graphs had been taken of him which showed spinal curvature with convexity to the left. The vertebrae he supposed were giving way. Paracentesis had been attempted under the hypothesis of emphysema, which was held for some time, and it had done rather harm than good. The growth was unusually vascular, and when a small portion of it had been excised, he thought it was probable the boy would have died at once, if they had not had at hand means for very quickly plugging the wound. The enlargement of the superficial veins round the tumour was remarkable, and indicated not only pressure on the azygos system, but also on the inferior and superior vena cavae. —Dr. Crookshank said he was much obliged for the attention given to this case, and in particular to Dr. Scrivitt, with whom he had consulted. In Dr. Harley's case he considered the mycelium demonstrated, not the clubs. In Dr. Skerrett's case the mycelium was seen by Gram's method; Dr. Skerrett had expressed himself doubtful as to the presence of the clubs, and had generously sent him some of the material for further examination, and, after a long time, he had been able to show the clubs there also. He was very sorry if he had overlooked any point in Dr. Eve's case, but he believed the demonstration of clubs in that case had been published. (Mr. Eve assented.) He thought it likely that if Dr. John Harley were kind enough to supply him with some material, he should be able to find clubs in it after some careful search. In the German cases there was certainly a different tendency in structure, and some variation in staining which led him to think it probable that the organism was polymorphic. At any rate when the actinomyces fungus was put under the same conditions in the calf it stained quickly, and the actinomyces in man; it was more difficult, but very easy, to stain the clubs. In cattle he considered it a very common disease. Many cases were mistaken for perleucht; many were disregarded. In man also some cases probably were overlooked. —Dr. Wethered begged to add a few words at Dr. Crookshank's request as to his recent experience in Germany of the difficulty of staining clubs in comparison with the threads.

**CLINICAL SOCIETY OF LONDON.**

**Friday, February 8th, 1889.**

**Christopher Hratn, F.R.C.S., President, in the Chair.**

**Narcolepsy.** —Dr. R. Caton (Liverpool) described this case. P.S., aged 37, was admitted to the Liverpool Infirmary on Sunday, 1888, complaining of extreme drowsiness. He had been a very healthy man until his thirtieth year, when he became rapidly stout, and the drowsines, which had troubled him more or less ever since, first came on. Unless in active exercise he was unable to keep awake, and even when walking in the streets sleep had come on. During sound sleep a convulsive closure of the glottis occurred, during which entrance or exit of air was entirely suspended, and the symptoms recurred. If the patient was not awakened by noise, the Rhiostasis was suspended for a minute, or a minute and a half, or even longer, and the most marked cyanosis occurred: at length thespam yielded, respiration was re-established, and the cyanosis disappeared. Attacks of this kind occurred, at short intervals, all night, and in the day also, during sound sleep. During sleep there was considerable salivation, none during the waking condition. The patient suffered from psoriasis, but was otherwise a healthy man. The symptoms were attributed to cerebral parasitic infections, leucococytes, or ptomaines in the blood. Salmi, Gautier, Bouchard, and others had demonstrated the existence of such bodies being narcotic, convulsant, and salivating action. Treatment consisted in the administration of phosphates, amidoform, and carbonic acid, under which the convulsions wholly subsided, and the drowsiness decreased greatly. —The President alluded to the Classical case of the fat boy in Pickering's book. The case quoted by Dr. Gurney in his very instructive and interesting account was one of these cases which he had used to sleep so heavily that her husband had connection with her without awakening her. He observed that many persons, who slept whilst reading or in church, suffered from a modified form of narcolepsy. He inquired whether the position of the head had not to do with the snoring, and whether by "salivation" was meant an augmented flow of saliva. —Dr. Saville alluded to a patient, a curate, who had applied to him on account of his inability to remain awake during his rector's sermons. He had examined the man thoroughly, and came to the conclusion that the fault was not entirely the rector's. He attributed the somnolence to a species of lethania. By restricting the diet and giving him back and acid he had been enabled to resist it. Somnolent tendency, Dr. Sprigge Phillips said, he had seen in a patient of his, who, in teryforms of that affection prolonged hypnotism was often present. —Dr. Half-Went observed that most cases of prolonged sleep were associated with increase in weight, and fat people were generally sleepy. —Dr. A. M. H. Hall mentioned the case of a very stout gentleman. He was of the weight of 5 feet 6 inches, but who weighed 25 st. 4 lbs. He was also overcome by constant fatigue, and allowed to him to take from a pint to a pint and a half of hot water daily. In three weeks he lost a stone in weight, and the somnolence was decreasing. The patient then had to go abroad and so passed out of sight. —Dr. Arkel was reminded of a case under Dr. Bastian. The patient was always to be seen sound asleep. He had had syphilis. He was known in the hospital as "the sleeping man," and could sleep at any time, even when walking about. He had had the disease of the salivary glands similar to Dr. Leake's, but no spasms of the glottis. No important changes took place under treatment, and no signs of disease of the nervous system could be made out. He gradually lost ground and died, and during his last days always had a very low temperature; on post-mortem examination, they found some emptying of the surface of the brain and some thickening of the mucous membranes. —Dr. Caton, in reply, explained that the patient had been a case of real snoring, but absolute temporary closure of the glottis, with suppression of the respiration, and placed the patient apparently in great danger, as he became quite cyanosed. The flow of saliva was very much increased; it saturated the pillow, and was itself a source of great inconvenience. The patient had never had syphillis. At the time the sleepiness came on the patient was gaining weight at a great speed, but when first seen by Dr. Bouchard, although the sleepiness was diminishing, the sleepiness had continued for a short time. Dr. Caton concluded that the case mentioned by Dr. Arkel more closely resembled his own than any other he had ever heard of. Dr. Bouchard had found that if the urine of a healthy man was injected into the system of a rabbit it produced many symptoms, amongst which was an increased flow of saliva. He thought this fact suggestive.

**Hystero-Epilepsy with Persistent Contracture, Analgesia, and Anesthesia, Limited to the Upper Extremity in a Male Subject.** —Dr. Savill showed and described this case. The patient was a hawker, aged 29, who had had fits for five years. The contraction, which was very marked and involved all the muscles of the limb, had come on suddenly two years and a half previously, after a series of bad fits. There was some diminution of volume, but the electrical reactions were normal. There was an anaesthesia and analgesia in the defined limits occupying the shoulder and arm. The form of the anaesthesia was truly epileptic in character. He had had one series of a severer kind while under observation, extending over sixteen days. Of these last he had two to twenty a day, and many of them presented four stages: epileptoid, convulsive, purposive acts, and delirium. There was marked retention of the field of vision, but otherwise the eyes and other special senses were normal, and there was no paralysis elsewhere. The patient was and had been healthy, and had had no local lesions or affection of the cranial nerves. The severe fits had been controlled by apomorphine, and the contractions had been treated with slight success by hypnotism. The anaesthesia was interesting as not corresponding to the distribution of sensory nerves whilst excited by well-defined lines parallel to the segment of the limb (segmental). The diagnosis of hysteria rested on this feature, the clinical character and history of the nature, the presence of hysterical stigmata and the character of the fit. —Hysterical tenderness observed that such cases were rare in women and still more so in males in this country, though sometimes found abroad amongst men of the Latin races. He had never met with a similar case. He claimed that the term functional disorder was peculiarly applicable to such cases, but of course it did not imply that organic lesions were present. He thought the term "hystero-epilepsy" was probably correct; there was nothing peculiar to the arm, but it was not known to be due to any organic disease of the nervous system inasmuch as any such disease producing all the symptoms in this case, without other symptoms, must be multiple, and could hardly occur without producing other symptoms. It was probably a case of functional disease, if one might use such a term in the present day; the limb being altered in an
the functions. There was a primary alteration of function, not depending secondarily on organic nerve-disease. Brown-Séquard had shown that in animals, epilepsy sometimes followed peripheral injury, and the same thing was met with in human beings. He mentioned the case of an individual who had severely injured the sciatic nerve. He subsequently developed epileptiform attacks ushered in by pain and spasm of the muscles in the leg, which spread thence to the rest of the body, and was of long duration, and caused by irritation of the exposed nerve. The excitation of the sciatic nerve gave rise to a sort of nervous explosion that produced temporary paralysis of the local muscles in the leg and anæsthesia over the same part.

In Dr. Savill's patient the effects were probably due to secondary irritation of the nerve-centres; only in that case a sort of explosion seemed to have taken place of the centres governing the arm, which unfortunately for him was permanent, and led to paralysis of the arm. He inquired whether the case could not be explained on the theory—Dr. Joseph Duhr said that at the Manchester Infirmary they not infrequently saw cases of hysterical affections following injury, with features of local paralysis and epilepsy, and in acute cases atrophy sometimes occurred. He mentioned that undoubted lateral sclerosis had followed that kind of contracture. He pointed out that the area of anæsthesia did not correspond to the distribution of any nerve.—Dr. A. T. Mivs mentioned that under the hypnotic influence the arm and fingers became marked more supple, but the effect was not permanent, and post-hypnotic quite ascertained. The patient could not be deeply narcotised. Dr. Myers thought the symptoms described as paralysis were simply contractures.—Dr. Hingston Fox asked whether there was anything lacking in the matter of sex?—Dr. Savill, in reply, said that the masculine element was well marked. The pathology of these cases was very obscure, and it was for that reason that he had brought it before the Society.

Raynaud's Disease, with a Peculiar Eruption on the Face. Scalp at Erythema Nodosum, like Erythema: Death from Pneumonia: Post-mortem Negative.—Dr. Samuel West brought forward this case. H. S., aged 17, came under observation for a peculiar eruption of the face. The fingers were observed to be purple, and on inquiry the affection turned out to be Raynaud's disease, the patient having suffered for about twelve months with recurrent attacks of blueness of the fingers and toes. There was nothing noteworthy in the patient's previous history or in her family history, save that the patient had a habit of putting her hand in cold water, which might be of a similar nature. The patient was admitted, and suffered from attacks of blueness of fingers and toes about twice a day for some time. The rash continued on the face. It consisted of a brawny desquamation upon an erythematous base covering both cheeks and the nose. The general appearance was as if the patient had had the parts affected powdered over with starch or flour which had partly caked. The urine was normal, and there was no spurious albuminuria. The paralysis of the double tongue was cutaneous and the face rubbed with zinc ointment. She left the hospital improved, but not well. A few days later she became worse, and the mother brought her back. There was no special change, except that the patient seemed very weak and feeble, and that the rash on the face had altered in character. It now looked as if the patient had erysipelas, which had been freshly treated with powdered starch. The rash involved the forehead as well as the nose and cheeks. Except for the debility and rest, no change had been noticed. The tongue was turned up, and the patient looked as if she was suffering from pneumonia, but no physical signs were obtained at the time, nor indeed up to her death, which occurred a week later from exhaustion, the rash on the face remaining unchanged. The post-mortem examination was negative, except that the right upper lobe was in a condition of pneumonia. The radial artery and median nerve and the maxilla were examined microscopically, and yielded no evidence of changes. The patient's death was attributed to pneumonia of the lung, which was thought to be really part of the disease, and if so had, it was believed, not been previously described.—Dr. Barlow observed that the more they saw of Raynaud's disease the more they saw that the term was very vague and comprehensive, and that it covered cases of very different symptoms. One of the common features of the disease was its being paroxysmal—that was essential; and, secondly, there was a chronic alteration of the skin. It was unsatisfactory to discuss skin diseases without seeing the case; but the drawings certainly pointed to some amount of chronic change, which had been designated "tachetic," and in which there was a certain amount of blood extravasation. Raynaud found altered blood pigment in such patches. In his (the speaker's) appendix to Raynaud's work he did not think he had given a sufficient amount of the skin attack described as in a case by Dr. Case, which had been accompanied by some nutritional changes in the eye. It was now fashionable in many countries to say there was no peripheral neuritis; but in many of the cases no peripheral neuritis had been found. The question, however, was as to the nature of the change.—Dr. Hingston Fox said it was interesting that the post-mortem examination was made shortly after the disease began, and before the peripheral nerves were involved. According to Mr. Hutchinson, the changes in these nerves were secondary, and occurred later in the disease. He asked whether the lung mischief might not come under the same head of vasomotor spasm.—Dr. Barlow thought that the post-mortem examination of the muscles of the face to interfere with the nutrition of the skin of the face.—Dr. West, in reply, said that no microscopic sections of the skin on the face had been made for obvious reasons. The changes were hardly noticeable after death. The patient had been under treatment for the skin affection on the face before the diagnosis of Raynaud's disease had been arrived at. The pneumonia came on in the ordinary way, as far as he could judge.

Living Symptoms.—Dr. F. Haviland Hall exhibited two patients. Case I.—Deep epitheliomatous ulceration of the right tibia. When the patient first came under treatment, the rapid course of the ulceration and the general appearance of the ulcer suggested the sloughing out of a gumma; but against this view were to be set the indurated edge of the ulcer and the enlarged and hard glands at the angle of the jaw. In spite of the temporary improvement under large doses of iodide of potassium, there could be no doubt at the present moment that the malady of the case was tuberculous ulcers of the subcutaneous tissue of the arms, and marked clubbing of the fingers and slight clubbing of the toes. With the exception of slight indications of emphysemata and some thickening at the root of the lung (? due to fibrosis), nothing abnormal could be detected in the chest to account for the clubbing.

**MEDICAL SOCIETY OF LONDON.**

**Monday, February 11th, 1889.**

Sir William Mac Cormac, F.R.C.S., President, in the Chair.

**On the Excision of Bone in Order to Promote the Healing of Certain Wounds or Ulcers or to Relieve Contracture Resulting in Connection with the Process.**—Professor Annandale, of Edinburgh, read a paper with this title. He remarked that the procedure was by no means new, and that his first paper on the subject was read before the Royal Society of Edinburgh more than twenty-five years ago, since which time he had himself operated upon several cases. For conciseness he considered the subject under the following four heads: 1. The removal of a portion of bone, not including its entire thickness, 2. The excision of a portion of the entire thickness of a bone, or, as in the case of the forearm and leg, of the two bones. 3. The partial or complete excision of a joint when the sore or contracture involved the soft parts in its neighbourhood. 4. The excision of a portion of the thighbone in order to allow the proper approximation of the ends of its companion bone which had suffered some loss of substance. In regard to the latter, he observed that, although scarcely included in the title of the paper, it was very nearly allied to it. He then described a number of cases illustrating his practice as recorded by other surgeons. One of the most interesting was that in which the Professor had successfully removed 2½ inches of the thighbone in order to relieve the contracture of the knee and heal the ulceration and healing of a wound of the leg. In conclusion, he stated that, as a primary operation in cases of injury this procedure was not likely to be useful except in rare cases, as it was impossible in the first instance to be certain of the exact amount of the loss of the soft parts, and he hoped that the experience of the operations referred to would encourage surgeons to make use of the principle in suitable cases. The President observed that the operation suggested by Professor Annandale might prove of service in cases which would otherwise be hardly accessible to surgical interference. He suggested, however, that in many such cases the transplantation of