in England alone for 1891 will be a little under or a little over fifty; of these I have been able to find, either in THE LANCET or the *British Medical Journal*, records of forty cases; of these forty cases, sufficient details are given in thirty-seven to enable me to say that twenty-seven occurred in hospitals or public institutions of some sort, and the remaining ten in private practice. Again, I have been able to ascertain the names and professional standing of the administrators in twenty-six instances, and I find that in by far the majority of cases the administrators have been comparatively young men—in fact, the average standing in the whole twenty-six cases was only four years and a half, and in sixteen it was less than two years and a half; this comparatively low average is of course largely due to the number of cases that are reported from hospitals, but as a matter of fact the same remarks apply equally to the much smaller number reported from private practice. Then, again, in these twenty-six cases I have been able to ascertain the particular medical school at which the administrators received their professional training, and arranging these schools into three groups, according to whether, in my opinion at least, the anæsthetic teaching was *nil*, very slight, or fair, I find that in these twenty-six instances the administrators had received no systematic instruction in seventeen cases, very little, if any, in five, and fair instruction in only four. In the same way in the previous year, 1890, ten cases are sufficiently fully reported; and, adopting precisely the same classification of the schools, six cases would come under the head of *nil*, two as very slight, and two as fair. With regard to other years, I may perhaps say that I have gone very carefully through the papers up to 1881, and find that precisely the same principle holds good throughout; but the actual figures are too small to make it worth while to tabulate them, as I at first intended. The question as to the professional standing of the administrators is of course a personal one, and obviously I cannot give you chapter and verse for my statements, and for a similar reason too I cannot well disclose the system of classification of the schools that I have adopted; and on these points, therefore, I must be contented if my deductions are accepted as matters of opinion; but I may perhaps claim for them that they should rank as the opinions of one who has gone very carefully into the subject. But however that may be, of this there can be no doubt whatever, that the greatest number of deaths occur in the practice of young administrators; that is, at just that period of their professional career when teaching is most likely to be of service and to stand in the place of that experience which they gain subsequently. Practical instruction during his student days, under the direct supervision and guidance of someone qualified to teach the subject, would furnish a man with a fund of information of far greater real value than would be obtained from the experience gained from many hundreds of cases without such teaching. Under the present arrangements, as I have endeavoured to show, such instruction falls to the lot of but a very small percentage; and my contention is that, if not compulsory, such instruction should at least be possible for all.

These are the chief reasons I would advance for the improvements I suggest; other arguments might readily be adduced—such, for instance, as that the habits of close attention and accurate observation entailed in the proper administration of anæsthetics render the study of the subject a not unworthy adjunct to any system of medical education. I think, however, that I have said sufficient to justify my conclusions.

C. A BRIEF INDICATION OF THE DIRECTION IN WHICH IT IS POSSIBLE TO MAKE THIS IMPROVEMENT.

An outline of the plan I would suggest is this: In the first place, candidates for the various degrees and diplomas should be required to produce evidence of proper instruction in the subject; this might well take the form of a certificate of having attended a definite course of lectures and demonstrations, and of having personally administered in a certain number of cases. This is, I think, the least that can be done by the examining bodies. In the second place, I think that at the hospitals the system of teaching anæsthetics should be the same as that adopted in respect to medicine, surgery, and other branches—that is, that after attending the classes the student should be appointed “clerk to the anæsthetist,” when, under the direct supervision and guidance of his teacher, he should administer to the necessary number of cases, and should keep whatever

notes and records it may be thought advisable. Finally, in the large hospitals especially, it would be of advantage to appoint resident anæsthetists to take charge of the administrations in the absence of the honorary officer. Some such plan as this would, I think, do much to place the teaching of anæsthetics upon a proper basis and that, too, without dislocating existing arrangements, and, if generally adopted, I feel sure that good results would follow.

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NOTES ON SOME HYSTERICAL CASES.¹

By JAMES KERR, M.A., M.D. CANTAB.

THE following three cases illustrate certain diagnostic points, and also call attention to a method of treatment seldom practised.

M. G—, aged thirty, came to the out-patient room of the infirmary complaining of fits, to which she had been subject some time. She was aware of their oncoming. A fit began by movements of the right hand and arm, then involved the muscles which draw the head over and towards the right; she then either lost consciousness or the fit passed off. She voluntarily added that sometimes after a fit she could see treble (triplopia) with the right eye for a considerable time. There was no period of aphasia or stupor after these attacks. She was made an in-patient and watched. There was no surface anæsthesia, but pharyngeal insensitiveness was noted; no further eye symptoms. She had fits as described; and although such attacks as hysterical manifestations are rare, yet, having regard to the pharyngeal insensitiveness, the transient monocular triplopia, and her general behaviour, hysteria was diagnosed, and she was discharged after a time unrelieved.

The next case, A. P—, aged thirty, came here seven weeks after her confinement complaining of gradual loss of power in the left hand during the three weeks preceding. Although she had no lead line, yet she was very sallow and anæmic; so iodide of potassium was given. A week later she was worse, and was ordered to be an in-patient. Some days later she was admitted, and on examination in the ward, surface and deep anæsthesia were found from two inches above the left elbow-joint to the finger-tips. There was also a rigid, semi-flexed position of the hand and arm. She had pharyngeal insensitiveness, but never noticed polyopia. Further examination of the eyes was deferred, and never accomplished. The diagnosis of hysterical contracture having been made, she was told that the doctor would return in a short time, and would cure her. This was accomplished after the usual ward visit by asking her to touch the top of her head with the left hand. This, of course, she could not do; so the wrist, being firmly held, was suddenly and forcibly raised and bent over the left shoulder. The patient screamed with pain, she said. So it was asserted, that if she had pain the sensation would return which she could feel in the finger-tips. The attention being drawn by stroking the hand and arm and pinching the fingers, in a very short time she began to feel in the fingers. The passive movements being repeated, and assertions made that she was regaining motor power, she was soon able to voluntarily extend the joints when passively flexed, and by a repetition of the manœuvres she had in the course of less than half an hour considerable motor power, and sensation enough to localise touch correctly. In the evening, after some little ebullition of temper, the condition recurred; but, by repeating the treatment, to which was added the assertion that the disease had no real existence, and could not recur, she was relieved, and the following day discharged. The contracture never recurred.

The next is the most interesting case, as it occurred in a powerful and intelligent man, J. T—, aged twenty-nine, a sign painter, of good history except that in 1889 he had a slight shock, being thrown on the floor by a sudden movement whilst working in a railway van, and later in that year he slipped in the street and sprained his thumb, which remained stiff for six weeks. On July 6th, 1891,

¹ A paper read at the Bradford Medico-Chirurgical Society on Jan. 12th, 1892.

whilst at work on a ladder, the rung broke, and he fell four and a half feet, bumping his head, and the back of his right shoulder; he was stunned, and, being picked up and taken to the infirmary, recovered consciousness on the way. He was after a few hours' detention made an out-patient, and attended as such during most of the month, complaining much of his head and of pain in the right biceps. He got such attacks of dizziness that he took to his bed and came under my care. He seemed on the verge of madness. The following note was taken on Aug. 1st: "The patient sits, preserving the same attitude, almost expressionless, but irrational and excited when drawn into conversation, complete loss of voluntary power in right hand and arm, thumb turned in, rigid, semi-flexed in position of contracture, which persists during sleep, right hand feels colder, but is really the same temperature (97.6° F.) as the left. There is superficial and deep anæsthesia of hand and arm, save a hyperæsthetic patch over the biceps, no glossy skin, no nutritional changes, lively reaction of all muscles to faradism. Over the rest of the surface to the right of the median line the perversion of sensation described as 'alochiria,' that is, that a touch on the right side is accurately referred to the corresponding point on the left side. There appears to be a negative sensory image of the right side projected on the left. This holds good only with respect to common sensation. The temperature sense is abolished on the right, and the muscular sense is also absent on the right side. There are no reflexes save the light pupil reflex elicited on the right side; the right eye cannot discern the fingers at the distance of a foot, the right ear only hears a watch on contact. On the left side there is a marked diminution quantitatively but no change qualitatively in the various functions. The left plantar reflex was decidedly lively compared with the other reflexes. The patient stands steadily, with eyes shut, the optic fundus is normal in both eyes, and the pharynx anæsthetic." The diagnosis of traumato-hysterical contracture having been made, and as for a month past medical treatment had been unavailing, it was resolved to try simple suggestion, which was ineffective. So the patient was hypnotised by the Nancy method. At the first sitting involuntary closure of the eyes was obtained; next, catalepsy and forced movements; and by the fourth time such phenomena as post-hypnotic negative hallucinations could be induced. He was sensible of the improvement in motor power; by suggestion partial transfer of symptoms was effected. By the eleventh sitting sensation in the hand was definitely re-established and motor power considerably regained, but fine tremor asserted itself on his attempting to write; this tremor could be nearly abolished by hypnotic suggestion, but reappeared post-hypnotically. Careful examination of the right eye showed considerable amblyopia—only central vision, in fact; at six inches distance he only saw the middle third of a match, and saw three images; when brought nearer the eye the match seemed immense (macropsy), "like a telegraph timber," he said; when some distance off it appeared "about a quarter the size it ought to" (micropsy). The field of vision of the left eye was also somewhat contracted; attention was paid to the sight in suggestions, and the increase in the field of vision was very apparent during the next three sittings. By the fifteenth sitting he was nearly well, and the last time I saw him there was but slight weakness in the right-hand grasp, the ocular symptoms persisted, but he was otherwise well, and forty days after beginning suggestive treatment he was at work as an "artist," which he has continued since. Charcot says that in these cases "without doubt the paralysis, already perhaps of long standing, may persist for months or years; nevertheless the cure ought to take place sooner or later, and our efforts ought to hasten the occurrence." The diagnosis of hysteria is probably made more often than the disease occurs; it is most important to make, not a negative, but a positive diagnosis, not merely to exclude other causes, but to find some definite evidence of lowered cortical activity, for that is the basis of hysterical symptoms. The emotional exaltation is merely a symptom of want of self-control, of lowered cortical activity; but, next to globus, probably one of the most frequent symptoms is pharyngeal insensitiveness, and then diminution of the visual fields is a fairly common one, the accommodation disturbance, monocular polyopia, and so forth being not so common. The polyopia is due to the action of the separate sectors of which the lens is built, the division being sometimes seen by a three-rayed star, with the

lowest leg vertical, to be seen in eyes otherwise apparently healthy. This varying action of the sectors is compensated normally by accommodation, which in two of these hysterical cases was thrown out of order. The macropsy occurs in myosis, and microspy in mydriasis; but why they should occur simultaneously in the same eye is not very evident. False impressions are formed from the difficulty in altering the accommodation either by contraction or dilatation of the iris.

Of alochiria, the rarest symptom of all described, which is known chiefly in connexion with cases of locomotor ataxia, no explanation has as yet been given. It seems to point to a dual action of the two hemispheres in every nervous act. In connexion with hypnotism it seems better not to look for hystero-genetic zones. One case reported by Charcot had the first fit produced thus, and passed into a convulsive habit. Another useful rule for the patients' benefit is always to insist on suggesting that no one else can hypnotise them.

Bradford.

NOTE ON A CASE OF APOPLEXY TREATED SUCCESSFULLY BY VENESECTION.

By W. H. RUSSELL FORSBROOK, M.D. LOND.

I THINK it well to record the following case as showing the value of venesection in an apparently hopeless condition.

The patient is aged forty-seven, a stout, plethoric, and muscular individual, with a specific history. He was said to have had an attack of left-sided hemiplegia about twenty years ago, with loss of speech, from which he recovered, except for a slight dragging of the left leg. In spite of this he indulged in hunting, shooting, and in every way lived a hard and active life. Between this time and 1881 he more than once lost his speech and memory for a few hours, and on one occasion was found in his garden unconscious. In October, 1881, he had two attacks of epilepsy within a few minutes of each other, without any warning except that he complained of feeling sick an hour before the first fit. Two days later he was about again as usual, although his medical advisers considered him in a precarious state of health, and from this time he has always been more or less an invalid. In the following December, when out driving, he again lost his speech, but recovered it in a few hours. In March, 1882, his wife, having left him in bed in his usual state, found on her return in half an hour that he had again lost his speech, that he could not swallow, that he was unable to protrude his tongue, and that his mouth was drawn to one side. It was afterwards found that his left arm and leg were again paralysed. For ten days his life was despaired of, and for many weeks he was very ill. He has, however, gradually regained the use of his arm and leg, and has become able to swallow fairly well, but his speech, though better, has remained difficult and unintelligible since this attack. During this illness he expressed his thoughts and wishes in writing, but his handwriting was changed, and has never been so good since. Latterly he has not walked so well; in fact, he has only taken carriage exercise, but has eaten and slept well. The above history is taken from notes made by the patient's wife.

On Feb. 8th of this year, at about 6 P.M., the patient was sitting in his chair asleep, when suddenly his eyelids were noticed to twitch, and he turned his head and eyes to the right side and threw up his arms. His face was slightly convulsed. When seen, about ten minutes later, he was lying outstretched and motionless on the floor of the room in which he had been sitting. He had bitten his tongue; his face was turgid and livid; his pupils were equal and rather contracted; his lips, ears, and finger-tips very purple. There was deep stertor, and all power of motion and sensation was lost; he was almost pulseless, and the cardiac sounds were feeble. As a fatal issue seemed to be directly imminent, I suggested to the patient's wife that her husband should be bled, as offering the best chance of relieving the immediate symptoms. She consented, and Mr. Pearce Gould was called in. He arrived at 7.15, when the case was explained to him, and after examining the patient he agreed that it would be judicious to bleed, although the case seemed hopeless. Mr. Pearce Gould then bled the patient to a pint from the left arm. Before