B. ADULTS. (INTUSSUSCEPTION RESECTED.)

No.	Operator.	Date of operation.	Sex and age.	Duration of symptoms.	Form of intussusception.	Death.
1	Küster	1879	M., 42 years	6 days	Iliac	A few hours
2	Fischer	1881	F., 27 years	?	Ileo-cæcal	†
3	Czerny	1883	F., 36 years	8 days*	Ileo-cæcal	A few hours
4	Obalinski	1883	M., 63 years	5 days	Iliac	The next day
5	Czerny	1884	M., 45 years	Chronic	Ileo-cæcal	2 days
6	Czerny	1884	M. 52 years	Chronic†	Ileo-cæcal	Recovered
7	Robson	1885	F., 33 years	7 days	Jejunal	§

* Chronic.

† Then acute.

‡ Death at close of operation.

§ Died in 2¾ hours of shock.

C. CHILDREN. (ARTIFICIAL ANUS FORMED.)

No.	Operator	Date of operation.	Sex and age.	Duration of symptoms.	Form of intussusception.	Death.
1	Waldenström	1873	M., 20 mths.	Sev. wks.	Ileo-cæcal	A few hs.
2	Royes Bell	1875	F., 16 mths.	6 days	Colic	7 hours
3	Brown	1882	M., 14 years	1 day	?	6 hours
4	M. Schmidt	1887	F., 10 years	7 days	Iliac	Same night

C. ADULTS.

No.	Operator.	Date of operation.	Sex and age.	Duration of symptoms.	Form of intussusception.	Death.
1	Caines	1866(?)	M., 23 years	5 days	Ileo-cæcal	17 hours
2	Hulke	1879	F., 16 years	1 year*	Ileo-colic	36 hours
3	Marchand	1882	F., 43 years	13 months	Colic	3rd day
4	Saltzmann	1882	F., 29 years	1 year*	Ileo-colic	14 hours
5	v. Wahl	1883	F., 44 years	10 days	Ileo-cæcal	½ hour
6	v. Winniwarter	1885(?)	M., 60 years	5 days	Colic	36 hours

* Chronic.

III. Artificial Anus without Laparotomy.

CHILDREN.

No.	Operator.	Date of operation.	Sex and age.	Duration of symptoms.	Form of intussusception.	Death.
1	Busch	1869	M., 7 mths.	14 days*	?	8 days
2	Hirschsprung	1871	? 22 mths.	?	Colic	40 hours
3	Stage	1876	F., 6 mths.	1½ days	Ileo-colic	2 days

* Four days acute.

ADULTS.

No.	Operator.	Date of operation.	Sex and age.	Duration of symptoms.	Form of intussusception.	Death.
1	Hauff	1841	M., 36 years	?	Ileo-cæcal	9 days
2	Pirogoff	1852	M., 16 years	Chronic	?	Shortly aft.
3	Robert	1856	F., 23 years	18 days	Asc. colon	2 days
4	Chassignac	1859	M., 39 years	3 months	Ileo-colic	5 hours
5	v. Thaden	1862	M., 23 years	?	Ileo-colic	10 days
6	Müller	1872	M., 33 years	Chronic	Ileo-cæcal	10 days
7	Heath	1881	M., 56 years	1 year	Ileo-cæcal	Shortly aft.

* Six months chronic, 3 days acute.

EPILEPSY AND MIGRAINE.

By SAMUEL WILKS, M.D., F.R.S.

JUDGING from what I hear and read, antipyrin has been as great a failure in the relief of epilepsy as it has been a success in migraine. I have now used this drug for nearly two years, and having seen its remarkable power in arresting attacks of headache, I can fully corroborate the high opinion held by the profession generally as to its merits. It has, however, by no means superseded other well-known remedies in their more enduring effect in the cure of this disease. As regards the power of antipyrin in epilepsy the result is very different, as not unexpected by me, who never have been able to discern the analogy between the two diseases, and which suggested the trial of the same remedy for both. This is no new opinion of mine, but if not hitherto expressed it has been out of deference to the great names of those who, in their writings, have associated the two diseases together. I have never myself seen the resemblance, but, on the other hand, have observed many and considerable dissimilarities. The only plausible reason for linking them together is their paroxysmal character; that is, persons who may be well to-day may have a fit or attack of migraine to-morrow, but the very difference in the nature of the paroxysm seems to me sufficient to dissociate them. In the one case, the patient may be as well as ever one moment, and the next moment may have fallen unconsciously down without there having been any warning of the occurrence; whereas, in the other case, the attack is approaching for hours, and very often some well-known cause has developed it. Nay, further, a migrainous person may, in the performance of some duty, predict an attack with certainty; he may, indeed, induce it. Then as regards the symptoms, there is nothing in common between them. The attacks are not only altogether unlike, but the epileptic, as a rule, is not a sufferer from headache, nor does the migraine patient become epileptic. Some years ago I took the trouble to ask the question of epileptics, and the almost invariable answer was that they did not suffer from headache. This is a very important and practical point, for if headache was present, it proved the case to be one not of simple epilepsy, but of fits due to injury, syphilis, or other cerebral disease, and which was often cured by the iodides and mercury when the bromides had failed. Then, on the other hand, I have no history of a migrainous patient becoming an epileptic. The former, as a rule, loses his trouble as years wear on, whilst the latter often becomes more confirmed in his complaint, or his brain altogether gives way. Amongst a large number of cases, I only remember one where there was a suspicion of the two maladies existing together. In answer to what I have stated, it would be maintained by those who regard the two affections as allied, that they admit the difference between the phenomena of migraine and epilepsy, but, nevertheless, they have a common pathology. This remarkable theory seems scarcely warranted by our ordinary mode of reasoning about cause and effect. The only plausible reason for such an opinion ought to be founded on the observation that the migrainous patient often becomes epileptic, or the reverse; but, as I have already stated, this is not true. It might also be maintained that the two affections are seen occurring in members of the same family. Now this, from a very long experience, I also deny. I know many families subject to migraine, but in none is there a single member epileptic. And more than this; the opposite fact is true, that the two diseases attach themselves to a totally different class of persons. The migrainous patient frequently belongs to the most cultivated and intellectual class of society, and is of the temperament called neurasthenic, whilst the epileptic, in my experience, belongs to a lower grade, and is generally the stupid one of the family; if, indeed, his fits are not associated with other grave defects of his nervous system. There is no lunatic or idiot asylum without its numerous epileptics, whereas some of the best descriptions of migraine are to be found in the Philosophical Transactions, given by the authors themselves. There may be, before an attack either of epilepsy or migraine, some altered mental condition; but, if so, in the former it is of the nature, first, of mania and then of stupor, whilst in the latter the mind is often more acute both preceding and during the attack. I will not go so far as to absolutely endorse an opinion expressed

by more than one observant medical man, that migraine is never met with amongst the lower orders, although it is difficult to conceive how such services as those of policemen or engine-drivers could go on were it at all common amongst the working community. A man or woman in a higher grade of society can afford to lose a day now and then without interfering seriously with their vocations. Moreover, there seems no good reason why the two diseases should be thought to have the same seat; in epilepsy it is proved that the brain is the seat of the explosion which causes the phenomena, whilst this is by no means certain in the case of migraine. Here the patient is bodily ill, his pupils are contracted, and thus unlike the dilatation of epilepsy; his stomach and bowels are deranged; his heart's action is depressed; he is cold and shivering, and apparently his whole ganglionic system is at fault. In a word, I see no resemblance between an attack of migraine and epilepsy. I observe they never pass the one into the other, they do not occur in the same families or in the same class of persons, and the remedies which relieve the two diseases are different.

Grosvenor-street, W.

SEA VOYAGES FOR HEALTH.

By A. CROSBEE DIXEY, M.R.C.P.Ed.

So many of our profession are daily ordering patients away for long sea voyages in search of health, with, as a rule, little or no practical experience themselves in the matter, more especially as regards the climatic changes the patient will have to encounter, that I venture to think the few following notes taken by myself in a voyage round the world may be of interest to the profession generally. We left Plymouth on Nov. 19th, 1887, by the New Zealand Shipping Co.'s steamer *Tongariro*, bound for New Zealand direct, *via* Madeira, Cape Town, and Tasmania. The temperatures on the voyage there read as follows:—

On the bridge of the “Tongariro.”

November 19th		43°	December 11th		65°
“ 20th		52	“ 12th		60
“ 21st		55	“ 13th		60
“ 22nd		54	“ 14th		48
“ 23rd		62	“ 15th		44
“ 24th*		66	“ 16th		44
“ 25th		72	“ 17th		44
“ 26th		77	“ 18th		44
“ 27th		80	“ 19th		44
“ 28th		86	“ 20th		44
“ 29th		86	“ 21st		46
“ 30th		80	“ 22nd		45
December 1st		80	“ 23rd		48
“ 2nd		77	“ 24th		46
“ 3rd		74	“ 25th		54
“ 4th		74	“ 26th		58
“ 5th		76	“ 27th†		66
“ 6th		68	“ 28th		65
“ 7th		68	“ 29th		64
“ 8th		69	“ 30th		66
“ 9th‡		64	“ 31st§		67
“ 10th		66			

* Arrived at Madeira.

† Arrived at Cape Town.

‡ Arrived at Tasmania.

§ Arrived at New Zealand.

For these temperatures I am indebted to the courtesy of Mr. Findlay, chief officer of the *Tongariro*.

Regarding the above temperatures generally, I must mention that they were taken in the deck-house on the bridge of the steamer at 12 o'clock noon in the shade, and that 8° of temperature must be added to each to represent the corresponding temperature in the saloons and cabins, which are of course warmer. Individually, we noticed the great rise of temperature in the first ten days from leaving Plymouth,—viz., from 43° on deck or 51° in saloon, to 86° on deck or 94° in saloon, a difference of 43°. This occurs in the tropics at latitude north, 8-41°, and continues until the Line is crossed; it is the most trying time for invalids. Another sixteen days bring the temperature down from 86° on deck or 94° in saloon, to 44° on deck or 52° in saloon, another difference of 42°. This occurs about latitude south, 47-58°, and is found to be less trying than the previous heat. From this until Tasmania is reached, the temperature gradually

rises to 64°, continuing about the same to New Zealand. Returning from New Zealand on April 5th, 1888, *via* Cape Horn, Rio de Janeiro, and Teneriffe, the temperatures read as follows:—

On board the “Rimutaka.”

April 5th		56°	April 27th		74°
“ 6th		55	“ 28th		76
“ 7th		52	“ 29th		78
“ 8th		53	“ 30th*		78
“ 9th		53	May 1st		88
“ 10th		55	“ 2nd		82
“ 11th		51	“ 3rd		80
“ 12th		52	“ 4th		84
“ 13th		48	“ 5th		89
“ 14th		47	“ 6th		89
“ 15th		47	“ 7th		82
“ 16th		47	“ 8th		82
“ 17th		46	“ 9th		78
“ 18th		46	“ 10th		78
“ 19th		44	“ 11th		70
“ 20th		44	“ 12th†		70
“ 21st		44	“ 13th		68
“ 22nd		48	“ 14th		65
“ 23rd		48	“ 15th		61
“ 24th		50	“ 16th		60
“ 25th		54	“ 17th‡		61
“ 26th		72			

* Arrived at Rio de Janeiro.

† Arrived at Teneriffe.

‡ Arrived at Plymouth.

For these temperatures I am indebted to the courtesy of Mr. Macrae, fourth officer of the *Rimutaka*.

The same remark applies to these temperatures as the former—viz., that 8° must be added to each to represent correct temperature in saloons and cabin. Individually, the rise from 44° on April 21st to 88° on May 1st, a difference of 44°, is the most trying part, and lasts, as in the outward voyage, until the Line is crossed.

The above temperatures may be taken as a fair average of what is usually met with in a voyage taken in the autumn to escape the English winter. Whether the patient is in a state to withstand these sudden changes it is for the physician to determine, but in any case it is well that he should know when giving an opinion that they have to be encountered. The important question as to whether a steamer or sailing ship is most beneficial must be decided according to the case; of course no fixed rule can be laid down. On a steamer one has the advantages of a shorter time in the tropics and an unlimited supply of ice whilst there, of a better table, and of warm sea water baths, so essential in rheumatic and gouty cases; on the other hand, there are the noises of the screw and the constant rush inseparable from a steamer being driven along at the rate of thirteen or fourteen knots an hour. For the majority of cases a steamer is more enjoyable, and the monotony is less, but for all cases of insomnia, mental cases, or where quietude is essential, a sailing ship is decidedly preferable.

I saw a case of overstudy develop into one of acute mania; this was a case that certainly should not have been sent out in a steamer. In the matter of clothing, invalids should be careful to have light clothing for the tropical weather, this is most essential; and also not to forget a warmer change for the cold which follows. Another important point is choosing one's cabin. Never take one with more than two berths; of these choose the *upper*, it is lighter and more airy; and if possible secure a deck cabin, bearing in mind that it is the extreme heat more than the cold that is most trying to invalids. The port or left hand side of the ship is the best going out; the right or starboard coming home. The extreme cold usually spoken of in coming round Cape Horn is, I think, greatly overrated. In this voyage the thermometer never fell below 44° on deck or 52° in the saloon; and the heat in the tropics, though trying, is far less than would be encountered in returning by the Suez Canal and Red Sea. It is frequently found that the stay of three months in the Colonies seems to do the patient more good than the sea voyage. In any case reaching there in the midst of their glorious summer, with new surroundings, magnificent scenery, and a perfect climate, must naturally have a beneficial effect on all but hopeless cases; and the patient returns with renewed health and vigour, with many pleasant reminiscences of places and people, and with the satisfaction of having escaped an English winter.