

But the dog can tell us not only the species but the individual. The almost inconceivable efficiency to which this gift is educated is the result of constant study. The canine mind and memory must be largely aromatic or made up of fragrances. We humans are on a much lower platform, but such as they are our powers should be utilised, for diagnosis sometimes depends upon their exercise. To say nothing of epiphytic and epizotic odours, such as those of favus, phtheiriasis, &c., typhus and small-pox and some other diseases can be identified by the smell of the patient. The smells characteristic of phthisis, rheumatic fever, &c., are probably a mixed product, due less to the micro-organisms than to the excretions. Bad smells are becoming scarce, particularly in hospitals, but greater importance attaches to the examination of (1) the secretions and of (2) the patients, and this duty must be faced where patients' lives are at stake.

The secretions.—An inspection of the fæces is not neglected by physicians, but other secretions are more accessible to students. The urine, which may smell of diabetes, of alkaline or acid decomposition and other fermentations and of various ingesta, is usually reserved for our examination. The smell of the vomit, a guide to the detection of volatile poisons and ingesta, such as alcohol, may also be the means of identifying the seat of disease. Life and death have often turned upon the question whether the smell of the vomit was stercoraceous. The examination of the sputum is also of daily and practical importance. Here, again, the difficulty is to procure it in its original septic state.

The patient.—As regards the patient, the most essential of our olfactory examinations of patients concern the nose, the mouth, and the ears. Most vital conclusions are sometimes based upon the septic smell detected in the ears of infants and young children; and the neglect of this examination may cost the child's life. A heavy, foul breath seldom escapes recognition, but we should in every case localise its origin by examining the patient's breath alternately whilst the mouth or the nose are closed. Often the smell is from the nose, as in ozæna and dry foetid catarrh; and unless recognised this may escape its proper treatment. The mouth is the most fertile source of distinctive smells, such as the respiratory effluvia in bronchiectasis or gangrene and other conditions, but most of the bad odours are of local production. Foremost as frequent causes of disease are dental caries and degeneration, as well as the foetid conditions of the gum found in hæmorrhagic stomatitis, in pyorrhœa, and in gangrene. Follicular foetid tonsillitis and various conditions of the retro-nasal fossæ have also to be accounted for. Putting all this aside, the breath is of vital diagnostic importance in diabetes and in uræmia, and patients with chronic disease should always be examined in that direction.

In conclusion, the subject of this address has hardly received full justice at my hands or much literary ornament. I came to you less prepared for an academical function than to talk as a student to students, to suggest some of those special hints which veterans often have to offer, and to discuss with you with the advantage of some slight experience your plan of campaign. May I have been so fortunate as to adapt my remarks to my audience and to their practical aims and to have in some measure fulfilled my intention to direct their whole-hearted attention to the every-day trivialities of clinical study and their thoughts sometimes also to the higher ideals of the art.

A FURTHER NOTE CONCERNING THE FRONTAL OR SUPRA-ORBITAL REFLEX.

BY WALKER OVEREND, M.A., M.D. OXON.,
LATE SENIOR PHYSICIAN TO THE TOTTENHAM HOSPITAL.

REFERENCE was made in an annotation in THE LANCET last year¹ to the facial or supra-orbital reflex and a summary was given of the recent researches of two observers—McCarthy and Hudsvernig. I cannot refer to the *Neurologisches Centralblatt* for a full account of their work, but I may state that I first described this reflex in 1896² under the

name of "frontal" and demonstrated it to medical friends as far back as in 1889. In this communication I indicated the reflexogenous area and came to the conclusion that it was a true skin reflex inasmuch as mere stroking of the skin is sufficient to evoke a response when the latter is in a condition of hyperæsthesia. McCarthy's statement that division of the supra-orbital nerve abolishes the signal corroborates this view. Further observation, however, has taught me that it is not only the supra-orbital but also the cutaneous and periosteal terminal twigs of the supra-trochlear, infra-trochlear, nasal, and lacrymal, in fact, *all* the end branches of the ophthalmic nerve, which are concerned. In other words, tapping of the nose (nasal) with the eyelids closed, of the inner surface of the nose and the eyebrow near the inner canthus (supra- and infra-trochlear), and of the external angular process of the frontal bone (lacrymal) is able to produce the movement. The terms "supra-orbital" and "frontal" as applied to the reflex are, therefore, inappropriate. Moreover, the term "facial" is still less accurate, since there are *several* reflexes (as the corneal and the lacrymal) which occur in connexion with the facial nerve and the face. There is one reflex in this region which has apparently escaped description—namely, an *aural* reflex which may be induced occasionally by stroking gently and quickly downwards the skin (supplied by the auriculo-temporal nerve) in front of the ear in young infants. After a little patience and perseverance the ear may be suddenly elevated—a result due to contraction of the attollens aurem which is supplied by the small occipital nerve. It seems to be a true skin reflex and identical with that which is more easily obtained in some of the lower mammalia. This reflex, moreover, obviously belongs to the area of the face.³ The term "facial" is consequently unsuitable and I propose that of "ophthalmic" as being more in accordance with its distribution.

In my former paper I expressed the conviction that the sign was not due to the communication of physical vibrations, since the area was most definite. Hudsvernig, however, proposes the cumbersome view that "it is an overflow of the muscular irritability to mechanical irritation into neighbouring muscles innervated by the same nerve," and is led to the theory because he has found that the contraction may be obtained on both sides after the right Gasserian ganglion has been removed. I have no opportunity of testing his statement, but before accepting his explanation the exact conditions and relations under which the signal is provoked must be carefully and thoroughly investigated. Moreover, granting the fact, another explanation is feasible. If the cornea near the external canthus of the *right* eye be gently touched or the eye-lashes pulled a twitch in a certain part of the lower *left* eyelid may be observed to accompany the movement in the right eye. Furthermore, a contraction of the same strand of fibres in the left eyelid may be subsequently and immediately provoked by tapping the right external angular process. It is difficult to conceive how the overflow could leap the bridge of the nose and make itself felt just in the same muscular fibres on the opposite side. As ordinarily demonstrated by a tap of the finger with the eyelids gently closed, I believe it is a periosteal reflex induced from the pericranium and periosteum supplied by the terminal twigs of the ophthalmic nerve, with a reflex centre corresponding to that of the corneal reflex in the medulla. I drew attention to the fact that in chorea and supra-orbital neuralgia the movement may be produced by tapping the head as far back as the parietal eminence. A similar distribution is often seen in hysteria. The reflex is absent in chloroform narcosis and in facial paralysis. I have found it difficult to obtain in paralysis agitans. In a patient with hemiplegia and hemianæsthesia it was absent on the paralysed side for several days after the attack, but when the skin of the normal half of the forehead was tapped *both* orbiculares could easily be made to respond.

My object in writing this note is to call attention to the more exact designation "ophthalmic" and to emphasise the view that the signal is a true reflex and obtainable from both the skin and the periosteum supplied by that nerve.

Clacton-on-Sea.

³ The aural reflex is most easily obtained in adults by tickling with a blunt-pointed instrument the skin of the external auditory meatus just opposite the tragus. The *opposite* ear, as a rule, is also elevated.

¹ THE LANCET, Nov. 30th, 1901, p. 1513.

² Preliminary Note on a New Cranial Reflex, THE LANCET, March 7th, 1896, p. 619.

BRISTOL MEDICAL CHARITIES.—During 1901 the employes of Messrs. J. S. Fry and Sons collected £565 for the various Bristol medical charities.

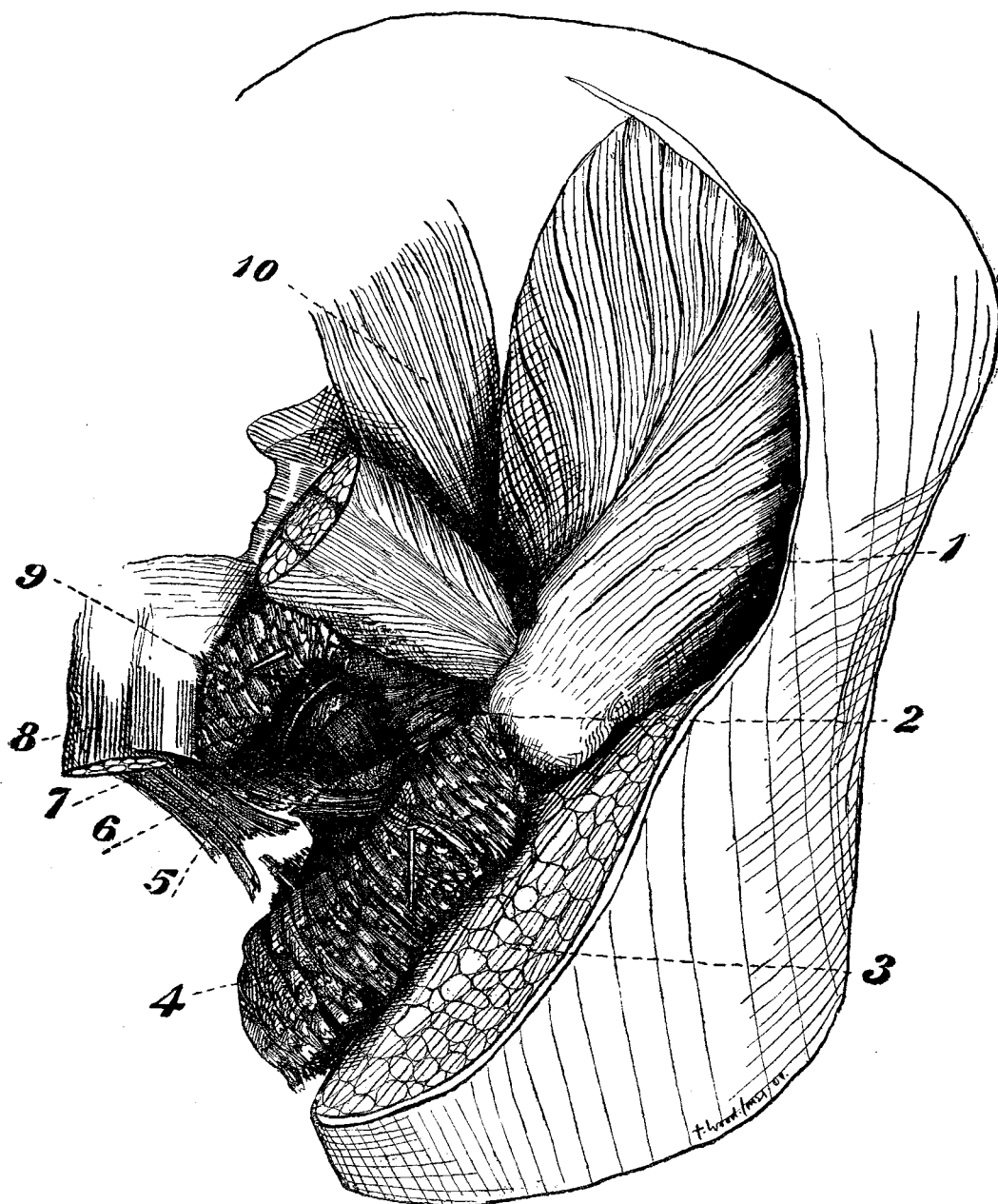
CASE OF RECENT TRAUMATIC PERINEAL DISLOCATION OF THE RIGHT HIP WITH A DISSECTION OF THE JOINT.

By HUGH M. RIGBY, M.S. LOND., F.R.C.S. ENG.,
SURGEON TO POPLAR HOSPITAL.

DURING May, 1901, two cases of dislocation of the right hip were admitted to the Poplar Hospital. The first was under the care of my colleague, Mr. A. B. Roxburgh. Both

For some reason the claws which grasp each side of the bale became unhitched. One of them struck the deceased on the left side of the face and simultaneously the bale of wool fell on the right thigh. It was impossible to find out how the deceased was actually standing at the time of the accident, but apparently the bale struck the right femur on its antero-external aspect, somewhere about the middle of the shaft. On admission to hospital there were an abrasion on the left cheek and two small wounds on the left side of the forehead. The right leg was flexed, abducted, and slightly rotated outwards. The amount of flexion was roughly an angle of about 30° with the horizontal and the amount of abduction was about 40° with the sagittal plane. The leg was kept firmly fixed in this position and any attempts at movement, either

FIG. 1.



View of the dissection from behind. 1, Gluteus medius. 2, Obturator externus (torn). 3, Gluteus maximus. 4, Quadratus femoris (torn). 5, Obturator externus (torn). 6, Head of femur. 7, Edge of acetabulum. 8, Origin of hamstrings. 9, Quadratus femoris (torn). 10, Piriformis.

were cases of perineal dislocation of the right hip-joint, both were in young, powerful men, and both presented practically the same physical signs and symptoms. In the first case (Mr. Roxburgh's) reduction of the dislocation was easy and recovery was uneventful; in my case, unfortunately, death suddenly took place a few minutes after an easy reduction under anæsthesia. The following are the notes of my case. The drawings, made by Mr. Wood Jones of the London Hospital, show the condition of the joint 24 hours after death.

A man, aged 23 years, was working in the hold of a ship in the docks. He was engaged in hoisting up bales of wool.

active or passive, caused much pain. There was lengthening to the extent of one inch on the affected side by spino-malleolar measurement. The great trochanter was buried and there were distinct flattening and broadening of the right buttock. A swelling which proved to be the head of the femur could be made out in the perineum. The adductors were tense and prominent, as was also the lower part of the gluteal mass. The patient was a man of very powerful build, the glutei and all the thigh muscles being exceptionally well developed. A diagnosis of perineal dislocation of the hip was made and reduction was proceeded with. Chloroform was administered. The right leg