Clinical memoranda : being selected cases from the wards of Dr. M'Call Anderson.

CLINICAL MEMORANDA:

BEING

SELECTED CASES FROM THE WARDS

OF

DR. M'CALL ANDERSON,
PROFESSOR OF CLINICAL MEDICINE IN THE UNIVERSITY OF GLASGOW.

SECOND SERIES.

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PREFATORY NOTE.

THE cases which follow were in my Wards in the Western Infirmary in 1894. They were selected on various grounds; generally not on account of their rarity, but because they were typical illustrations of definite forms of disease, or because they illustrated special points in etiology, diagnosis, or treatment.

By continuing these reports year by year, it is hoped that a mass of material may be collected which may prove useful for reference, or in connection with statistics.

My cordial thanks are due to Drs. William R. Jack and W. Ernest Thomson for the careful reports which they have taken under my supervision.

T. M'CALL ANDERSON.

2 WOODSIDE TERRACE,
GLASGOW, *December*, *1894*.

CONTENTS.

CLINICAL MEMORANDA.

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13. *Intrathoracic Tumour—Aneurysm* (?)

J. M'K., æt. 57, a leather-cutter, was admitted to the Western Infirmary on 6th June, 1893, complaining of a dull pain across the front of the chest, with cough, expectoration, and loss of flesh.

At 18 years of age he had an attack of typhus fever, at which time his father, mother, and one of the family of seven children died of the same disease. The rest, as far as he knows, are alive and well. He has no information as to any other relatives. With this exception, he has always been a very healthy man.

His present illness dates from a severe wetting which he got, while at work, five months ago. The earliest symptom was a feeling of nausea, followed by vomiting. The nausea was more or less continuous, and he vomited now and again, bringing up only small quantities at a time. An attack of vomiting sometimes lasted for over an hour. These symptoms continued for about three weeks, and were followed by complete loss of appetite. Ever since he has been unable to take ordinary food, and has steadily become thinner. When the vomiting ceased, he began to experience a dull pain across the upper part of the sternum, which, since then, has been almost constantly present, varying, however, considerably in intensity. Usually this pain is worst in the mornings. It is not aggravated by coughing. At the same time he began to have pain in the stomach, which has been persistent. It is present both before and after meals, and is of a dull heavy character, which is not altered by taking fluid food. Such food, in fact, tends rather to relieve than to aggravate it. Between meals he is a good deal troubled with flatulence, and with the regurgitation of watery mouthfuls of a sour

taste. For the past five months he has had to restrict his diet to articles such as soft bread, rice, and milk. He never had any difficulty in swallowing solid food, such as dry bread or meat, but, immediately after reaching the stomach, it caused a very sharp cutting pain, and was vomited in about two minutes. Thereafter the pain was much relieved, though not entirely removed.

His bowels have been somewhat costive since his illness began, but not more so than formerly.

With the exception of the pain, he had no chest symptoms until about two months ago, when he began to have a slight cough. It was at first only a hawking to free the throat from a clear tenacious material, but it quickly became more severe, and was accompanied by a tough yellowish expectoration which never contained blood. He does not think that it has become worse of late. He has had no loss of voice, nor more than a slight temporary hoarseness on one occasion, since his illness began.

He has had no deficiency of eyesight during the past five months, nor any headache. He had never noticed, until it was pointed out to him three weeks before admission, that the veins on the left side of the chest and down the left arm were much distended.

The loss of flesh during his illness has amounted altogether to about 16 lb.

On examination of the chest, it was found that there was slight flattening of the left side—not very distinct to the eye, but made out by the cyrtometer—and movement was slightly defective. To percussion and auscultation, the right lung was normal. The left presented a slight relative dulness in the outer part of the infraclavicular region, and the respiratory murmur was weak all over the left front, but without râles. The area of cardiac dulness was normal, and the apex beat was in the fifth interspace, within the nipple line. The hepatic dulness was also normal. Over the manubrium sterni, and on both sides of it, but more to the left than to the right, there was an area of dulness measuring three inches transversely, and tapering downwards in the form of a cone until it merged in the cardiac dulness. There was visible pulsation in the fourth left interspace at the sternal margin, and also a less distinct pulsation in the second right interspace. On auscultation, a soft blowing systolic murmur was heard all over the base of the heart, and it was also present in the mitral area, whence it was conducted towards the axilla. A very faint pulsation could be felt on deep pressure behind the

manubrium sterni. Upon deep inspiration the breathing became somewhat noisy. When the patient was made to swallow dry bread, there was occasionally dysphagia, the bolus apparently sticking for a moment about the level of the cricoid cartilage, and giving rise to pain. The superficial veins were enlarged in both arms, but especially in the left, and over the left side of the chest. The vessels were distinctly tortuous and rigid. The pupils were equal, and responded equally to accommodation.

Over the gastric area the percussion note was distinctly tympanitic. There was no dulness at any part, nor could any tumour be made out by palpation. There was tenderness, however, on the left side of the epigastrium, at about the level of the eighth costal cartilage. The spleen was not enlarged. The patient had a somewhat sallow appearance. He weighed, on admission, 7 st. 9¼ lb. There was no fever. Urine normal.

He was confined to bed, his bowels were regulated by a laxative every second night, and he was kept upon light food in six small meals. He was also put upon quinine, and as he was sleepless he had 30 grs. of sulphonal at night.

Soon after his admission it was noted that the right radial pulse was very distinctly stronger than the left, and tracheal tugging, in a slight degree, became apparent. His general health and weight improved, without much change in the condition of the chest, until the middle of July, when his weight fell from 7 st. 12 lb. to 7 st. 10¼ lb., and he had an attack of sharper pain across the chest, lasting for two days. From that time, however, he again improved, and left of his own accord on 29th September. The size of the thoracic tumour remained the same, but the systolic murmur was less audible and the veins less engorged. The sternal pain was only now and then present, and was much less marked, although there was an occasional momentary pain which shot into the back and down the left arm. His appetite was better, and there had been no vomiting during his stay, although morning eructations and a sour taste in the mouth were still present. It was still necessary, also, to give aperients every second night. His cough persisted, but was now unaccompanied by expectoration, and had become short, hard, and almost laryngeal in character. It was, however, infrequent. He complained of shortness of breath on rising to go to stool. The pupils remained equal. His weight had increased to 7 st. 12½ lb. During the latter part of his stay he was taking iodide of potassium.

14. *Aneurysm of the Abdominal Aorta.*

W. C., æt. 43, a harbour porter, was admitted to the Western Infirmary on 1st December, 1893, complaining of pain in the spine and over the front of the chest, and also of breathlessness.

He was first admitted on 25th June, 1888, suffering from pain in the back and abdomen of six weeks' duration. It was then noted that twenty-two years previously he had an attack of gonorrhœa, accompanied by sore throat and a rash on the skin. He recovered from this under treatment. Twelve years before his first admission (*i. e.*, in 1876) he had an attack of rheumatism in the shoulders and arms, the pain being markedly nocturnal, as was that of which he complained on admission. On examination, V.S. and V.D. aortic murmurs were found. In the abdomen there was an expansile, heaving pulsation near the umbilicus, with a systolic murmur. He was dismissed much improved, but again returned with similar symptoms on 23rd February, 1891, and left much improved on 30th May, 1891.

He remained for twelve months so well as to be able to resume his usual work. Then the pains previously complained of returned with greater severity, and since that time he has only been able to work one day in every three. He has great breathlessness, especially on exertion, as when going upstairs. He has at times noticed swelling of the feet and ankles after a day's work, but there has never been any considerable dropsy.

He now complains of great pain in both loins, which is increased by pressure, and of pain at the angle of the left scapula. The pain is much more severe at night than during the day. He has also pain across the middle of the chest in front. During November he had three or four attacks of violent pain over the aortic cartilage, which he described as like a bunch of needles running into the skin. These lasted from 15 to 20 minutes.

On examination the pulse was found to be fast (96 per minute) and "shotty" in character. The cardiac dulness extended from the left border of the sternum to 1 inch outside the nipple line, and reached the middle of the third rib above. The apex beat was diffused, and could be made out in the fourth and fifth interspaces. There was a faint systolic murmur at the apex, but it was most pronounced over the sternum at the level of the second interspace, where it had a harsh character. A diastolic murmur was also heard here, but better over the aortic cartilage. It was softer, and more

of a blowing murmur, than the systolic. It was very faintly heard at the ensiform cartilage, and became more distinct on passing towards the manubrium. The systolic murmur was carried upwards into the vessels of the neck on both sides. The liver was enlarged, and tender to pressure. It measured 5½ inches in the nipple line.

In the lower part of the epigastric region, and slightly to the left, there was an expansile pulsation. There was dulness at this point, which could not be accurately separated from the hepatic dulness, into which it merged. On auscultation a distinct blowing systolic murmur was made out. It was most audible about 2 inches below the ensiform cartilage, and became fainter both above and below that point; but it was still to be heard at the umbilicus, and for a little distance on either side of the middle line.

The patient was treated by large doses of iodide of potassium (up to 1 oz. daily), dry diet, and absolute rest in bed. As he suffered much from sleeplessness, sulphonal was administered. There was little improvement, either in the physical signs or in the symptoms, until the 21st December, when the pain in the chest, which had been the most severe, became much alleviated. Two days afterwards he left against advice, insisting on returning to work.

15. *Recurrent Paralysis of the Third Nerve and Hemicrania.*

M. D., æt. 26, married, was admitted to the Western Infirmary on 12th December, 1893. She complained of severe headache, drooping of the right upper eyelid, and defect of vision in the right eye.

There is no history of a neurotic tendency in the family. Her father died in youth of "consumption." Her other relatives are alive and well. She married in 1888, and has had two children, both healthy. There have been no miscarriages.

With regard to her previous health, she does not remember the illnesses of her childhood, but she has certainly not had rheumatism, and does not think she has had scarlet fever. As far back as she recollects she has been subject to headache, with attacks of "biliousness," occurring, on an average, once in six weeks, and lasting for about a week at a time. During the first two days of such an attack, she frequently vomits, bringing up a quantity of yellow material, and for the rest of the time she has a feeling of *malaise* and aggravated headache. In other respects she was quite healthy up to the beginning of her present illness. Menstruation commenced

when she was about 16, and has always been regular without pain or discomfort. There has never been any special excitability at the periods, although she admits that she is a "nervous" woman, and very easily excited; and this feature has become much more prominent since her present illness began. She has never suffered from any typical form of hysteria. She is unaware of any cause for her symptoms, and there has been no shock or fright that could have given rise to them. She has never had any paralysis or paresis of other parts, nor has there ever been anæsthesia or paræsthesia of any part of her body.

The present illness began in June, 1890, although even before that the right upper eyelid had occasionally "felt heavy" during a severe attack of headache. At that time she had a worse attack of headache than usual, which lasted for a few days. It was accompanied by drooping of the right upper eyelid and external squint. She was treated at home by the application of a fly-blister to the shaved head, and this was followed by a complete but temporary recovery. She remained free from symptoms for two months, when a similar attack took place. Since then there have been recurrences at more or less regular intervals, always followed by recovery. But in the second week of March, 1893, she had an exceptionally severe attack. The headache was very violent on the day of onset, and was followed next morning by the usual ptosis and external squint. The headache was much relieved by treatment, but the condition of the eye persisted till June, 1893. She was in the Western Infirmary from 30th March till 13th May, and was dismissed *in statu quo*. In June, however, all the ocular symptoms spontaneously disappeared. She remained well till the beginning of October, when she again had a violent attack of headache, and next day all the symptoms returned, and have been present ever since.

From the commencement of her illness she has noticed a gradual loss of colour, and she is now very much paler than she used to be. She feels weaker, also, than formerly, and is very easily tired. If she is excited she suffers from palpitation, and on going upstairs becomes breathless, and has to rest frequently. Occasionally also, without any apparent cause, she has a "fainting fit," but this has not happened often. She has no pain in the chest, nor has she ever been dropsical. Her bowels are regular, and her appetite fair.

The headache, of which she complains, has always been

limited to the right side, and usually to an area of about two inches square at the external and upper part of the forehead. The pain is generally dull and heavy, and is not worse at night. It is not constant, but comes and goes at irregular intervals. During the exacerbations, it seems to extend slowly from the area referred to downwards to the outer wall of the orbit, and this is accompanied by a feeling of heat in the eye. When still more severe, it extends also in a backward direction along the side of the head, and then bends downwards behind the ear. In the earlier attacks the ocular symptoms and the headache disappeared at the same time, but, in the last two, the affection of the eye has persisted long after the headache. In the present instance, the latter disappeared a few days after admission, and any recurrence has been easily checked by phenacetin.

During the whole of her stay the quantity of urine passed by the patient has been, on the average, below the normal. On twelve days it was above it, usually only slightly, but it thrice reached 70 oz. On the other thirty-five days the average quantity was about 40 oz., although it was frequently below this. When she was asked if she had noticed the diminution, she said that she had, but only when she had an attack of vomiting, when the quantity passed in 24 hours was always very much less than natural. The vomiting always occurred, according to her statement, when the headache was most severe. It was quite painless, and preceded by only a slight feeling of nausea. There was no vomiting while she was in hospital, but her account is so far confirmed by the circumstance that on 31st December she had a more severe attack of headache than any other during her stay. It ceased after the administration of phenacetin, and did not end in vomiting, but on that day the urine fell to 14 oz., the smallest quantity noted. During her former residence, from March to May, 1893, the quantity passed was also variable, and chiefly too little. There was then no albumen present, but sugar was found in the proportion of 4·65 grains to the ounce. It has been repeatedly searched for on this occasion, but no trace of it has ever been discovered. In other respects the urine is quite normal.

On examination, the heart and other organs are found to be healthy. The reflexes are normal. There is no evidence of syphilis. There is no anæsthesia over the area of headache, but a slight inaccuracy exists there in determining the exact point touched by a needle, the sensation being referred about an inch to one or other side. The sense of pain is not

interfered with. There has been no fever throughout the case.

The treatment adopted was to give phenacetin when necessary for the relief of the headache, and on 18th December and 31st December a blister was applied to the nape of the neck. On 9th January Faradism was commenced, one pole being applied to the nape of the neck, and the other moved about round the affected eye. A tonic was also given which contained arsenic and strychnine. Under this treatment the general health considerably improved, and the symptoms of anæmia became less prominent. Its effects upon the ocular condition are contained in Dr. Thomson's report.

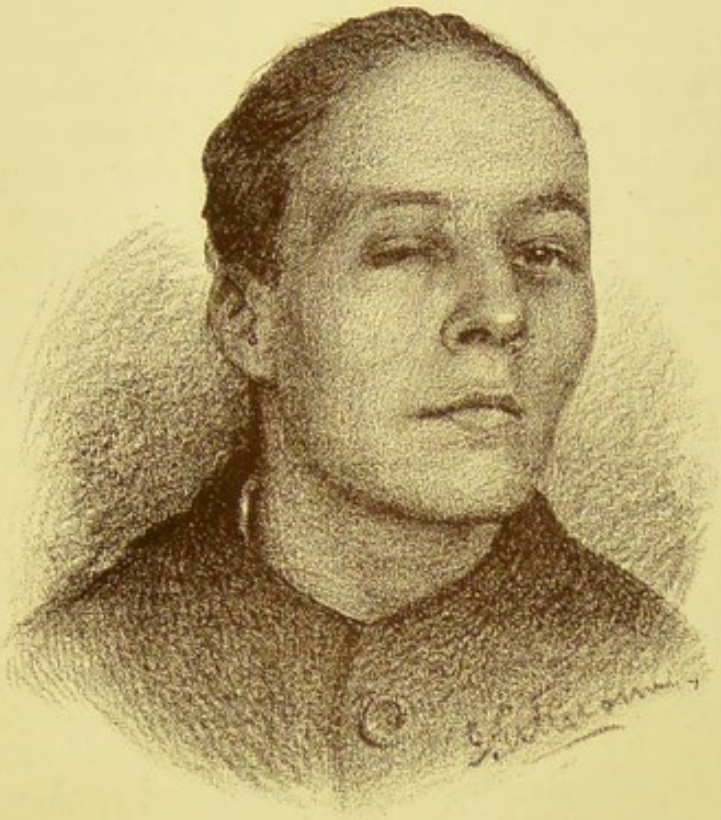
The accompanying photograph, which was taken during the patient's first visit to the Infirmary, gives a very good representation of the condition during an attack.

Report of the Ocular Condition by Dr. W. Ernest Thomson. —This patient was in the Western Infirmary on a previous occasion, from 30th March till 13th May, 1893. The eyes were examined at that time by Drs. Thomas Reid and Hinshelwood. Their report is essentially the same as the following account of her symptoms on admission, 9th December, 1893. It is to be noted that, although there was no improvement at her dismissal (13th May), the symptoms spontaneously disappeared in June, and remained absent until October, in the beginning of which month, after a violent attack of headache, the old symptoms reappeared.

Examination of Eyes on the present occasion.—Right visual acuity $\frac{6}{12}$, left $\frac{6}{6}$, both in good daylight and uncorrected by lenses.

There is complete ptosis of the right upper lid, with apparent partial ptosis of the left; but upon closing the right eye with the hand, the patient is immediately able to raise the left upper lid to its full extent. There is therefore no real ptosis of the left lid.

The patient habitually covers the right eye with her handkerchief in her hand, in order to avoid distressing diplopia, and, if not allowed to do so, the head is thrown backwards, and the face is turned to the left side, while the eyes are fixed on any object. On raising the right upper lid, the pupil is found to be dilated to a medium extent, and does not react either to light or accommodation; and on telling her to look straight forward with the right upper lid thus held up, the head assumes the above mentioned position, backwards and turned to the left, the eyes accordingly assuming a position relatively to the face which



corresponds to the action of the right external rectus and superior oblique muscles—namely, downwards and to the right. It is noticed also that while, as noted above, the left lid rises when the right is held down, if the right be held up, the left droops more than before, and covers a considerable portion of the pupil. In short, every possible effort, voluntary and involuntary, is made to avoid the diplopia which is here so marked.

Although the distant vision is fairly good, she cannot read at the ordinary distance with the right eye. There is *paralysis of accommodation.*

Regarding the *range of motion* of the right eye, the patient is capable of sustaining an effort of fixation only when the eye is turned to the right. In other directions she is only able to make a temporary effort, the eye almost immediately rotating back into its position of rest, which in this case is downwards to the right.

The Diplopia.—The patient's head being held steady, and the two upper lids held up, a coloured glass is held before one eye; on looking at a candle held at two metres directly in front, there is diplopia, which is "crossed." This diplopia disappears when the candle is carried to the right, and becomes more manifest (images farther apart) when it is carried to the left. There is also double vision when the candle is raised or lowered directly in front of the patient. She denies the existence of diplopia at all points to the right of a median vertical line, but her statements must not be relied upon absolutely, either in this respect or regarding the inclination of the double images.

There is therefore paralysis, or at least paresis, of all the muscles supplied by the third nerve—namely, the levator palpebræ superioris, as shown by the ptosis; the internal, superior, and inferior rectus and the inferior oblique, as shown by the position of the eye at rest, and by the character of the diplopia; and of the ciliary muscle and sphincter pupillæ, as shown by the absence of accommodative power and the semi-dilated and immovable pupil.

Ophthalmoscopic Examination is almost impossible owing to excessive lachrymation when the lid is raised by the finger. It is noted, however, that there is no marked change in the fundus, and that there is a total hypermetropia of 1 dioptre. (Dr. Hinshelwood confirmed this observation).

The Fields of Vision (16th and 18th December).—The field of the right eye for white light is normal; but the fields for colour show very considerable limitation peripherally. The

day (18th December) was somewhat dull, and the pieces of coloured taper used as test objects were rather small; but, notwithstanding these facts, there can be no doubt that the colour fields are limited to a great extent, and limited in their natural order, green being most tardily recognised, and yellow most easily named, blue and red being intermediate. Green is only recognised when brought quite near to the fixing point.

The Subsequent Course of the Case—16th December.—The diplopia is not so distressing. The mobility of the right eye has improved, and some sustained effort of fixation can be made. The accommodation, however, is still in abeyance, and the reaction of the pupil to light has not returned.

28th and 31st December.—There is no further improvement in the ocular condition.

1st January, 1894—11 A.M.—The right eyelid could be partially raised for the first time since admission, allowing the pupil to be seen, but the upper segment of the cornea is covered by the lid. No great complaint is made of diplopia. The opening of the right eye is accompanied by an extremely rapid tremor of the right upper lid, accompanied by drooping and similar tremor of the left lid.

2 P.M.—Coincident with a fresh attack of hemicrania, the right upper lid began to droop again. On looking straight forward only the lower part of the pupil is now visible to the observer.

10 P.M.—10 grains of phenacetin having been administered, the hemicrania has become less severe, and by a determined effort the right upper lid can be fully raised, the act being accompanied by drooping and violent tremor of the left lid. As before, if the right lid be held down, the left can be fully raised.

2nd January.—No change.

10th January.—The range of movement of the right eye is distinctly improved towards the left, in the sphere of action of the internal rectus. Accommodation is still quite in abeyance and the pupil is fixed. The divergence of the right eye persists. The power of raising the upper lid is certainly no better than on 1st January. Patient says her general health has improved.

17th January.—The ptosis suddenly and completely disappeared this morning.

20th January.—Ptosis still absent, accommodation still in abeyance, pupil fixed, ocular movements much improved, but diplopia still present. A chart was made of the colour fields.

The day was fairly bright, and the coloured tests larger than

on 18th December, two circumstances which must be set against the fact that the fields are less contracted than on 18th December. On the other hand, the field for white is contracted on the temporal side, which was not the case on 18th December, when the field for white was normal.

23rd January.—For the first time perimetric tracings were taken of the left eye. The day was fairly bright, and the test objects the same as those used in the second tracing of the right eye—namely, the test colours supplied with Priestly Smith's perimeter. The field for white shows sector shaped defects giving the field of vision, as shown on the chart, an irregular stellate shape. The colour fields are also contracted, but in a much less regular manner than those of the right eye.

26th January.—The fundus of both eyes examined and found normal by Dr. Jack.

28th January.—The ptosis returned this morning after a severe attack of hemicrania.

29th January.—The pupil is more dilated than before this last attack. By a strong effort patient can slightly raise the eyelid. This she was unable to do yesterday. The headache has disappeared. The ocular movements maintain the improvement noted on 20th January; there is still diplopia to the left of the middle line. Dismissed in *statu quo.*

31st January.—The ptosis again disappeared when at her home.

6th February.—The ptosis is still absent, the ocular movements are fairly good, but accommodation and pupillary reaction are still absolutely in abeyance.

16. *Paraplegia, Anæsthesia, Bladder and Bowel Troubles, and Bedsores—Perfect Recovery.*

D. M'G., æt. 42, a timekeeper by occupation, was admitted to the Western Infirmary on 8th January, 1894, suffering from loss of power and numbness of the lower extremities, and severe pain affecting both legs below the knee. These symptoms were of three weeks' duration.

No neurotic tendency could be made out in the family history. Up to the onset of his present illness he had been exceptionally healthy, the only affection he can remember being an attack of pain in the left side, about four years ago, which lasted a few days. The doctor in attendance called it pleurodynia. It passed off under treatment, and has never returned. He has always been very temperate.

For some weeks before the beginning of the symptoms of

which he complains he had a severe cold. He neglected it, and continued his work. About three weeks before admission it became worse, and he had to take to bed. Two days afterwards he began to suffer from pain in the legs, and on the following day, in getting out of bed, he fell at full length on the floor. He could not rise, and was lifted back into bed, when it was found that both lower limbs were completely paralysed. He had not lost consciousness. Anæsthesia set in at the same time in the affected parts. Soon afterwards his bladder began to trouble him. He had difficulty in micturition, sometimes amounting to retention, and pain across the hypogastrium, symptoms which improved under diuretic medicine. His bowels were at first costive, but soon became loose. He lost control over the sphincter, and passed all his motions in bed. About a week after the onset three or four bedsores formed over the sacral region. Besides the numbness, there was a sensation of tingling in the feet, and to a less extent in the hands also. He was treated at home until the cold, which had led to "congestion of the lung," was recovered from, when he was sent into hospital.

On examination it was found that there was almost total paralysis of both lower extremities, only a very slight degree of motion being present in the toes. Anæsthesia was absolute, and extended to within a short distance of the umbilicus. The knee-jerks were completely absent. There was no ankle clonus. He stated that there was no loss of power in the arms, but the dynamometer registered only 10 kilos. in either hand. The bladder was over-distended, as was shown by dulness in the hypogastric region, and the urine was therefore removed by catheter.

The pains in the legs were constantly present, and always severe, although more so at certain times. They were worst in the feet. They had no shooting character.

Dr. M'Call Anderson came to the conclusion that the lesion affecting the spinal cord was of a syphilitic nature, for the following reasons:—

1. Nineteen or twenty years ago, after exposure, he had some "very trifling" affection of the penis, the precise nature of which he does not remember. He was treated, for a fortnight only, by internal remedies, and "cured." There were no secondary symptoms.

2. He married in 1881, at the age of 30. The following record gives the issue of his wife's pregnancies:—

(*a*) Six months' child, still-born, March, 1882.

(*b*) Seven months' child, still-born; rash on trunk.

(*c*) Eight months' child; said to have been dead for two weeks before birth.

(*d*) Six months' child, still-born.

(*e*) Female child, at full time, apparently healthy; is now 5 years old, and is at present in the Royal Infirmary with disease of the ulna and tibia.

(*f*) Miscarriage at second or third month.

(*g*) Boy, at full time, apparently healthy; died a fortnight after birth from "collapse of lungs."

(*h*) Miscarriage at second month, a year ago.

3. The pains in the legs were markedly worse at night than in the daytime. He has also occasionally had slight nocturnal headache.

The treatment consisted in putting the patient on a water-bed, attending to the bladder and bowels, and dressing the bedsores with boracic acid powder. Daily inunction with mercurial ointment was begun on the 9th of January, and for some time antipyrin was given every evening on account of the pains in the legs.

A fortnight after admission he found that he could draw up his legs in bed, and since then the power has rapidly returned. At the same time the anæsthesia became less marked, and, finally, completely disappeared. About the 28th of January he ceased to be troubled with retention of urine, and regained control over the sphincter ani. The bed-sores healed rapidly, and were quite cicatrised about the same time. The use of antipyrin was also stopped on that day, as the pains in the legs had gone. On the 10th of February he was able to rise and walk a short distance in the ward. Massage was then begun in addition to the other treatment. He could walk a longer distance every day, and, though his legs were tremulous at first, they were perfectly steady when he was examined on 23rd February. Anæsthesia was then completely gone. There was still a slight tingling sensation in the fingers and toes. The knee-jerks, however, had not returned, although the plantar and cremasteric reflexes were normal. The grasp of the hands was much more powerful, the dynamometer registering 36 kilos. in the right and 30 in the left hand on 28th February (as compared with 10 kilos. on admission). This patient left the Infirmary on 13th March, at which time his recovery was perfect—he could walk as well as ever he did, and the knee-jerks had returned. Before leaving he was shown at a meeting of the Glasgow Pathological and Clinical Society.

17. *Case of Psoriasis treated by Thyroid Extract.*

A. M'C., aged 10, was admitted to the Western Infirmary on 16th December, 1893, suffering from psoriasis of four years' duration. His general health had always been good.

The eruption began on the back of the elbows, in the shape of small dull red patches, which became scaly, and gradually spread, involving successively the legs, trunk, and head. On several occasions it disappeared from all parts but the knees and elbows, and spread again, usually in spring or autumn. It appears to be aggravated by sea air.

On examination, the trunk, scalp, and limbs are found to be the seat of numerous patches of eruption, of varying size. There are a few small spots on the face. The colour of the patches is a dull red. They are mostly circular, and all covered with typical silvery scales. The buttocks, knees, and elbows are chiefly affected. Over the scapulæ the disease tends to be rupioid.

It was decided to use thyroid extract, and the initial dose was half a thyroid tabloid (Burroughs, Wellcome & Co.) twice daily, each tabloid containing 5 grains of the healthy sheep's gland. The dose was increased as follows:—

1894.	
Jan. 4, . .	Half a tabloid thrice daily.
„ 9, . .	One tabloid twice daily.
„ 18, . .	One tabloid thrice daily.
„ 22, . .	One tabloid four times daily.
„ 26, . .	One and a half tabloid thrice daily.
Feb. 7, . .	Two tabloids thrice daily.
„ 11, . .	Two and a half tabloids thrice daily.
„ 19, . .	Three tabloids thrice daily.

It was not increased beyond this point. Two days after the beginning of treatment the scales were much less adherent, and desquamation freer. In five days desquamation was very profuse, and many patches were free of scales, a red raw surface being left, which was moist in many places. The lecting was most observable on the buttocks and knees, where the appearance was eczematoid. These parts were dressed with ung. bismuthi oleatis. On the 4th January they had healed up, while desquamation was still very free. It continued so throughout, and on 4th February it was noted that the patches on the front and on the back of the trunk had assumed a much paler tint, the change beginning in the centre of the patch and extending towards the periphery, so that the eruption there was ring-like in form. Two days after-

wards a number of small red spots appeared upon the face, and in the course of the day coalesced, so as to form large patches, which, however, were not scaly. By the 14th thin scaly plates had appeared upon their surface, while the rest of the body continued to improve. On the 23rd the rupioid patches on the shoulders had disappeared, but for a faint indication of their edges. A month later the eruption was much paler all over the trunk, and a decided, though slow, improvement was noticed. Without presenting any special features, this improvement continued. On the 4th May, just before the patient left hospital, the eruption had completely disappeared from the face, trunk, and extremities, with the exception of a somewhat rough condition of the skin of the buttocks, while on the external aspect of the left thigh there was a spot, about one-sixth of an inch in diameter, which still presented silvery scales. On the lower part of the legs there was considerable pigmentation where the patches of disease had existed, but no trace of eruption. One or two scaly patches persisted on the scalp.

During the treatment the boy complained of sickness and bad headache on two occasions before 28th December, and he again complained of sickness on 23rd February. With these exceptions, he suffered no inconvenience. His weight on the 22nd December was 3 st. 9¼ lb.; on 8th January, 3 st. 10½ lb. After this it fluctuated somewhat, but on the whole he lost flesh, the lowest recorded weight being 3 st. 4½ lb. on 14th April, while a week afterwards, when he was last weighed, he had gained 1½ lb. The temperature was not affected. No record of the quantity of urine was kept.

18. *Spinal Symptoms consequent upon Caries of the Vertebræ.*

A. G., female, 10 years of age, was admitted on 16th November, 1893, after a week's stay in Professor Buchanan's wards. Her complaint was of weakness and stiffness of the legs.

In the third week of January, 1893, she had a severe attack of enteric fever. She recovered slowly, and was sent on the 8th of May to a convalescent home at Largs. While there, about the end of May, she fell on her back on some bricks, a week after which her present symptoms set in. The first of these was pain in the spine between the shoulders, followed later by pain in the small of the back and in the left shoulder. These pains were supposed at the time to be rheumatic. She returned from Largs on the 1st of August, when her parents

thought her not so well as when she went there. She then complained greatly of pain in the upper dorsal and lower cervical spine, these parts being very tender on pressure. She also had pains in both shoulders, especially the left, and they at times shot down both arms, causing her to cry out. Her power of walking gradually grew less, the legs becoming weak and stiff. Nine weeks before admission a swelling was observed above the left iliac crest. There was throbbing pain in it, and, as it did not improve, she was sent to the surgical wards on 8th November. While there the swelling did not increase in size, and was painless. She was therefore transferred to Dr. Anderson's care.

Examined on admission, the skin was found to present a slight roseolar rash, fading on pressure. She lay in bed in a somewhat rigid posture, moving very little. She perspired freely. The lower limbs were found to be very stiff and rigid, and ankle clonus was distinct on both sides. The knee-jerks could not be elicited, probably owing to the rigidity. She could not stand with her heels together, even with the eyes open, and in walking had to be supported on either side. It was then observed that she raised the feet a good distance from the floor, and kept them widely separated. She has never had involuntary spasms of the legs, but at times voluntarily draws them up on account of shooting pains in them. Owing to the pain the head was held very stiffly, and the movements of the neck were limited, especially in a backward direction, but also laterally. Pressure upon the spine gave rise to pain over the sixth and seventh cervical vertebræ, and also over the lumbar vertebræ. There was also a fulness above the left iliac crest, where pressure gave severe pain. Her general health seemed to be good. She was well nourished, and had been growing stouter during the month before admission. The urine was normal, but, for a short time after admission, there was incontinence.

She was put upon half a drachm of syr. phosphori three times a day, and was ordered absolute rest on her back. This was the sole treatment. Under it the symptoms improved one by one. Five months ago the shooting pains in the legs had ceased, and a month later the pain in the back disappeared. Three months ago the ankle clonus could no longer be obtained. At the same time the iliac swelling gradually diminished in size, and the rigidity began to grow less. Two months ago pain set in in the small of the back and down the left leg, but had quite disappeared in six weeks. She has been getting up for about a month.

Examined upon the 24th of May, 1894, it was found that clonus had completely disappeared. The knee-jerks were still absent, although rigidity was gone. She could now walk without assistance. In doing so, she swayed slightly from side to side, and the right foot had a somewhat stamping tread. The feet were well turned out, and kept somewhat apart. She could walk backwards without difficulty, but could not keep to the line of a single plank, and in turning rapidly she staggered. When standing with her heels together, and her eyes shut, there was considerable lateral oscillation.

Her general health has been good throughout, and her temperature has always been normal.

19. *Case of Pseudo-hypertrophic Paralysis.*

P. B., a boy of 8, was admitted on the 9th May, 1894, complaining of weakness of the legs of about two years' duration.

The family history had no bearing on the case.

His mother says that he never was a good walker, although he was a strong child, and began to walk when 10 months old. Two years ago he had measles, and has not been strong since. He went to school at that time, and since then the defect in his gait has become much more noticeable.

The first symptom observed, two years ago, was that he was very apt to fall, and had considerable difficulty in rising. From that time also there was a tendency to walk on the toes. He began, too, to find it hard to go upstairs, and to do so he always put the right foot first, and dragged up the other after it. He can run very little, and does so on his toes. His mother has noticed that the calves of his legs have been increasing in size, but at the same time becoming softer than formerly. She has not observed any difference in the arms, which she thinks are not weaker than they were.

On examination the boy is seen to be rather emaciated, but the calves of the legs are decidedly prominent. They are equally enlarged, and measure $10\frac{3}{8}$ inches in the widest part (upper part of right thigh, $11\frac{1}{2}$ inches; left thigh, 11 inches). The superficial reflexes are normal, but the knee-jerk is absent in both legs. As tested by Faradism, the solei and gastrocnemii are found to be normal, while there is no reaction in the extensors of the knee or flexors of the hip. In the other muscles of the body the reaction is normal, but feeble. This is probably due to wasting.

When he walks it is observable that there is a very marked lordosis, the shoulders being thrown far back, and the lumbar curve greatly exaggerated. The gait is waddling, the upper

part of the body swaying from side to side. There is a distinct tendency to walk on the toes. When laid on the floor he rises in the characteristic fashion—first rolling on to his face, then getting on all fours, and finally climbing up the thighs.

Mentally he seems to be somewhat deficient. He has rather a vacant look, and is slow to understand and to answer questions.

The temperature has been normal since admission. The urine is pale, neutral in action, of specific gravity 1005. It contained no albumen until 5th June, when a trace of it was found.

He is being treated by massage and Faradisation, and the administration of a tonic containing 2 drs. of tinct. nucis vom. and 1½ dr. of liq. arsenicalis in a six ounce mixture. Of this, 1 dr. is given thrice daily after food.

20. *Case of Tubercular Peritonitis—Recovery.*

A. H., æt. 9, was admitted to the Western Infirmary on 7th March, 1894, complaining of cough of three months', and pain in the abdomen of two weeks' duration.

His father and mother are alive and healthy. He has two brothers, of whom the younger is "very delicate." One male child was still-born. He has one sister, who is quite healthy.

The patient himself has always been "delicate." He had measles two years ago, and one year ago an attack of bronchitis, for which he was admitted to the Infirmary. He remained well, after dismissal, until three months previous to readmission, when he "caught cold." Since then he has been troubled with cough, and in the last three weeks he has been getting very thin. Two weeks before readmission he began to complain of severe pain in the lower part of the abdomen, and during that time he was subject to diarrhœa. Distension of the abdomen was also present. For the last four or five days of this time, he has suffered from an intermittent pain across the forehead, and been feverish at night.

State on Admission.—Temperature, 100·8°; pulse, 140; respirations, 40. He looks frail, and is distinctly anæmic. The chest is spare, the eyelashes long and black. He lies in bed with the legs drawn up. At night there are profuse perspirations. In the chest numerous scattered bronchitic râles were found, but at the apices there was nothing abnormal. The cardiac sounds were naturally rapid, but the heart was otherwise normal.

The abdomen was found to be uniformly distended. It

was tender, and on palpation resistant. No enlargement of the glands, or tubercular thickening, could be made out, but he kept the abdominal muscles very tense during examination, and so hindered a certain conclusion. On percussion the flanks were found to be much duller than other parts of the abdomen. That part which was quite clear extended from the level of the umbilicus upwards over the gastric area. Change of position did not cause complete disappearance of the dulness in the flanks, although it became decidedly less. Probably, therefore, there was some effusion of lymph on the parietal peritoneum. A slight wave of fluctuation could be got on placing the hand on one flank and tapping the opposite flank.

Diarrhœa, though previously marked, was not a prominent feature of the case after admission.

The temperature was hectic in character, running up to 103° about midnight, and falling considerably towards morning.

On the 13th of March he was noted to be "much brighter," and on the 25th it was noted that the improvement had continued. His temperature was often above 100°, and when it was so, iced cloths were applied to the abdomen (for half an hour) every two hours, and with the most satisfactory result, both as regards the removal of the tenderness and the lowering of the temperature. He also slept and ate better, and was much more cheerful.

Thereafter, he remained several months in hospital. The temperature, up to 17th March, frequently ran up to 101°, and not seldom to 102° or over. From that date till 25th April, the average of morning and evening temperatures was about 99·4°, but on the latter day it rose in the evening to 100·6°. Until May 17th it remained below 100°, but then rose in the evening to 102·2°, and on the 25th, after an interval of temperatures below 100°, to 101·6°. The last temperature of 100° was noted on the evening of 5th June.

As a rule he had one motion per diem, and only once more than two, on 31st March, when there were three.

During March he was not weighed. The average weights thereafter were:—

	st.	lb.	oz.		st.	lb.	oz.
April, . .	2	8	2½	July, . . .	2	8	13
May, . .	2	7	13	August, . .	2	10	12
June, . .	2	7	10	Sept. 1, . .	2	9	12

When last examined, the day before he was dismissed, it was found that a considerable dulness remained in the flanks,

and the abdomen was rather full, but the tenderness was quite gone, and the temperatures, as above mentioned, had been for some time about normal.

There was evidence of matting together of the coils of intestine.

The pulse-rate was 96. There was no cough. The respiration was quite quiet, and its rate normal.

The general condition was much improved.

The treatment adopted was as follows:—

1894.	
March 9, . .	Fomentations to abdomen. Milk and limewater. Tinct. of opii, 26 minims, as enema, when required to check diarrhœa.
,, 12, . .	Antipyrin, 5 grs., when temperature over 100°.
,, 14, . .	Iced cloths to abdomen when temperature over 100°. Atrop. sulph., $\frac{1}{250}$ gr. at night.
April 29, . .	Atrop. sulph., $\frac{1}{200}$ gr. as pill at bedtime.
June 23, . .	Pill stopped.
July 2, . .	Pill recommenced.
July 3, . .	Quinæ sulph., 1 gr., t.i.d.
July 18, . .	Ol. morrhuæ, 1 dr., t.i.d.p.c. To be much in open air.
Aug. 7, . .	Ol. morrhuæ, 2 drs., t.i.d.

He was dismissed on 19th September, when his condition was as above stated.

21. *Case of Bulbar Paralysis of Nine Months' Duration.*

Mrs. J., aged 35, was admitted into Ward VII, on 24th September, 1894, complaining of difficulty of articulation for the last eight months.

Her parents are both dead, but the cause of death is unknown to her. Altogether she has had twelve children, two of whom died in infancy; the other ten are alive and well. Last year she suffered from rheumatic pains in both shoulder joints. (There is also a rheumatic condition of the right tempora-malar articulation.)

The present illness began nine months ago with severe pain in the throat after catching cold, and along with this pain there was some difficulty in swallowing. Shortly after this the difficulty in speech commenced. She states that at the beginning of the illness there was some difficulty in protruding the tongue, but that it has now disappeared. The food has occasionally collected between the gum and cheek. There has been no difficulty in swallowing after the food has reached the

back of the mouth; indigestion has been troublesome for a number of years.

On examination there is nothing noteworthy regarding the lungs, heart, liver, or kidneys.

The face has a very peculiar expression in its lower part. In repose the lower lip tends somewhat to droop forwards, and the angles of the mouth are drawn downwards (the left side more than the right?) The patient generally has a handkerchief in her hand which she applies to the mouth, although she denies that saliva is constantly dribbling away. In repose she does not always require to support the lower lip, for, even when sitting up, the mouth can be kept closed. The lips can be pressed together, but the necessary movements in whistling or blowing out a candle cannot be performed. When speaking, she often assists the lips with the hand, the lower lip overlaps the upper (it must, however, be remarked that she is almost toothless), the naso-labial furrows become exceedingly well marked, the skin over the sides and alæ of the nose is thrown into long narrow wrinkles, the angles of the mouth are drawn down, and the skin under the chin is thrown into folds; the whole expression of the face being lachrymose except for the fact that the eyes give no indication of grief.

The speech is exceedingly deliberate and syllabic, but owing to the defective articulation it is very hard to understand. The following are the letters with which there is greatest difficulty: "c" ("psee"), "d," "g" ("dyee"), "h" ("apsch"), "j" ("dyay"), "l," "r" ("ah"), "v" ("bee"), "x" ("echs"), "z" ("yed").

The remaining letters she can articulate much better than would be supposed from the extremely defective articulation of words.

The tongue can be protruded, but is incapable of much voluntary movement in other directions. It can, however, be moved from side to side when protruded, and the tip can be the least bit raised. There is fibrillar tremor of the tongue, but atrophy is not apparent.

The arch of the palate is as nearly as possible symmetrical on each side. Paralysis of the palate is not apparent, but nevertheless the speech is distinctly nasal. On the other hand, fluids do not regurgitate through the nose. There is no defect of sensation of the palate or fauces.

Swallowing is apparently not very difficult for fluids, but solids always require assistance with fluid. She does not (when watched at least) push the food backwards with the

finger, but takes a sip of milk or water, some of which always dribbles from the mouth as she swallows. Food taken too quickly is apt "to go the wrong way."

Regarding the collection of food under the tongue and between the gum and cheek, the patient's answers are contradictory, but she has not been observed to use her finger in clearing away *débris* from these situations. She seems to admit having had to do so previously, but declares that it is not now necessary. She makes a similar statement regarding dribbling of saliva, yet she almost constantly has a handkerchief at hand, and generally near the mouth.

The only points which could be made out regarding reflexes are that the triceps, and flexor and extensor wrist reflexes, are perhaps a little exaggerated, especially on the left side; knee jerks active, but not definitely exaggerated, while there is a slight tendency to ankle clonus on the left side.

The larynx was examined by Dr. Walker Downie, and found practically normal. The ocular fundus was also found normal by Dr. Ernest Thomson.

Treatment has consisted of arsenic and strychnine, with a daily application of the continuous current to the spine. The digestion has improved since admission.

22. *Case of Wide-spread Erythematous Lupus Illustrating the Value of Iodide of Starch.*

Mrs. T., æt. 25, housewife, was admitted to the Western Infirmary on 2nd June, 1894, complaining of an affection of the skin of one year's duration. At the time of admission it involved the head, face, hands, feet, and the right side of the chest anteriorly.

The family history had no bearing upon the case.

The patient is a married woman, but has had no family. There have been no miscarriages.

For two years previous to the appearance of the eruption, she was in poorer health than usual, and was easily tired, but she had no very definite symptoms.

The disease first attacked the back of the ears, where the skin peeled off in small scales. The right hand was next affected. Here the disease began on the radial side of the back of the hand in round red spots, across the middle of which there was an appearance "like a cut." These increased in number and size, and gradually coalesced. The left hand was next attacked in the same way and in a similar situation, and some spots appeared upon both forearms and both wrists. Shortly afterwards the face was involved in the eruption,

which began in round red spots extending and coalescing at their margins, but here there was no fissuring. In the beginning of the year the feet were involved, the disease appearing first upon the heels, and then attacking the toes. A week before admission a few spots appeared upon the right breast, and have been rapidly followed by others.

On examination a number of patches of diseased tissue, with elliptical or crescentic margins, were to be seen in the situations above mentioned. They were of a livid red colour, with a distinctly raised edge, but there was but little induration or infiltration of the remainder of the patch, and there were no evidences of dilated, blocked up follicles. They were not itchy, but when she overheated herself she complained of a burning sensation in them. There has been considerable pain in the affected parts of the hands and feet, especially the latter. The eruption has always been dry. Its colour varies from time to time, being sometimes quite pale, and sometimes of a brighter red than usual.

The treatment, begun on 4th June, consisted in regulation of the bowels with ext. cascaræ liq., and in the administration of iodide of starch. No local applications were made. The initial dose of the iodide was 1 dr. thrice daily, but it was gradually increased to 4 drs. thrice daily.

On 8th July, a marked improvement was observed. At first the hands, face, and feet alone improved, but after a time the improvement extended to the chest. The spots had lost their livid colour, and were quite pale. In the face, it was difficult to make out the line of demarcation between the healthy and the diseased skin, while the feet were so far recovered that the patient could walk freely, though she was quite unable to do so on entering the Infirmary. She said, too, that she felt much stronger. No fresh spots had appeared. The improvement began very shortly after administration of the iodide.

On the 20th of July, there was no visible affection of the face, and the margin of the former patches could with difficulty be felt. On the breast, their situation was shown only by a slight pigmentation. On the hands and feet, they still preserved a pale pinkish colour, with a slightly darker margin, which, however, was not elevated, and from which induration had disappeared. Across some of these elliptical patches a straight cicatrix was found to run, indicating the line of the former "cut."

She left a day or two afterwards.

This is a rare form of a not very common affection. It is rare in so far as, instead of being limited to the face, or face,

ears, and hands, it was widely diffused over the body. But, although wide-spread, it had not a deep hold upon the surface; hence, when it disappeared, it left little or no cicatricial thinning of the skin. The influence of iodide of starch in strumous affections was brought under the notice of the profession by Professor M'Call Anderson many years ago, but he has always held that it is only in exceptional cases, and when given in full and continuous doses, that it proves curative. And it is impossible to tell beforehand which cases are likely to yield, and which to resist it.