

diagnosis arises. In a case reported by Dr. Jas. Taylor⁴ there was considerable weakness of the lower limbs and inability to see near objects (cycloplegia), but the palate had never been affected—at least, not to such a degree as to produce regurgitation of fluids through the nose or other discomfort. Dr. Dundas Grant⁵ has noted an example of diphtheritic paralysis in an adult involving the soft palate, but without loss of the knee-jerks. Speaking generally, it may be said that in adults the prognosis is better even than it is in children. In the latter the prospect is a decidedly good one, though weeks or months may elapse before the complete restoration of function. There is also some risk of cardiac and respiratory paralysis, and hence a period of complete rest is advisable. But in the great majority of cases, rest, massage, electricity, and tonics, such as strychnine, produce the best results, and the patient regains a full measure of muscular power.

A question which has been much discussed is whether non-diphtheritic inflammations of the fauces, palate, and pharynx ever produce a condition simulating diphtheritic paralysis. Probably most physicians would be inclined to say that the occurrence of such a paralysis was a proof of the diphtheritic nature of the throat affection. But there is some evidence which appears to qualify this proposition. It may, indeed, be stated as certain that inflammatory conditions of the throat in which neither the clinical nor the bacteriological characters suggested diphtheria, have been followed by paralyses which corresponded in every respect to those which occur in a certain number of undoubted diphtheritic cases.⁶ Mr. Hutchinson⁷ dealing with this point quotes examples of cycloplegia as sequels to quinsy and pharyngeal abscess, though he recognises these as quite exceptional clinical sequences. Of equal interest with these records are examples of paralysis, corresponding more or less to the diphtheritic order, after certain other specific diseases. Mumps and pneumonia have each been credited with this responsibility, but the principal interest in this respect is attached perhaps to enteric fever. In a case reported by Dr. Waller G. Stewart,⁸ evidences of palatal paralysis and of multiple neuritis affecting all four limbs followed an attack of enteric fever, and Mr. Sydney Stephenson⁹ has noted a permanent paralysis of the ciliary muscle in similar circumstances. Experience, therefore, may be advanced in support of the argument from analogy that paralysis of the soft palate though peculiarly liable to be due to the poison of diphtheria may exceptionally be traced to the operation of other specific toxins, and more especially perhaps to the toxin of enteric fever. Some statistics¹⁰ showing the absence of the knee-jerks in 29 out of 100 cases of enteric fever may be held to lend support to this proposition. Paralyses of the external ocular muscles which have been observed to follow measles and other febrile disorders cannot be said to be exactly parallel to diphtheritic paralysis, as in this condition these muscles are very rarely affected. But palatal paralysis, loss of power in the ciliary muscle, and absence of the knee-jerks may be regarded as peculiarly suggestive of diphtheria. It is, therefore, all the more interesting to observe that each one of these has been noted as a sequel of enteric fever.

There is one other consideration, of doctrinal as

well as of practical interest, in connection with diphtheritic paralysis on which a single remark may be made. The law which governs its occurrence entirely evades definition. Of two cases equally severe in the degree of faucial disturbance one suffers from paralysis, the other escapes. Or it may be a case slight at the outset is subsequently paralysed, whilst a serious and extreme case passes into complete convalescence without any trace of paralytic development. Such facts are indeed puzzling. That mere chance determines such experiences is a suggestion no one will accept. All the same, satisfactory explanation is, so far, beyond us. Possibly it is to be found less in a variation in the amount or virulence of the poison than in a varying susceptibility of the patient. What exactly this is and upon what circumstances it depends it were hard to say. But in spite of the advance of bacteriology it still remains true that the cause of the symptomatic disturbances which are regarded as the expressions of various diseased states is not simple but complex. And amongst other influences must be included idiosyncrasy, or the capacity for reaction which is to be numbered amongst the factors that determine individuality.

¹ Trans. of the Glasgow Medico-Chirurgical Society, vol. i. ² St. Thomas's Hospital Reports, vol. xxviii. ³ Buzzard's Harveian Lectures (1888). ⁴ Polyclinic, vol. vi., p. 132. ⁵ *Ibid.*, p. 149. ⁶ Brit. Med. Journ., March 4, 1899, and August 2, 1902. ⁷ Archives of Surgery, vol. iv., p. 209. ⁸ Brit. Med. Journ., March 2, 1901. ⁹ The Ophthalmoscope, January 1904. ¹⁰ Brit. Med. Journ., March 23, 1901. ¹¹ Lancet, February 9, 1901.

HYDATID DISEASE OF THE LUNG.

A CASE of this unusual disease is reported by Miss Aldrich Blake, M.D.¹ The patient, a woman of 51 years, had complained for some months of cough, with expectoration and loss of flesh. There was dull percussion and deficient respiratory murmur over the greater part of the right back, but exploration failed to detect any pleural effusion. A skiagram revealed a dark shadow in the right lung with a convex upper border at the level of the third rib. Hydatid hooklets were found in the sputa. Under chloroform portions of the seventh and eighth ribs were removed and the cyst evacuated. The contents, consisting of 3 pints 18 oz. of daughter-cysts with very little fluid, were removed by finger forceps and gentle syringing. Some of the cysts in the lower part of the cavity were bile-stained, but no perforation of the diaphragm could be recognised. The subsequent progress of the case was uneventful. It is noted that nothing like a mother cyst was seen either at the operation or in the after-treatment of the case, and in explanation of this it is suggested that the mother cyst may have been quite small and that the main mass of the hydatid was an exogenous formation. The circumstances, of course, suggest that the original site of the disease was the liver, and that the thoracic condition was a secondary development. There is no doubt that such an order of events may occur without any positive evidence of hepatic disease, and the primary cyst may be small and beyond the reach of physical examination. The present writer has recently seen a case in which, on the view that the patient was suffering from gall-stone, the abdomen was opened, but with entirely negative results. Later, though the patient ceased to complain of pain,

he developed a febrile temperature with sweatings and loss of flesh. For some time no explanation of these conditions could be discovered, but after several weeks signs of fluid effusion at the base of the right chest were detected. An exploratory needle obtained a purulent-looking fluid, and when a rib was resected the discharge contained numerous hydatid hooklets and daughter cysts. There can be little doubt that here the original condition was a hydatid cyst of the liver, which at first caused pain, perhaps by producing a limited diaphragmatic pleurisy or a localised perihepatitis. So inconspicuous was this cyst, presumably on account of its small size and its situation on the upper surface of the liver, that it escaped the observation of the surgeon at the exploratory operation. Subsequently the diaphragm was perforated and a suppurative pleurisy was established. The patient made an excellent recovery. Not only may hydatid disease of the liver exist without distinctive symptoms and the condition fail to be recognised until extension to the chest has occurred, but an equal condition of quiescence may obtain in hydatid disease of the lung. This is probably very exceptional, but it occurred in a case reported by Dr. F. J. Smith.² The patient was a boy in whom there were no physical signs and no symptoms worth mentioning, yet he is described as having coughed up the whole of a hydatid cyst in fragments. All these cases illustrate the necessity of bearing in mind the possibility of hydatid disease in cases of more or less obscure disease within the thorax.

¹ Brit. Med. Jour., July 23, 1904. ² Lancet, February 9, 1901.

TREATMENT OF PUERPERAL INFECTION.

CABANES¹ records the results of treating puerperal infection with iodised gauze. He prepares the dressing by steeping gauze in a solution of sterile water and potassium iodide in which 4 per cent. of iodine has been dissolved. The uterus is first douched with an antiseptic solution, and, if necessary, curetted with a blunt instrument. The uterus is then loosely plugged with the prepared gauze, and the vagina is douched out and iodoform gauze is placed in contact with the cervix to absorb leakage of iodine and prevent its injuring the vagina. This dressing is changed every 12 hours.

¹ Medical Press, July 13, 1904.

THE MENTAL EFFECTS OF ALCOHOL.¹

THE mental effects of alcohol differ according as they are the result of a single large dose or repeated smaller doses. The latter may have been kept well within the bounds of "moderation" and yet under the stress of shock or illness they may be responsible for evidences of mental disturbance. A tendency to delusions of persecution is very common in chronic alcoholics. Visual illusions, or delusions based upon them; delusions of the grandiose, boastful, or vain-glorious order; and those of a suspicious and persecutory character are almost invariably caused directly or indirectly by alcohol. Alcoholic insanity may be hallucinatory or delusional in type, both varieties tending to terminate in dementia, which

in some instances may be the primary form. The most characteristic symptom of alcoholic insanity is paramnesia—a failure of memory for recent events, a loss of the quality of nerve cells by which images of past sensations are retained and consequently a defect of the power of associating ideas. This condition—with its resulting confusion of memory—is largely responsible for the deliberate and shameless lying which usually distinguishes these patients. There is also a mental restlessness and wandering, the patient being confused as to time and place. Another peculiarity of chronic drinkers is the impulsiveness of all their reactions when these become excited. Hence such patients exhibit violent temper and unrestrained licence in action and speech. In one class the moral nature is much perverted but there still remains the knowledge of right and wrong and the capacity, under a sufficiently powerful stimulus, to abstain from alcohol.

¹ Dr. Robert Jones, British Jour. of Inebriety, July 1904.

SURGICAL OR TRAUMATIC RHEUMATISM.

THIS term is applied by Dr. Jas. Weir¹ to a condition characterised by aching pain and stiffness in a joint, muscle, or tendon, influenced as a rule by atmospheric conditions, and following, it may be after a considerable interval, some form of local violence. Dr. Weir's argument is that whilst in some of these cases a constitutional cause may have to be recognised and treated, the most important therapeutic measure is the use of Corrigan's button. He has met with numerous examples of this condition in which, though a long course of internal medication had proved of no avail, the cautery gave prompt relief. He has had a similar experience in cases of lumbago which had been unsuccessfully treated by high frequency currents.

¹ Glasgow Med. Jour., July 1904.

AN EXAMINATION OF THE APPARATUS PROPOSED FOR THE QUANTITATIVE ADMINISTRATION OF CHLOROFORM.

DR. WALLER and Mr. Wells¹ have conducted an inquiry into the efficiency of three forms of apparatus designed for graduated administration of chloroform for anæsthetic purposes. First, the Dubois pump, which, it is claimed, delivers continuously, at any convenient rate between 4 and 20 litres per minute, air charged with chloroform vapour at the nominal percentage of 1.2, 1.6, and 2, was found to work easily and well, and the chloroform percentage remained below 2 while the pump was working. A loose face piece should be used and the anæsthetic mixture supplied freely. The drawbacks are the cost (£20), and the fact that the instrument is rather complicated and heavy. The surplus chloroform may be inconvenient to anæsthetist and operator but escaping as it does into the air of the theatre, the inconvenience, owing to the considerable dilution, is trifling.

The Junker apparatus (Krohne and Sesemann) consists of a face piece, freely open to the air, from which the patient inspires definite volumes of chloroform by means of a small accessory pump that drives measured amounts of air through a bottle containing