Hume, of Devonshire-street, Islington, who has kindly supplied full notes of the case while it was under his care. When first examined, the throat was found to be congested, but not ulcerated; the symptoms of paralysis of the palate and pharynx much as described; but in addition there are recorded as present deep pain about the cricoid cartilage, transient pains in the arms, numbness in the fingers, involuntary twitchings of the facial muscles, ringing noises in the ears, and an absence of paralysis of the legs, for the patient walked some distance to the surgery. Next day, exactly a week from the commencement of these symptoms, the patient could not rise out of bed; he had squinting, double vision, giddiness so great as to keep him in the recumbent posture, nasal voice, dysphagia, numbness of the finger-tips, "general loss of muscular power," defect of pronunciation, especially of the consonants *d* and *c*, frontal headache so severe as to make him cry out, and at night delirium. A blister to the nape of the neck was followed by speedy disappearance of the more urgent symptoms, and in a few days his sight became natural, his voice was restored, and he could swallow well and had a good appetite. The hands, however, became worse, the numbness passing upwards from the finger-tips, and the patient being unable to use a knife and fork. At this time his legs did not feel weak, but they soon after did so, and that, according to the patient's own account, rather suddenly. He states that one day whilst walking he was seized with pain in the calves; this did not disappear until night. Next morning the feet were numb, and the power in the legs thereafter was gradually lost. At no time were there any bladder or bowel symptoms, deafness or loss of smell, shortness of breath or palpitation. The squint, dysphagia, &c., did not return; at times there was slight headache; in other respects the general health was good.

On admission the patient could not walk or stand alone, and his hands were so far paralysed that he could not feed himself. A careful examination made a few days after determined the following results:—Feeble grasping power of both hands; considerable paralysis of muscles of legs; the feet cannot be flexed or extended against slight resistance; the patient is unable to pull or push off his slippers; walking is just possible, but peculiar. The patient on rising separates his feet, fixes his eyes on the ground, balances his body by raising his arms well from his sides, and having apparently thus gained his equilibrium, advances with a weak, rocking motion, the joints appearing peculiarly lax, and the trunk swung from side to side as the corresponding foot is planted on the floor. After half a dozen such steps the patient seems glad to catch at a bed for support. When standing, after balancing, he sways, and would fall if the eyes were shut for a moment. In the hands and feet there is a continual feeling of numbness. There is evidently some impairment of sensation in the hands, but not in the feet. Diminished electrical sensibility and irritability to faradisation both in arms and legs, but especially in the latter. Sight and eyes normal in every respect; ophthalmoscopic appearances as in health; a drumming noise in the ears, with some deafness; other senses perfect; no headache; sleeps well; mind evidently unaffected; no paralysis of palate; no cicatrix or loss of substance visible in the throat; tongue fairly clean; no dysphagia; appetite good; bowels regular; no pulmonary symptoms; voice natural; pulse 92, regular, of medium size, soft and weak; cardiac signs not abnormal; urine passed naturally; no albumen. Ordered two tablespoonfuls of strychnine and iron mixture three times a day, and a five-grain pill of mercury with aloes at night.

Nov. 12th.—Condition unchanged, except that for the last day or two the patient has complained of a "palpitation" in his knees, feet, and hands, passing after a few minutes' duration from limb to limb.

15th.—The patient believes his limbs are weaker. He walks as before, but states that he has fallen twice in the ward.

27th.—During the last week the patient has decidedly improved; he walks with much less "roll." Two days ago he began to suffer from slight sore-throat, with swelling of the glands externally.

Dec. 2nd.—Throat symptoms have disappeared; walks better; hands stronger.

10th.—Since the last note the patient has recovered so much that he can walk with only the slightest perceptible

"roll," and grasps firmly with both hands. His general health has continued good. He leaves to-day for a convalescent hospital.

The treatment was the same from the beginning throughout his stay in the hospital—simply tonic.

QUEEN'S HOSPITAL, BIRMINGHAM.

HYDATID CYST IN THE MENINGES OF THE BRAIN.

(Under the care of Dr. SAWYER.)

WE are indebted to Mr. Sunderland, resident physician's assistant, for the notes of the following case.

Joseph C—, aged twenty-nine, was admitted Sept. 16th, 1872. He stated that for the last ten weeks he had suffered from a very severe pain in the back part of his head and at the nape of the neck, which had lately prevented him from working. He had been troubled with noises in his ears. For the last few weeks he had vomited several times every day, the sickness coming on suddenly, and without any apparent cause. His friends had noticed that he staggered sometimes, that he was getting deaf, that he had a stupid look, and that his memory was becoming impaired. There was no history of syphilis.

State on admission.—The patient was a powerfully built and well-nourished man. His expression was vacant. He had a little difficulty in pronouncing his words; he doubled up the syllables like a man with general paralysis. All the special senses were a little blunted, and his perception was impaired; there was no paralysis of any nerve. The pupils were equal, normal in size, and responded to light. His optic discs were hyperæmic. He could walk a little when supported on either side; when left to himself he fell down in a heap. He complained of a constant pain, which was subject to frequent and great aggravations, in the back part of his head and neck; he suffered from buzzing noises in the ears; he vomited several times daily. The tongue was clean. Pulse, temperature, and urine normal. The pain in the head almost entirely prevented sleep. Bowels obstinately constipated.

Oct. 5th.—The patient has been getting rapidly worse, the pain becoming more violent, and the vomiting more frequent. To-day he became insensible; breathing stertorous, pupils dilated, urine and feces passed in bed.

6th.—He has improved a little since yesterday; he can be roused when spoken to.

12th.—Yesterday he fell into profound coma; dilated pupils, &c. He died this morning.

Post-mortem examination.—On removing the brain, the sulci between the convolutions were found to be filled with opalescent fluid. At the base, the space between the anterior border of the pons Varolii behind, the optic commissure in front, and the middle lobes laterally, was occupied by a convex cyst with thin opalescent walls. The right third nerve wound round the side of the cyst, and was flattened out, and a fourth of an inch in breadth; the left third nerve was also flattened out, but not so much as the right. The optic commissure was pressed on by the anterior wall of the cyst. The lateral ventricles were filled with serous fluid. The fornix was semi-diffuent. On opening the third ventricle from above, the cyst could be seen bulging into and forming part of its floor. The corpora albicantia had disappeared. The cyst was single, and seemed to have become developed in the posterior subarachnoid space. The heart and lungs were normal. A hydatid cyst, as large as a foetal head, was found in the right lobe of the liver. Another large cyst was found in the left kidney.

GENERAL INFIRMARY, LEEDS.

RETENTION OF URINE; RELIEF BY PNEUMATIC ASPIRATOR; EXTREME DYSPNOEA; TRACHEOTOMY; TEMPORARY RELIEF; DEATH.

(Under the care of Mr. PRIDGIN TEALE.)

WE have on a previous occasion spoken of the indispensable value of laryngoscopic examination in cases of dyspnoea. The following case illustrates in a most marked manner the truth of our remarks. Whatever may be the pathological condition which gives rise to paralysis of the vocal cords, it is certain that the dyspnoea is owing to

the closure of the glottis; and, therefore, an opening made into the trachea, or even into the larynx below the glottis, will give relief. If, however, the dyspnoea be due to actual pressure with partial closure of the trachea, the recurrent laryngeal nerve being unaffected, the operation of laryngotomy or tracheotomy will be of no avail. The fact that the paralysis is due to aneurismal pressure on the recurrent nerve ought not to be a cause for any delay in the performance of the operation when the symptoms have become urgent; but, of course, it is always desirable that the presence of an aneurism should be diagnosed. The method of relief of the bladder, as practised by Mr. Teale in the subjoined case, is unusual, but seems to be of value.

James D—, aged thirty-eight, was admitted July 26th, 1871, with retention of urine. He had suffered from stricture for more than eight years, and had several times been admitted into hospital with retention. No larger catheter than No. 6 could ever be passed into the bladder. The present attack began with inability to pass urine at 1 A.M. on July 26th, from which time up to his reception into hospital at 1 P.M., no urine had been voided. As no instruments whatever could be passed into the bladder, he was ordered an opiate and a warm bath. At 6.30 P.M., as he had been twice in a warm bath without relief, and his distress was becoming severe, Mr. Teale introduced one of the smaller needles of the pneumatic aspirator above the pubes into the bladder, and drew off 13½ ounces of urine. The needle with tube attached was allowed to remain for one hour, during which time 2½ ounces of urine drained away. The following day he was able to relieve the bladder by the urethra, no inconvenience whatever having resulted from the use of the aspirator.

On August 15th he was readmitted in order to undergo perineal section, in consequence of the frequent relapses of retention of urine. He now looked wretchedly ill, and suffered so much pain in the back that serious intra-thoracic mischief was suspected. The resonance of the chest was natural all over. Neither bruit nor dulness could be detected at the back of the thorax, where he complained mostly of pain. There was a double murmur over the aorta, extending along the course of the subclavians, especially the left.

A few days later, on entering the ward, Mr. Teale found that the patient's voice had become hoarse and croaky, and that he had a suffocating cough; he was therefore at once examined with the laryngoscope, and the left vocal cord found to be paralysed. Mr. Teale inferred that some tumour was pressing on the left recurrent laryngeal nerve, and from the acuteness with which pain had commenced, and the rapidity with which the symptoms had developed, he thought it probable that the source of pressure was an aneurism of the left side of the arch of the aorta. Instructions were given to Mr. McGill, the house-surgeon, to be prepared at any time to perform tracheotomy, should urgent dyspnoea set in.

Two days later, whilst Mr. Teale was in the hospital, the patient was seized with intense difficulty in breathing, and was in danger of suffocation. The symptoms were so urgent, that tracheotomy was performed by Mr. Teale without removing the patient from his bed, and immediate relief was obtained. He lived for four days in moderate comfort.

At the post-mortem a small aneurism about the size of a billiard-ball was discovered in the arch of the aorta, compressing the left recurrent laryngeal nerve. In his clinical remarks, Mr. Teale referred first to the value of the laryngoscope in pointing towards the cause of the sudden interference with voice and breathing, and giving a hope that tracheotomy might relieve the more dangerous symptoms; secondly, he pointed out that the cause of the dyspnoea was an aneurism. He nevertheless relied on tracheotomy for giving relief to the breathing, seeing that the seat of interference was in the larynx, and not lower down in the trachea below the point at which tracheotomy could give relief.

MR. RATHBONE, M.P., has liberally offered to supply the infirmary of the Manchester Union with trained nurses, or, at all events, to inaugurate a system of skilled attendance on the sick, in lieu of the pauper nurses commonly employed in workhouse hospitals. The proposal was warmly seconded by Mr. Cane, the inspector of the Local Government Board, and was referred for consideration to a special committee.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

TUESDAY, JAN. 21ST, 1873.

SIR W. JENNER, BART., K.C.B., PRESIDENT, IN THE CHAIR.

DR. MOXON exhibited the Lungs from a woman who had died of acute pleurisy on the right side. The lymphatic vessels of the subpleural tissue were full of pus. At the root of the right lung there was a large abscess. He had shown a somewhat similar specimen a few months ago. In that case the lymphatic vessels throughout the lung, as well as the superficial ones, were full of pus; in the cæcum was an ulcer, and the lacteal glands were in a calcified condition.

DR. POWELL asked if the lymphatics were only distended, or was there evidence of inflammation of them? Might not the condition be due to inflammation, and the vessels filled with their own products?

DR. MOXON said the lymphatics were distended with pus; the bronchial abscess was old, and pus degenerated; there was no pus in the cavity or tissue of the pleura.

MR. BENJAMIN DUKE exhibited a specimen of Anchylosis of the Hip-joint from a young woman. She had died recently of tubercular meningitis. The specimen showed good bony union between the head of the femur and the acetabulum; the patient some time before her death could get about well on crutches.

MR. W. ADAMS asked what was the age of the patient, and what time had elapsed between the disease and bony anchylosis? In all such cases the tendency to bony anchylosis was supposed to be slight, and usually many years were required.

MR. DUKE said that the girl was seventeen when the disease came on; she died three years after. There was firm anchylosis after two years.

MR. W. ADAMS showed a Fœtus with arrest of development of the arms and legs. Both arms and legs were similarly affected. The arms were shorter than natural; no malformation of the joints or the hands; the legs were shortened and twisted. The mother, a woman aged forty-one, who had had ten children, all healthy, attributed the malformation to having seen, when four months pregnant, a cripple whose limbs were similarly deformed. The specimen had been presented to the College of Surgeons by Mr. W. H. Wilkinson, in whose practice it had occurred.

DR. MURCHISON showed a Spindle-celled Sarcoma of the Liver. He thought the specimen illustrated a cause of enlargement of the liver not described, and the importance from a clinical point of view of studying the diseases hitherto called cancer. At the latter part of 1871 he was consulted by a patient, aged thirty, who during the previous eighteen months had had two or three paroxysmal attacks of pain below the right ribs; there was no vomiting nor jaundice; after two or three days the pain ceased. He was supposed by those who had seen him to be suffering from hydatids of the liver. He complained of a burning pain in the hepatic region, and had lost flesh. He was rendered uncomfortable from the size of the tumour, which had increased much during the last month. The tumour occupied the right side of the abdomen, reaching nearly to the pubes; the liver was greatly pushed up by it; the surface was uneven, with soft, doughy excrescences, not elastic, and gave no signs of fluctuation. He did not think it was a hydatid tumour. On inquiry, he found that one eyeball had been excised nine years ago by Mr. Hulke for malignant disease. He wrote to Mr. Hulke, who had sent him a drawing he had made of the growth, which was a spindle-celled sarcoma growing from the choroid. Since then the patient had been in good health, and the functions of the body had been well performed. He then saw Sir W. Gull, who gave the same opinion. The patient came to him again eight months after. The tumour had increased in size; the pain had ceased, and his only inconvenience arose from the bulk of the growth. The bulging was more elastic. After consultation with Sir W. Jenner, an exploratory puncture was made with a fine trocar into one of the elastic swellings; nothing came out but a drop of blood, which, examined by the microscope, revealed nothing. He then saw several other physicians.