine and tube casts.

The child died early in January of this year from an acute intercurrent nephritis with dropsy.

There could not have been a more typical picture of arthritis

deformans. I had never before seen the cervical vertebræ involved in a child. There did not seem to have been any determining factors, as the disease began insidiously and at an unusually early age.

VIII. Unusual Types of Night-Terrors—Day-Terrors.

Two cases of night-terrors were brought for consultation; one illustrating the association with adenoid vegetations; the other a somewhat unusual type, allied to hysteria.

S. H., boy, aged seven, sent by Dr. Tompkins, of Fredericksburg, Va. For between two or three years he has had at intervals attacks at night, usually after he has been asleep for an hour or two, in which he would arouse, jump out of bed, and talk sillily, as if demented. He at first rarely had more than one attack in the night. They have been always much worse if he had a slight fever. In some of the attacks he is excessively frightened, but as a rule he jumps up and gets out of bed, talks in an incoherent, senseless way, and seems dazed for a few minutes. On the day following the attack he is depressed and miserable. From the onset of the trouble he has breathed very noisily at night, and snored and snorted a great deal. He once last year had the throat treated with very great benefit, but the condition has now become aggravated, and is very much worse.

The boy's facies suggested adenoid vegetations; both tonsils were enlarged, and growths could be felt in the vault of the pharynx.

I have heard from the mother recently; she says that the local treatment of the throat has benefited the child very greatly, and he had had only three attacks in three months.

The character of the attacks were not like the usual night-terrors of children. He never awoke screaming, but he would always get out of bed, on the edge of which the mother would find him sitting, talking in an incoherent way, and he would be quite dazed for a minute or two. It was really more of the character of night-mare than night-terrors, the distinction between which has been well drawn recently in an article by Coutts (*American Journal of Medical Sciences*, February, 1896).

The following case may be described as nocturnal hysteria:

L. K., a lad aged eleven, the youngest child; mother very nervous, and as a younger woman, had hysteria badly.

For two years the boy has had at irregular intervals, usually one or two in a fortnight, curious attacks at night. As a rule he would go to bed feeling quite well. After sleeping for two or three hours, he would rouse, calling out loudly, "I cannot get my breath," "I cannot get my breath," would sit up, gasp for breath, the whole body

and hands trembling and shaking, so that even the bed would shake with the movements. The hands and feet would become cold and clammy, and he would get cold to the waist. He was always very terrified in the attacks, and would grasp his mother or anyone who sat by him. He would not change colour, but during the attack would sob, and often grasped at the throat. The incessant complaint, however, was a choking feeling and that he could not get his breath. On the morning following the attack he always seemed very despondent and depressed.

There has been no variation whatever in the character of the attack during the two years. The difficulty in breathing was the point upon which he always laid stress, so much so that his elder brother nick-named him "Breathee." He has passsd two, or even three weeks without an attack.

He had been treated systematically by several physicians; had had his eyes and throat examined, but the attacks have not lessened.

The boy was delicate looking. There was a slight facial tic, consisting in movements of the muscle of the eyes and lips. During the examination he frequently drew deep breaths, often with a little lateral movement of the muscles of the lower jaw. The abdomen during the examination was constantly protruded and flattened with great rapidity, owing apparently to rhythmical contraction of the diaphragm. His mother had noticed this at times, and she spoke of it as a trick. He wore glasses for a refraction error.

The boy had gone to school, had progressed fairly well with his studies, and though often nervous and irritable, he had never had an attack of shortness of breath in the day time. The attacks never seemed to have been brought on by errors in diet. The examination of the heart and lungs was negative.

I saw the other day with Dr. Chatard a remarkable case of "day-terrors" in a child of six, belonging to a very neuropathic family. For nearly ten years she had had attacks in which she saw things, and putting her hands over her face, would, for a few minutes, be in a perfect paroxysm of terror. At first the attacks came on only when she had a little fever, but for the past year they have been more frequent, and she has had as many as four or five in a day. She would see frightful objects in certain pictures, and often in the same one, which to comfort her would have to be turned to the wall. The attacks were most common in the evenings after the lamps were lighted, and when she went to bed. She never, however, awoke out of sleep in the attacks. Before their onset she was often peevish and worrying. The hallucinations were chiefly of animals of frightful size and aspect,

and these she would see appear from the pictures, or from the doors, or even from persons faces, or her father's little finger. During the attacks she rocked herself to and fro, and shook in an agony of fright.

She is a bright, intelligent child, very well nourished. The paroxysms are of such intensity and so distressing to the mother that some months ago a doctor recommended that she should take a whiff or two of chloroform, and this controls the paroxysm immediately. She knows when they are coming, and now will tell her mother to get the chloroform ready.

She has at intervals been a mouth-breather, and she has at present enlarged tonsils and a few adenoids, which the mother was urged to have removed.

IX. Tobacco Angina.

Considering the wide-spread use of tobacco, it is extraordinary how rare are toxic effects. In hospital and private work combined I do not see half a dozen cases in a year in which the symptoms are directly due to the habit.

The manifestations of the so-called tobacco heart are usually disturbances of rhythm, increase or diminution in the frequency of the beats, and pain. In young boys, who smoke cigarettes, the irregularity and palpitation are often associated with anæmia, and there may be a systolic murmur at the apex with signs of slight enlargement of the heart.

The pain of tobacco heart, usually sharp and stabbing, may occur without any palpitation or irregularity, is frequently nocturnal, and in many smokers is the very first indication that the limit of toleration has been reached. Attacks of cardiac pain of such severity as to warrant the designation of tobacco angina are, in my experience, very rare, and the term should be limited strictly to cases in which all the prominent features of an anginal attack are present : not every form of severe heart pain due to tobacco should be called angina. An excessive smoker may be attacked suddenly with palpitation, rapid action of the heart, and a sensation as though the organ were "running down," and with this there may be much oppresson in the chest, and a gasping respiration. I have known such an attack, coming on abruptly, without any warning, to begin a series which has continued for months, and which necessitated the giving up not only of tobacco, but also of tea and coffee.

In other cases pain, without disturbance of the rhythm of the heart, or any subjective sensation of palpitation, is the most prominent symptom ; thus, a young man, aged 29, began nearly five years

ago to have nocturnal attacks of severe pain about the heart. It was suggested at that time by his physician that the excessive use of tobacco was the cause, and they disappeared entirely when he gave up the habit. He has been smoking now for nearly a year, and has had the attacks again at intervals. Just after falling asleep he is awakened with a severe pain in the region of the heart, which almost takes his breath away, and makes him cry out loudly. It rarely lasts more than a minute or two. The heart's action is rapid ; he never has any sweating ; he does not change in colour, nor do the hands and feet become cold ; he has never had any pain down the arm. The attacks have never followed exertion. He has occasionally had transient attacks in the day time. He feels confident that tobacco is the sole cause, as when he stops for three months the attacks disappear.

The following case is a type of what may be termed the true tobacco angina :

T. W. J., aged 45, seen June 12th, 1895. Patient is a very vigorous, healthy-looking man, who has enjoyed uniformly good health. In November he had influenza and felt wretchedly for two months. He has been a heavy smoker since his fourteenth year. Some years ago he stopped for one year, as he had attacks in bed in which he felt as though the heart had stopped, and he would have to jump out of bed and gasp for breath. He got well and has smoked ever since.

On the 6th of January he had a sudden, severe attack, to which he attributes his present nervous condition. He had been smoking on an average twelve strong cigars a day. The attack began with a peculiar feeling in the chest, not exactly pain, but great distress. He turned pale, belched gas constantly, perspired, was cold, and he could not lie down, and felt as though he was going to die. He had no agonizing pain, but he felt a sense of terrible oppression, and had numbness in the hands and wrists. The heart's action during this attack was scarcely perceptible, the pulse very feeble and fluttering. It lasted altogether two or three hours and alarmed him very much. For several days afterwards he felt prostrated and weak, and for a month he had a sort of faint feeling, particularly after eating. These faint attacks have distressed him very much. They would come on at intervals, and he would turn pale and sweat profusely. He never has actually fainted in them, but one day in the barber's chair he very nearly lost consciousness. They recurred for about two months after his severe attack. He has been very nervous and uneasy about himself and has been greatly worried. He has stopped tobacco since January 6th.

The patient was a robust-looking man, of good colour, and very

strongly built; there was no arterio-sclerosis. The apex beat was within the nipple line, visible, readily felt, of normal intensity; there was no increase in the cardiac dulness. The heart sounds were clear; there was no accentuation of the aortic sound. There was no enlargement of the liver and spleen.

Up to April 17th, 1896, when last heard from, this patient had had no return of the severe attacks and had been better in every way.

Huchard, whose section on angina pectoris due to tobacco is the most exhaustive in the literature (*Traité des Maladies du Cœur*, 2n l edition), states that it is most commonly of the vaso-motor type, accompanied with extreme pallor of the face, vertigo, contraction of the pulse, a tendency towards syncope, chilling of the extremities and cold sweats. He recognizes, in addition to the functional form, an organic tobacco angina, in which the attacks occur in men with pronounced sclerosis of the arteries.

I have never known a fatal instance of angina pectoris which could be directly traceable to tobacco. I know, however, of two cases of sudden death in men only a little over thirty, both very vigorous and active, who were not known to have heart disease, and both of whom were most excessive smokers. In neither case, unfortunately, was an examination made.

In connection with this question of smoking I would like to enter a protest against the indiscriminate abuse of what Ben Jonson calls "the most sovereign and precious weed that ever the earth has tendered to the use of man,"—particularly in the form of the cigarette. In the *British Medical Journal* for February 15th, 1896, there is an extract purporting to be taken from a paper by Dr. G. F. Shrady, in which he says, "To smoke a cigarette is to use tobacco in its very worst form. It will produce physical irritability and mental and moral strabismus." As a cigarette smoker of some twenty-four years standing, I would like to make the counter-statement, that to smoke a cigarette (a good one, of course!) is to use tobacco in its *very best form*, and that in moderation it soothes physical irritability and corrects mental and moral strabismus.[1] The inference is obvious, *quoad* the editor of the *Medical Record*, at least from my point of view,

X. Unusually Persistent Oxyuris.

From its habitat, this parasite is, as a rule, one of the easiest to dislodge. There are cases, however, in which it resists all attempts, and the condition becomes chronic. It is Finlayson, if I remember

[1] I am speaking of adults. Boys and young men are better without tobacco in any form.

correctly, who reports the case of a man aged 40, who had suffered with thread worms from his childhood, and had failed to get relief at the hands of many prominent helminthologists. Until last year I had never met with a chronic case. The following is an instance in which the worms persisted, in spite of vigorous treatment, for three years and a half :

Mr. X., aged about 25, consulted me January 15th, 1895, complaining of seat-worms, with which he had been troubled for two years and a half. He had the usual symptoms of itching and irritation, particularly at night and after exertion. He had consulted a great many physicians, and had used nearly every remedy which has been recommended. As a rule after the use of injections, such as quassia, he would have freedom for a week or two ; then the symptoms would recur again, and he would see the parasites in the stools. Once he thought they had disappeared for nearly three months, after the use of quassia injections every day for nearly three weeks. In September he again made a systematic attempt to get rid of them, using the strong quassia infusions, a quart at a time, and retaining the injections for about half an hour. Since that date he has not seen any worms, and he considers himself cured.

XI. Is the Coin Sound Distinctive of Pneumothorax ?

I have always believed that the *bruit d'airain* of Trousseau was never heard except in pneumothorax. I have often examined for it in very large excavations without ever noting its presence. In the first edition of my "Text-book of Medicine" I stated with reference to the diagnosis of pneumothorax that "In those rare instances of total excavation of one lung the amphoric and metallic phenomena may be most intense, but the absence of dislocation of the organs and of the succussion splash of the coin sound suffice to differentiate this condition. Why the coin sound is not heard it is difficult to determine, unless its production is connected in some way with a certain degree of air-tension, which is not present in a vomica, however large."

The following case led me to change this opinion :

Henry S., aged 57, seen July 11th, presented all the signs of chronic pulmonary tuberculosis, which, according to his statements, had lasted for seven years. On the 12th the condition noted was as follows : The patient is propped up in bed, breathing at 48 per minute. He is a small-framed man, much emaciated. The sterno-cleido-mastoid muscles stood out prominently, having between them a deep episternal notch, and the clavicular spaces are deep. The left side expands

more than the right. There is a well marked cracked-pot sound at the right infra-clavicular region, with impaired resonance in the first and second spaces. In the axilla the note is fairly good. On auscultation there is at the right apex pure amphoric breathing, with occasional metallic rales after coughing, as low as the second rib. Below this the breath sounds are somewhat enfeebled with prolonged expiration. Over the dull areas in the axilla and the right back breathing is tubular and there is a loud to and fro friction rub. At first I regarded the case as one of large cavity at the right apex. There was a note that the coin sound was tested for on this day and not noted.

He remained in very much the same condition through the summer.

On my return Dr. Thayer called my attention to the remarkable character of the ausculatory signs at the right apex. The note above the fourth rib had a somewhat wooden, tympanitic quality, and the breath sounds here were purely amphoric. From this point into the axilla there was tubular breathing. Behind, the amphoric signs were present from the apex nearly to the angle of the scapula. The breath sounds were loud and amphoric in quality. Dr. Thayer called my attention to the loud and ringing character of the coin sound, which he regarded as produced in a very large excavation. I must confess that I rather leaned to the opinion that a localized pneumothorax had developed.

The note I made early in November was as follows: Listening in the second interspace in front, while someone taps in the mid-scapular region behind, the coin sound is heard with great intensity, and the amphoric quality of the breath sounds and of the rales is of exquisite grade.

The following are extracts from the autopsy note: The right lung is firmly adherent anteriorly. The anterior margin is 4·5 cm. from the edge of the sternum. The adhesions between the lung and the parietal pleura are very strong, and over the upper lobe the pleura is greatly thickened. A large part of the upper lobe is occupied by a cavity, the walls of which average, including the pleura, 4 mm. in thickness. The walls are covered with granulation tissue and present here and there papillary projections, which on section contain remnants of branches of the vessels and bronchi.

XII. Head-swaying in Children.

Among the curious co-ordinate movements in children, head-nodding and head-banging are among the most interesting. [1]

The following case presents an interesting condition, which I do not

[1] I have given a brief statement of the different forms of these co-ordinated movements in my *Chorea and Choreiform Affections.* Blakiston & Co. 1894.

remember to have seen described, in which the head is swayed from side to side in a rhythmical manner:

E. C., female, aged five, third child; always healthy; when born was not a blue baby, and instruments were not used. Developed naturally and had no trouble with teething. Both mental and bodily growth were normal, and she is now a well-nourished, healthy-looking child, very bright and intelligent.

She is an Hebrew, and many members of the family are excitable and nervous. The parents are bright, intelligent people.

From the time the child sat up it was noticed that she moved the head from side to side, or dropped it on the shoulder, and this habit has persisted. The father states that it was noticed from the very earliest infancy. She never has had any other movements; never any rotation of the head, or head-nodding, or any twitching of the muscles of the face or of the arms. She is not a mouth-breather, and she sleeps quietly. At times, however, she is very restless and gets on her hands and knees in her sleep and bores her head into the pillows and climbs up until she knocks her head against the foot of the bed, as her father says, "rooting about like a pig." She never has had spasms, and has been a very healthy child in every respect.

Present Condition.—A very well-grown child for five years; heathy looking, with a bright, intelligent face and well-shaped head. She has no squint, no nystagmus; the pupils are equal and react to light. The tongue is clean, the palate well formed; the tonsils are a little enlarged. There are no movements of the face or of the hands; at times she is a little nervous with her hands, but as a rule there is nothing whatever noticeable, and it is really only when her attention is not called to it that she begins the swaying.

When first seen there was nothing to attract attention, and while taking the history no movements were noticed. Her father said that for a couple of years, so long as her attention was directed to it, she would refrain; thus coming in the long railway journey yesterday, knowing that she was coming to see me, she did not make any movements whatever. If, however, her attention was diverted by anything the movements would at once begin. I sent her into an inner room to watch the type-writing machine, and in a position at which I could readily see her. In a few moments she began swaying the head from side to side, at the rate of a little more than sixty movements in the minute. The excursion from the middle line is about a foot. There was no rotation, and there was no jerking character to the movements, but a rhythmical, swaying motion. When she became a little excited the movements were rather more

In the Journal, with no. XIII
The title changes to
'Ephemerides, 1897'

rapid; thus I counted 47 in 40 seconds, and then the shoulders participated slightly. The father says that sometimes the body will sway with the head.

In every other respect the child seems perfectly natural.

XIII. Rheumatic Neuritis Associated with Subcutaneous Fibroid Nodules.

I do not remember ever to have met with a case quite similar to the one I here report. The presence of the subcutaneous nodules, so common in rheumatic conditions, warrants, I think, the diagnosis. It is interesting, also, to note the great sensitiveness of the muscles, a striking feature in the neuritis due to alcohol and following typhoid fever.

Mr. W., aged 60, sent by Dr. Lockwood, July 1st, complaining of pains in the arms and legs. Patient is a tall spare man, who has always enjoyed good health, with the exception of dyspepsia, to which he has been subject at intervals for many years. He has taken very good care of himself. He is a moderate drinker. There is neither gout nor rheumatism in his family.

Early in March of this year he began to feel pain in the right leg, chiefly about the ankle and instep, as though there was a band about them. It was sharp, but not very acute. He has felt at times a little numbness and tingling, and on several occasions there was a little redness of the skin about the ankle. Very soon the left leg became affected in the same way, and one day there were very sharp stabbing pains down the back of the leg. He describes here, too, the same sensation, as if there was a band about the ankle; he still has it at times. There was neither swelling nor pain in the joints. At this time the trouble was confined altogether to the legs. While the pain did not incapacitate him, it was a source of a good deal of annoyance and distress. About two months ago the arms began to be affected. There were ill-defined pains about the shoulders, without anything to be seen or localized, but with a good deal of tenderness of the forearms, particularly of the muscles, when he laid them on anything. He does not seem to have had any paræsthesiæ. The muscular power of the arms has been perfectly good. The chief distress really has been a soreness on pressure; yesterday there was so much pain in the arms that to get relief he had to sit with them stretched out on pillows. Early in the attack he noticed the presence of certain nodules on the legs and arms, which would appear and disappear. Beneath the skin a few inches from the elbow of right arm, just along

the margin of the ulna, there is a subcutaneous fibroid nodule, very superficial and prominent. There have been others in this region which have disappeared. There is no thickening of the ulnar nerve; there are no trophic changes. The muscles themselves are not very sore to the touch, though there is much pain in them when the arm is resting in certain positions. The blood vessels are not specially thickened. There is no soreness along the musculo-spiral nerve, but there is a little tenderness of the brachial cords. On several occasions there has been a little redness. One of these small nodules which was on the edge of the left tibia, has disappeared entirely. There is no atrophy of the muscles in arms or legs. The knee jerks are present, perhaps a little plus. The pupils are of medium size, and react well to light. There are no tophi on the ears.

July 8th. He has not been so well. The soreness in the arms and about the left wrist is very great and there has been subcutaneous redness and swelling. There is now on the extensor surface of the left arm, midway between the elbow and wrist, a raised red area about 3 by 2 inches. The redness looks fading, but this part is distinctly puffy. It was a patch similar to this which appeared on both ankles at an early period of the disease.

The subcutaneous fibroid nodule on the right arm has disappeared. There is one now on the inner surface of the left knee, which feels like a small shotty body beneath the skin. It is a little sensitive. There is another small nodule just on the inner surface of the patella. The left instep is distinctly swollen and red, and it is tender just above the outer malleolus.

Dr. Lockwood informs me that Mr. W. improved through the summer, and gradually got quite well after a course of baths at one of the springs.

XIV. Bright's Disease or Myxœdema.

There are few practitioners who, having once recognised myxœdema, do not recall cases of the disease which they have treated as chronic nephritis. There are instances in which the diagnosis is by no means easy, of which the following is an illustration.

Mrs. L., aged 44, seen February 28th, 1895, with Dr. Norris, complaining of swelling of the legs and face. She was a married woman with ten children, and had always had excellent health. Ever since she has been "grown-up" she has had a tendency to swelling of the feet, particularly at night. For a year or more she has been getting pale, and she thinks she has gained in weight.

In August last she noticed that her feet and ankles were swollen,

the left much more than the right, and recently the left hand has seemed a little puffy. The face has been a little swollen and flabby for several months, and the eyelids become œdematous in the morning.

The patient had a pale yellow, very muddy complexion ; the skin was dry, but there was no great puffiness of the eyelids, nor had she the broad features so characteristic of the myxœdematous facies. There were no folds of skin on the forehead, which showed a little brownish discolouration. The skin of the backs of the hands was dry, and not especially puffy, but she says that this morning the left hand was swollen. The neck was not swollen ; there were no large supra-clavicular pads ; the thyroid gland could be felt. The legs were swollen, particularly below the calves. The circumference at the ankle was almost the same as in the upper part of the leg. The swelling was particularly marked about the malleoli. There was no pitting like an ordinary œdema, but she says that at night the legs are very much larger than in the morning. There was no change in the voice. For some time she has been very despondent and low-spirited.

The pulse was 70 ; there was no increase in the tension. The temperature was 98.5°. She did not complain of coldness. There was no optic neuritis or retinitis. She did not pass a larger amount of urine than natural. It was normal in colour, specific gravity 1017, always contained a trace of albumin, but no tube casts.

The case had been regarded as one of Bright's disease, but her condition was certainly suggestive of myxœdema. She took three grains of the thyroid extract three times a day for a month before any change was noticed ; then the legs became softer, particularly in spots, and by the middle of June the hardness and swelling had almost disappeared, and the legs were very much smaller. She became thinner; the appetite was better ; the dryness of the skin had disappeared, and she was in very much better spirits.

In the latter part of the year she had to take larger doses of the thyroid extract. The change in her mental condition has been quite marked. Dr. Norris wrote that " her intellect is not at all dull, and she is full of energy, and says she feels stronger than she did." She has, however, had a little return of the swelling of the legs.

Throughout the year 1896 this patient has improved very much. She took a trip to England and returned greatly benefited. She has continued to take the thyroid extract, finding that if she omits it for a few weeks the swelling returns. Dr. Norris reports that perhaps the most striking feature in the case is the alteration in her disposition, which became quite natural again, and has remained so.

XV. Remarkable Noisy Expiration in Chronic Emphysema.

One evening a few years ago as I was travelling from Boston to New York in the Pullman car, a party of three or four gentlemen got on the train at, I think, Providence. One of them attracted immediate attention by the extraordinary noise which he made, and which could be heard by everyone in the car. It was a remarkable rumbling, noisy, gutteral expiration, very distressing to hear. The man sat in the compartment just across the aisle from me, and the most astonishing feature was that in spite of it he seemed quite comfortable and engaged in conversation and did not look distressed. He was a very large, well built man, and looked, indeed, the picture of health. In a few minutes the expiration became less noisy, but it still was prolonged, interrupted, and audible. The party moved away, having secured the drawing-room of the next car, and I made a little memorandum of the condition as one with which I had never met.

On April 10th, 1896, I recognized the owner of the remarkable noisy expiration in a Mr. ——, who was shown into my consulting room.

The thorax was very voluminous, barrel-shaped, the percussion note hyper-resonant even through the thick, heavily coated chest wall. Everywhere over the chest inspiration was quiet; in a few places piping sounds were heard. Expiration was very greatly prolonged, and accompanied with loud, whistling rhonchi. I have rarely heard such marked disproportion in length between the expiratory and inspiratory murmur. The pulse was good; the heart sounds were clear; evidently the compensation of the right ventricle was well maintained. He complained a great deal of distressing cough, and of the most extraordinary nocturnal paroxysms of dyspnœa, in which he had to sit up in a chair for hours at a time, leaning forward, and feeling all the time, as he expressed it, on the brink of suffocation.

He has lately for the first time had some swelling of the legs. For five or six years he has been troubled, particularly on any exertion, with loud noisy expiration. The air blubbers out, as he says, with a great deal of effort and noise, so that people do not like to have him about. In a way it is an exaggeration of the puffing and blowing which very stout people make on exertion, but in its staccato quality it was unlike any form of expiration I had ever heard. When perfectly quiet he could control it, but any exertion brought it on at once.

XVI.—Chills and Fever in Post-Partum Anæmia.

I saw, Nov. 11th, 1893, a Mrs. W., aged about 24, who had been confined about seven weeks previously with her first child. The labour was long and tedious, but there was not more than the average loss of blood. She had been a healthy, somewhat stout woman. Following delivery she became gradually anæmic, but with that exception there seemed to be no special cause for uneasiness. About two weeks before I saw her she began to have chills and high fever, followed by heavy sweats. The attacks recurred every four or five days and were naturally a source of great distress and anxiety to the patient's friends and to her physician. A local infection was suspected, but on repeated examinations nothing could be determined.

When I saw her she had a pronounced anæmia, with both corpuscles and hæmoglobin at about fifty per cent.; no leucocytosis; no plasmodia In spite of the anæmia her general condition was good, and I gave a favourable prognosis, and noted the case as one of post-partum anæmia. I learned subsequently from her physician that the chills recurred for several weeks, but that ultimately, under the use of iron and arsenic, she steadily improved and got quite well.

On June, 26th, 1896, Mrs. C., aged 35, from North Carolina, consulted me for anæmia, chills and fever. She had been delivered just two months before of her first child. The labour was difficult and she had lost much blood. For two weeks she did well; then she began to have fever for a part of each day. Usually towards evening she would have a chilly feeling, and sometimes an actual rigor, which would be followed by high temperature, and then a profuse sweat. She had got very pale, though she feels pretty well, has been up and about, and has been able to nurse the baby. For the past two weeks her temperature has scarcely ever been below 102°, and she has had as she expresses it, terrible night sweats.

The patient looked pale and a little thin; the temperature was 102.2°; pulse above 100, full in volume. Though she had had no cough, from her general appearance and her history I fully expected to find that she had either some local pelvic trouble, or had pulmonary tuberculosis. She had no uterine discharge and she was perfectly well in the pelvic regions. There were anæmic murmurs. The spleen was a little enlarged; the hæmoglobin was under 60 per cent; there was no leucocytosis. The most careful examination of the lungs could detect nothing abnormal.

I was rather doubtful about this case, and did not feel at all certain that the diagnosis of post-partum anæmia would be borne out by sub-

sequent events. The absence of leucocytosis seemed a hopeful feature. The recurring chills and high fever giving place to a continuous fever also seemed to me to be rather against a septic process. I urged her to go to the sea-coast, and to rest so long as she had any fever, to be in the open air, and to take plenty of good food.

I heard from her to-day, Feb. 9th, 1897, and she states that the fever and sweats gradually lessened, though the latter were very stubborn. "With the return of cool weather I rapidly regained my strength, and now I feel perfectly well again."

These two cases stand out in my experience as showing rather unusual features for post-partum anæmia. The condition in both had been regarded, naturally enough, as septic, though there were no local troubles apparent. Fever is common enough in all forms of severe anæmia, but recurring chills, fortunately less frequent, are very liable to lead the practitioner into error.

XVII.—Lineæ Albicantes.

One is not often consulted about the atrophic lines on the skin, but two patients came this year worried about their presence.

A young girl, aged 17, stout and comely, was brought by her father from a neighbouring city, much distressed at the appearance of certain spots upon the knees and thighs and arms, particularly on the latter, as she was approaching the 'low-neck and short-sleeved' phase of existence. She had had scarlet fever badly about four years ago, and these marks had been noticed for the first time during convalescence. They had increased within the past two years, and were a source of much annoyance. They were chiefly about the knees and outer surface of the thighs, where they formed bluish bands, unusually distinct, 1 or 2 cm. in length, and 5 to 1 cm. in width, narrowing, as is usual, at the ends. There were three or four about the extensor surface of each elbow; two of these were large and attracted attention at once. She insisted that changes took place in them when she was 'out of sorts'; they get red and feel itchy, and in cold weather they had a bluish tint.

The other case was a young married man, in the stout stage, a well-nourished Hebrew, who had been badly scared by the appearance of ugly looking scars on the skin of the lower abdomen. On either side in the iliac regions the skin presented three or four pinkish-blue lines of atrophy. They felt like fissures in the skin, and the cuticle could be picked up readily. They had appeared since his marriage three months ago, and had been a source of much uneasiness to himself and to his wife. A few weeks ago I saw a remarkable instance of the development of the disease following a very rapid increase in weight during three months from 145 to nearly 190 pounds. They were similar in position to those in the case just mentioned, forming cur-

vilinear bands, extending on either side from near the costal border to the iliac fossæ. The longest one of these was ten inches, and nearly three-fourths of an inch in breadth at its widest part. They were reddish blue in colour, and over them in certain lights, the whitish smooth cuticle glimmered.

There appear to be three different groups of these curious lineæ: (1) Those due to distention, as from pregnancy, lineæ gravidarum, and which develop in dropsy and in consequence of rapid increase in subcutaneous fat.

(2) Post-febrile atrophy, met with particularly after typhoid fever and also after scarlet fever, as in the case just mentioned. I have seen a number of instances after typhoid fever; the lineæ are usually about the outer aspect of the thighs, and upon the shoulders. I saw an extraordinary instance in 1895, at the seaside. One Sunday a number of us were bathing off the rocks, and my attention was directed particularly to a back the lower part of which was scored in deep transverse lines, one above the other, white and scar-like, but separated by narrow lines of healthy looking skin. The possessor of them told me that they had developed four or five years ago after a protracted attack of typhoid fever in Chicago.

(3) Idiopathic, seen in both men and women, about the knees, outer aspects of the thighs, abdomen, elbows and over the shoulders. This variety, quite as common in men as in women, has rarely the extent of the mechanical form

In none is the condition of any moment, and except the young lady above mentioned, I know of no instance in which the lineæ were a cause of disfigurement.

XVIII.—Two Cases of General Bromidrosis.

General bromidrosis, particularly of the aggravated form, as in one of the cases I here report, is a truly terrible affection. As a local disorder it is not uncommon, particularly of the feet, but the variety in which the function of the entire skin is disturbed is rare, and usually very intractable.

Case 1.—A. B. aged 36, resident of British Columbia, consulted me August, 1893, complaining of offensive sweating of all parts of the body, and perceptible to persons in his vicinity. He has always been a very healthy man; has never had rheumatism. Nine years ago he had a doubtful sore on the penis, not followed by secondaries. He has always been fond of physical exercise, and has sweated a great deal. He has never suffered with offensive sweating of the feet or of the armpits.

The present trouble began a year and a half ago. His attention was first called to the odour of a pair of trousers which he had worn the day before. He then appreciated that there was a very definite odour from the skin; it was not worse in the arm-pits or in the groins, but general and very noticeable in the undershirt when removed at night. Last summer he had to stop playing cricket on account of it. The underclothing is never stained, and he does not think there has been anywhere an excess of sweating. The hands are sometimes moist but have no beads of perspiration. Naturally the condition has troubled him very much as it is at times noticeable to the persons in the room in which he works, and any ordinary sized room in which he remains for a few hours smells of it quite distinctly. He describes the odour as not the exaggerated odour of the sweat in the arm-pits, but rather a stale musty smell, not unlike the odour of the parings of the frog of a horse's foot. His general health is not impaired. The urine is sometimes high-coloured and he states that at times it has had an odour similar to that of the body. On his way from British Columbia he stopped for a couple of weeks at the Banff mineral springs, and there, under a line of treatment suggested by Dr. Brett, he improved very much.

Present Condition.—The patient is a strong, robust looking man. The skin is everywhere natural looking; not moist. There are no changes whatever to be noticed. On removing the underclothing there is a very definite, musty odour which clings to the garment for some time. The same smell is perceptible in the palms of the hands and on the surface of the chest and back. It is not at all like the smell of ordinary axillary sweat, but reminds one very much, as the patient says of the parings of a horse's hoof or of corn. The skin was nowhere particularly greasy; there was no specially offensive odour about the feet.

The urine, of which I saw two samples, was clear, highly acid; the morning sample had an odour somewhat resembling that of the body.

The reaction of the sweat could not be tested, as when I saw him there was no visible perspiration. The strong alkaline treatment on which Dr. Brett had placed him seemed to have been of such striking benefit that I urged the continuance of it, and a fortnight later I heard from him that the improvement continued. In case this did not succeed I advised the persistent use of pilocarpine.

I heard from this gentleman on the 14th of December. He states that he kept on the alkaline treatment, and after October 1st, the offensive odour entirely disappeared. I heard subsequently that this patient has remained quite well.

Case 2.—Mrs. X., aged 36, consulted me September 22nd, 1893, complaining of an intensely disagreeable odour of the sweat. When she came to make the appointment she handed a piece of dark alpaca which she had the day before worn about the upper part of her chest. It was thickly covered with a whitish gray material which microscopically presented fat droplets and epithelial scales.

The patient, a very healthy women, has been married 13 years and has three children. She states that as long ago as ten years her husband had noticed that the odour of the perspiration in her stockings was particular offensive, and would hang them outside the room She herself had not noticed it and it gradually improved. Two years ago, after a severe shock in consequence of the sudden death in her presence of a friend she began to have very profuse sweating about the head and body. She states that on the head the colour of the perspiration was quite greenish, a statement corroborated by a friend who came with her. The odour is particularly marked now about the axilla and the trunk. The perspiration of the feet is no longer fœtid. Every day over the upper part of the chest and around the neck and down the back there forms a floury sediment which she says is at first greasy, but when the clothes are taken off it dries like a crust of sugar, and on her skin it looks sometimes as if there was flour. She perspires a good deal at night and her night gown smells very badly in the morning. During the day it is not quite so noticeable if she keeps quiet, but if she is up and about and on her feet a good part of the day it becomes very perceptible. She has been nervous at times and the trouble has affected her very much.

Patient is a robust, healthy looking woman. The odour of the room in which she sits is very noticeable ; of a musty, stale character, not recognisable as a very strong axillary odour. She compares it herself to some forms of cheese, and she says that at times the sweat from the back is as offensive as the worst Swiss cheese. The hands are perspiring and the musty odour is perceptible. The odour is very strong on the upper part of the neck and back, and in the arm-pits. The skin is moist, not particularly greasy. There was no floury powder at the time of the examination, but she says that the lining of the dress which she had just taken off would, when exposed for an hour or so until it dried, be quite white with this material, and sometimes the hair in the axilla is quite frosted with it. The peculiar odour is most noticeable in the upper part of the body. It is scarcely perceptible on the legs.

Oct. 6th. Patient returns to-day, after having tried local applications of carbolic and salicylic acids and scrupulous cleanliness. The

odour is worse and is apparent at once when she enters the room. It is very pungent and strong. She states that it is now present over the whole body. The thick, floury exudate is still confined to the upper part of the chest and neck, and is present in a thick layer on the clothes which she wears next to the skin. She was ordered a hypodermic of pilocarpine, an eight to a sixth every other day, and the fluid extract of jaborandi, eight or ten mimims on the intervening days.

A few days subsequent to her visit, I got into a street car and instantly recognized by the odour that this poor woman was in it, although she was sitting at the far end.

Dr. Abel made an analysis of some of the seborrhœal material, and I add here notes and extracts from his letter.

"The material for analysis consisted of small white scales and crumbling material which I rubbed off from some pieces of alpaca cloth which has been put around the neck to protect the collar of the dress. This material had a very disagreeable odour. Analysis showed the presence of proteids, fats, organic and inorganic salts. Failing to detect anything in the nature of a neutral compound (ethylsulphide, for example) which would account for the odour, I made an extract of the material with alcohol and ether, expelled the alcohol and ether, and subjected the residue to distillation with a current of steam, first rendering acid with dilute sulphuric acid. The distillate thus secured was milky in appearance and of an acid reaction. On standing, oily droplets formed on the surface. This distillate had an odour which was indistinguishable from that of the original material. Judging by the odour, I concluded that the acid droplets above referred to consisted of fatty acids, as caprylic, caprinic, capronic acid, etc. When a drop of each of the three acids just named was thrown into a little water and the whole shaken, the odour of this mixture was like that of the distillate.

I concluded that there must be several of these evil smelling acids present, as the odour was more marked than that given by capronic acid alone. You will observe that the above statements are based solely on the odour of the oily droplets floating in the distillate. It was impossible to make an analysis of these droplets, separating out the various acids, the material being insufficient in amount for this purpose."

A few months later I heard that this poor woman had died suddenly under circumstances strongly suggestive of suicide. I was not surprised as she was in a state of hopeless despair, having tried all remedies in vain.

Ephemerides, 1897.

By William Osler, M.D.

XIX.—Vertigo and Ocular Defects.

The association of vertigo and ocular defects has long been recognised. The occurrence, too, of ocular symptoms in the severer types of labyrinthine vertigo is also well known. The most satisfactory account in any of the standard works is that by Gowers. "Ocular symptoms, secondary in origin, are present in some instances. In cases of ear disease, an increase of pressure within the ear, as by pressing firmly the antitragus over the opening of the meatus, may cause nystagmus. During paroxysms of vertigo the patient may be conscious of a jerky movement of objects, a quick motion in one direction and slow return, like that sometimes produced by nystagmus, and I have known it to correspond with intermitting tinnitus. This apparent movement may sometimes alone be caused by pressure on the meatus; and nystagmus may be produced, with vertigo, by disease of the middle ear, of course through the secondary affection of the labyrinth. It has been known to persist after the ear disease was cured, even for ten years. I have several times known double vision to occur during or after a paroxysm: in one case of pure aural vertigo, each attack was followed by double vision, jerky movement of objects, and distinct erroneous projection in the direction of the movement, so that, if the patient attempted to touch an object, the hand went too far in that direction. Slight diplopia is sometimes due to nystagmus that is not quite equal in the two eyes. It is apt to cause an error in diagnosis."

Gowers does not refer to the association of refraction errors with vertigo, nor under the section on treatment he does not suggest that they should be sought for.

Recent literature contains several cases in which dizziness and vertigo have been completely relieved by glasses. So far as I can learn, however, none of the cases were of such severity as to come in the category of Menière's disease. In the following case the vertigo, which was of the most intense character, and had persisted for eighteen months, was completely relieved by properly adjusted glasses.

Mr. H., aged 54, consulted me on the 4th of April, 1894, complaining of vertigo, and stomach trouble. He has been a healthy man with the exception of attacks of biliary colic.

of albinism. These pseudo-albinos would be characterised by the fact that the lack of pigmentation is not so marked nor so persistent, by the gradual deepening in colour noticed in the hair as age advances by the appearing of freckles; here again beards will often grow, though not always; nor will there be usually gryphotic changes in the nails, nor hypoplasia of the teeth. Yet here, as in many other things, fast and hard rules are only good enough to be broken.

The patient is a brick-maker by occupation. His habits have been good. He has been a steady smoker until about a month ago.

For about eighteen months he has had attacks of severe vertigo associated with flatulency. The first one occurred while he was sitting at the table in a restaurant drinking claret-punch. He jumped up and said to his wife, "Catch me, catch me," and had to get hold of the table to steady himself. He had a sensation as if a cannon-ball had burst in his head, and as if everything was in motion. The attack lasted about an hour. He did not vomit, but looked pale, and broke into a profuse perspiration. He has had only two attacks of similar severity, one while in his carriage. He said it seemed as if the horse was down and everything was turning over. This attack lasted about an hour. He had to go to bed and felt very badly, and after it he felt confused in his head.

The milder attacks have occurred with great frequency. Scarcely a day passes without one or two; thus, yesterday after breakfast his stomach felt badly and he had a good deal of belching. Then, as he expresses it, his head went off at once, and he generally cries to his wife, "Come and catch me." Coming home just before dinner he had another spell. When they are at all severe he gets pale and cool, and perspiration rolls off his face in beads. He belches all the time during an attack, and on some days he belches continually. He had no pain whatever in the chest or elsewhere. The attacks do not come on during sleep, but he has had several of them while in bed.

From his statement the vertigo apparently is both subjective and objective. Objects go to the right, but he feels that he turns also. In the attacks it is impossible for him to walk. It appears to him that one foot goes about ten feet higher than the other. If the head is held tight the attacks do not appear to be so severe. He has never lost consciousness, though he sometimes feels faint. There is no throbbing at the heart. The longest interval he has ever passed without an attack is two weeks.

He lays the greatest stress upon the condition of the stomach, and says that everything comes from it, and that the belching is incessant and most distressing.

Though he did not complain of difficult hearing, it was evident that he was a little deaf, and on questioning him he stated that deafness had been coming on for several years past, particularly in the right ear, in which there is a ringing noise almost constantly. In the spells it is much louder, and sometimes there is the explosive burst already spoken of. He thinks he is never without the noise in the ear.

Dr. Theobald, to whom I referred the patient for examination of

the ears, wrote that there was deafness in the right ear, due to changes in the auditory nerve or its expansion in the labyrinth, and that there was also slight deafness in the left ear. The examination of the eyes showed a rather high grade of hypermetropia, with a decided amount of astigmatism, which he thought would be materially benefited by glasses, as the error of refraction was possibly an important factor in causing the attacks: the condition of the ears was such that it was reasonable to suppose that they also might have something to do with it. The change in the patient from the use of the properly adjusted glasses was most remarkable. He came to see me again towards the end of May, and said that he was living a new life; that not only had he had no severe attack, but that the milder attacks had disappeared completely. His stomach still troubled him, but he said was not nearly so bad as it had been.

Towards the end of June the patient began to have attacks of severe vomiting, and died within two weeks of the most aggravated, incontrollable attacks due, as was shown post-mortem, to an acutely developing malignant disease of the stomach.

From the date of the adjustment of the glasses by Dr. Theobald about the 10th of April, until the 22nd of June, when he took to his bed, he had been very actively at work, had gone about alone, and been able to drive himself, which he had not done for more than a year and a-half; with the exception of the dyspepsia he had been as he expressed it, in first class health.

The central connections of the space nerve or vestibular branch of the auditory offer an explanation of the oculo-motor phenomena in labyrinthine vertigo. Bonnier[1] has discussed the question from various standpoints. Of the three nuclei of the vestibular nerve, two, the internal and the nucleus of Deiters, send fibres directly to the nucleus of the sixth nerve on the same side. A second less direct association is through the superior olive, which receives branches from the same centres and has connection also with the sixth nucleus. A third association is with the third and fourth nerves through the direct and crossed connections which exist between their nuclei and those of the sixth pair.

After referring to well known facts bearing upon the experimental production in animals of nystagmus and strabismus, Bonnier reports several cases of great interest, in one of which disturbance of accommodation followed auditory irritation. In a patient with a plug of wax in the meatus and transient deafness, the irrigations drove the plug against the drum. There had never been vertigo, only slight

[1] *Revue Neurologique*, Dec. 15th, 1895.

deafness and roaring. Following the injection the accommodation was paralysed in the affected side, and continued so for several hours. On the following day a second injection caused the same symptoms.

A condition of irritation and instability of the space-nerve centres may possibly be kept up by serious accommodation errors. Physiological, clinical and well established anatomical data, show the association between the labyrinth and the oculo-motor mechanism. The case which I here report bears on a practical aspect of the question, inasmuch as the patient obtained complete relief from a vertigo of the most intense and persistent character by the use of carefully adjusted glasses.

RETROSPECT

OF

CURRENT LITERATURE.

Surgery.

UNDER THE CHARGE OF GEORGE E. ARMSTRONG.

Cancer of the Rectum.

QUÉNU. "Étude clinique sur le cancer du rectum."—*Revue de Chirurgie*, 10 Janvier, 1897.

Dr. Quénu gives in this paper the results of some very close study of the onset of cancer of the rectum. Nothing is clinically more obscure than the onset of malignant disease in this region. The disease has often made great progress before any alarming symptoms are developed. The evolution to a certain point, of an epithelioma of the rectum is compatible with an appearance of health. Pain may be absent or only a vague sensation of weight about the sacrum, such as many people suffering from constipation complain of. Among the early symptoms which should arrest the attention of the surgeon and lead to further enquires, may be mentioned: At the outset—In a certain number hæmorrhage is the first manifestation noticed; in others abnormal sensations or a failure of the general health.

Hæmorrhage may occur suddenly and in considerable quantity after a stool. Four cases, giving this history, are mentioned. The first hæmorrhage in one instance was said to be half a glassful; in another, three hæmorrhages in one day, aggregated over a litre, and in other cases it is said to have been very abundant.

The occurrence of these large initial hæmorrhages is difficult to explain; it would be expected to occur during a period of ulceration; perhaps it may be due to venous obstruction and engorgement, or to secondary hemorrhoids which often accompany or follow rectal neoplasms.

More frequently the hæmorrhage observed at the commencement is not abundant, but appears as a few drops, accompanying defecation. The fæces are, as it were, enveloped in a little blood.

The blood is generally red, but if taking place slowly may lie for

Ephemerides, 1897.

By William Osler, M.D.

XX. The Blood Coagulation Time in Jaundice.

It has long been well known that in chronic jaundice there is a marked tendency to hæmorrhage, and in operating upon such cases surgeons have to count upon this as a possible serious accident. Within the past few years I have known of three fatal cases of hæmorrhage following operations under these conditions. A recent case suggests the possibility of the value of taking the blood coagulation time.

A man, aged 34, came under my care in May, 1897, with pains of a doubtful character in the abdomen. There was some increased acidity of the gastric juice with which we thought possibly they were connected. He did not improve, and returned at the end of September with jaundice. He had lost a good deal in weight, had much pain in the region of the liver, which was tender and slightly enlarged. The onset of the jaundice with pains suggested gall stones, and Dr. Finney operated. The patient almost bled to death on the table, blood oozing from the skin incision and from the deeper parts, and about the torn adhesions. As all efforts were occupied in controlling the bleeding, it was impossible to make any determination of the nature of the trouble. The wound was packed with gauze, and the patient was taken back to the ward in a very exhausted condition. He bled very actively every time an attempt was made to remove the gauze, and it was at least three weeks before all of it was taken out of the wound. His blood coagulation time, as taken with Wright's tubes, was between ten and eleven minutes, more than double the normal. It certainly would be advantageous to test this point in cases of chronic jaundice before operation, and it might be worth while also to follow out Prof. Wright's suggestion and to give the calcium chloride in full doses for a period of ten days in order to increase, if possible, the coagulability of the blood.

XXI. Facial Paralysis with Herpes Zoster.

The association of facial paralysis with herpes zoster has been recently studied by Eichhorst *(Centralblatt f. innere Med., 1897, Bd. 18,)* who has been able to add seven cases from the literature to the

The mortality statistics in cases in which resection of intestine has been done does not encourage surgeons to operate except in desperate conditions.

The mortality in all cases ranges from 48 per cent. to 100 per cent. in various tables which have been compiled. In children the mortality, as an average, is higher than in adults.

Cases in which resection has been done in conditions similar to my case are so rare that so far as I know no statistics are available.

Balyer has mentioned four cases of resection of intestine for primary sarcoma of the bowel ; of these 2 died, and the result of the others was not reported.

Primary sarcoma of the bowel is extremely rare. Balyer, quoted above, gives only 14 cases. Of these 92 per cent. were in males, and the majority of cases between the ages of 40 and 50. They were all of the small-celled variety. They did not produce intestinal obstruction.

In looking through the literature, I have only been able to find six cases of sarcoma of the mesentery reported. These were reported by Luke of Cincinnati, Stobbe of Leipsic, Masse of Berlin, Tamsburg, See and Arnott of London. Of these one was a myosarcoma, three were of the spindle celled variety, one was a myxosarcoma, the remaining one not classified.

The tumour, when fresh, weighed 585 grammes. Its measurements were 11.5 x 9.7 x by 9 c.m. The length of the appendix, which was normal, was 3.5 cm. The length of bowel removed was about 50 cm. The mass contains a part of the ascending colon, the cæcum with its appendix and a long piece of the ileum. All this, with the exception of a few inches of-ileum, is welded together into one solid mass. The free piece of ileum is thickened and leathery.

The perforation is near the junction of the ileum and cæcum and forms the outlet of a long tunnel through the thickened wall of the bowel. On the peritoneal surface, the borders of the perforation are raised and thickened. The peritoneum is thickened and covered in places with deposits of lymph, and completely invests the mass. Thus there was no meso-cæcum or meso-colon, a condition often noted by Treves and others.

The walls of the intestines are enormously thickened and friable. No ulceration of the mucous membrane is present except at the seat of perforation.

There is no obstruction anywhere to the passage of fœcal contents, the lumen of the bowel being permeable throughout.

list of eleven collected by Ebstein. The following case has recently come under my observation.

Dr. ———, aged 56, whom I have seen at intervals for the past two or three years, with chronic bronchitis and emphysema, came complaining of paralysis of the left side of the face with herpes behind the ear. For a week or ten days prior to the the onset of the eruption he had pains of a neuralgic character on the left side of the head. During this attack he came to consult me, and I found a small crop of fresh herpes in the mastoid region, extending to the nape of the neck along the line of the hair. He had evidently suffered a great deal of pain, and had been kept awake at night, and was a good deal pulled down. Two or three days subsequently he noticed that the face was drawn to one side. When I saw him the facial paralysis was complete on the left side, and it has persisted for now more than a month. Apart from the rarity of such cases it is interesting to note the persistence of the neuralgia before the onset of the herpes, the distribution of the herpes in the region of the cervical nerves, and the occurrence of the paralysis in the region of the facial nerve without any herpes in the area of its distribution.

XXII. Paralysis of the Ocular Muscles in Albuminuria.

In a case of motor oculi paralysis, in the absence of past diphtheria, we usually look for tabes or syphilis. I had never had my attention called to the possibility of its occurrence in albuminuria and Bright's disease, and I see no mention made in the last edition of Gowers, a work in which one usually finds reference to all recorded complications. Knies in his work on the relations of disease of the eye to general diseases states in connection with paralysis of the ocular muscles in albuminuria that "they are so frequent, however, that in every case of sudden or rapidly developing paralysis of the ocular muscles with the character of basilar, root or nuclear paralysis the urine should be examined for albumin. The cause generally appears to consist of a hæmorrhage in the region of the nerve roots or nuclei, possibly even in the nerve itself." The following case seems to belong to this group.

Mr. B., aged 52, seen in consultation with Dr. Scott, complaining of kidney trouble and diplopia. The patient had been a very healthy man. Syphilis could be positively excluded. Three years ago he had pains in the right back, and once a quite sharp attack, which was diagnosed kidney colic. He had pneumonia five years ago, and with those exceptions he had had no serious illness until June, of 1897, when he began to have headaches which troubled him a good deal.

Dr. Scott examined the urine and found that he had albuminuria. Tube casts were not discovered. He had dyspepsia and lost twelve pounds in weight. About the middle of June he had paralysis of the left external rectus, which caused a very annoying diplopia. The combination of headache with the diplopia led to the suspicion that there might be some serious brain trouble. He was given iodide of potassium; the headache gradually disappeared, and the paralysis of the external rectus has been slowly improving, so that now he has scarcely any trouble from it.

The patient was a very healthy looking man, with slightly more sclerosis of the arteries that his age alone warranted. The pupils were equal, reacted to light and on accommodation. There was no limitation of the fields of vision, the optic nerves were normal, and there were no changes in the retinæ. The knee jerks were present and his station was good. The urine at present contains no albumin. The case is of interest as syphilis and tabes could be excluded with certainty.