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 empyema, which was held for some time, and it had done rather harm than good. The growth was extremely vascular; and a small portion of rib 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 stopping the hemorrhage. 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 venae cavae. — Dr. Crookshank said he was much obliged for the attention given to this case, which was a most interesting one, and one of much importance. In Dr. Harley's case he considered the mycelium demonstrated, but not the clumps. In Dr. Skerritt's case the mycelium was soon seen by Gram's method; Dr. Skerritt had himself described it as doubtful as to the presence of the clumps, and had generously sent him some of the material for further examination, and, after a long time, he had been able to show the clumps there also. He was very sorry if he had overlooked any points in Mr. Eyre's case, but he believed the demonstration of clumps in that case had just been published. (Mr. Eyre 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 clumps in it after some careful search. In the German cases there was a certain difference in structure, and some variation in staining which led him to think the organism was polymorphic. At any rate when the actinomyces fungus was put upon a slide and in the calf it stained up pretty well, and in the man's lung in man; and so it was difficult, but very easy, to stain the clumps. In cattle he considered it a very common disease. Many cases were mistaken for periauricular; many were disregarded. In man also some cases were probably 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 clumps in comparison with the threads.

CLINICAL SOCIETY OF LONDON.

FRI DAY, FEBRUARY 8TH, 1889.

CHRISTOPHER HRAFT, 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 Hospital on January 19th, 1889, complaining of extreme drowsiness. He had been a very healthy man until his thirtieth year, when he became rapidly stout, and the drowsiness, which had troubled him more or less ever since, first came on. Unless in active exercise he found it impossible 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. The symptoms were attributed to excess of poisons excreted, leucocytes, or ptomaines in the blood. Salvia, Goutier, Bouchard, and others had demonstrated the existence of such bodies having narcotic, convulsive, and salivating action. Treatment consisted in the administration of apomorphine, iodoform, and charcoal, under which the convulsing spasms and the salivation entirely subsided and the drowsiness decreased greatly. — The patient was still under the influence of the drug, as it has been continued. The case quoted by Dr. Guy of a young woman who 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 to do with the snoring, and whether by 'salivation' was meant an augmented flow of saliva. During drowsiness from the state of sleep — Dr. Savill 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 lithia. By restricting the use of 'salivation' and giving him barbituric acid he had enabled to resist the somnolent tendency. — Dr. HALE-WHITCOMB alluded to the case of a very stout gentleman, aged 29, whose height was 5 feet 9 inches, but who weighed 250 lbs, who also suffered from constant snoring, and who allowed himself to take from a pint to a quart of 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. AKERS 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, every when walking about. He had the abdication of theowers, but no spasms of the glottis. No salivary gland 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 only found some wasting of the surface of the brain and some thickening of the membranes. — Dr. CATON, in reply, explained that there was no real snoring, but absolute temporary cessation of the glottis, which superimposed a sleep had been asleep a short time, and placed the patient apparently in great danger, as he became quitecyanosed. The flow of saliva was very greatly increased; it saturated the pillow, and was itself a source of great inconvenience. The patient had never had syphilis. At the time the sleepiness came on the patient was gaining weight at great speed, but when first seen by Dr. Caton, although the sleepiness was diminishing, the sleepiness had continued for a short time. Dr. CATON, in reply, explained that the case mentioned by Dr. Arkel made, closely resembled his own than any other he had ever heard of. Dr. Bouchard said 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 described 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 had 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 arm and shoulder. The type of the kind 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: epileptic, convulsive, purposive acts, and deliberation. There was marked retraction of the field of vision, but otherwise the eyes and other special senses were normal, and there was no paralysis elsewhere. The patient had been seen in both inginal regions. The severe fits had been controlled by apomorphine, and the contractures had been treated with slight success by hypnosis. The anaesthesia was interesting as not corresponding to the distribution of sensory nerves whilst bounded 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 case, the presence of hysterical signs and symptoms, and the character of the function, which had marked 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 no organic lesions were present. He thought the term "hysteriform" was probably correct; that was still a matter of the arm, but it was not hysteriform 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 a
the functions. There was a primary alteration of function, not depending secondarily on organic nerve-disease. Brown-Séquard has 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 through the whole body, and with them a paralytic gait. Here excitement of the sciatic nerve gave rise to a sort of nervous explosion that produced temporary paralysis of the local muscles in the leg and anesthesis over the same part.

In Dr. Savill's patient the effects were probably due to secondary irritation of the nerve-centres; only that in this 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 this theory; Dr. J. H. G. Buxy said that at the Manchester Infirmary they did not infrequently saw cases of hysterical affection following injury, with features of local paralysis and epilepsy, and in acute cases atrophy sometimes occurred. He mentioned that undoubted lateral sclerosis had followed this kind of contracture. He pointed out that the area of anesthesis did not correspond to the distribution of any nerve.—Dr. A. T. Buxy mentioned that under the hypnotic influence the arm and fingers became markedly more suspicious, but the effect was not permanent. He added that the disease had only lasted several months. The patient could not be deeply narcotised. Dr. Myers thought the symptoms described as paralysis were simply contractures.—Dr. H. G. 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 was a Peculiar Eruption on the Face. Scalp atrophy resembling Erysipelas: 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 eruption 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 his family history except the history of his coldness of fingers and toes in cold weather, 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 albumen. The pathologist said that the eruption was almost entirely confined to 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 freely treated with powdered starch. The rash involved the forehead as well as the nose and cheeks. Except for the debility and rest, no improvement was noted on the fourth day. The fingers were again fully rose, 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 median nerves were examined microscopically, and yielded no evidence of changes consistent with the history of the case. The diagnosis of Raynaud's disease was the more they saw that the term was very vague and comprehensive, and that it covered cases of many 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 disease without seeing the case; but the drawings certainly pointed to some amount of chronic change, which had been designated "tächetic," and in which there was a certain amount of blood extravasation. Raynaud found altered blood pigments in such patches. In his (the speaker's) appendix to Raynaud's memoir he did not think he had given a sufficient account of the skin attack as described in a case by Dr. Case, which had been accompanied by some nutritional changes in the eye. It was now fashionable in many cases to apply there was peripheral neuritis; but in many cases no peripheral neuritis had been found. The question, however, was as to the nature of the change.—Dr. H. G. 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 late in the disease. He asked whether the lung mischief might not come under the same heading of vasomotor spasm.—Dr. Charles noted that the movement 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 Sponges.—Dr. HAVILLAND HALL exhibited two patients. Case I.—Deep epitheliomatosus ulceration of the right tonsil. 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 granulation; but against this view were to be set the indurated edge of the ulcer and the enlarged, 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 malignant nature of the disease. Case II.—H. P., aged 28, with fibro-lipomatous tumours in 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 emphysema 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 operation was performed 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 entire thickness of one of the bones of the forearm or leg 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 tibia and fibula at the intersection and healing of a fracture upon 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 expressed the hope 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