

reflex being intact, and plantar titillation immediately evokes the usual muscular jerk. There is perfect control over the sphincters, and the urine is voided in a full stream. There is no lack of intelligence, the eyes are full of expression, the head of normal size and shape, with no sign of hydrocephalus. Pressure on the tumour produces no symptom of distress, nor does it alter materially the size or shape. It has a very broad base, and the edges of the spinal aperture can be felt, the finger-tip detecting a large irregular ovoid opening communicating with the spinal cavity. The size of its base indicates its non-pedunculated character. The measurement in circumference at base is seventeen inches, and across from side to side eleven inches. It is as transparent as a hydrocele. The case, when first seen, did not encourage the idea of attempting a cure by injection, and I may mention that it has been tapped frequently, but has rapidly refilled each time.

The curious and interesting points about this case of hydrorachis seem to me to be these: the size of the sac; the full development of the lower extremities; the power of progression; the absence of pressure on the spinal cord, and thus the sphincter integrity. While the size of the opening would point to the possible pressure on the cord. If broad based tumours are more likely to press upon the cord than pedunculated ones, how is it there is no evidence of pressure here? Suppose the nerve structures are carried forward in front of the fluid, I think we might reasonably on physiological grounds expect to find evidence of nerve pressure, or malnutrition from nerve stretching, or from nerve atrophy. There is no talipes in this case. We are told not to puncture the front part of these tumours so as not to injure the nerves, but is there any evidence that the puncture of nerve structure in this part of the body by a fine needle has been productive of permanent mischief? This case seems to me, if not unique, at least curious and prompts the following considerations. If the subarachnoid fluid both of the brain and spinal canal normally does not exceed two ounces, how is it that this tumour is so large? We know the fluid is reproduced rapidly when withdrawn, and the withdrawal when complete produces symptoms analogous to plethora of the blood-vessels, and when it is in excess it also produces convulsions and other evidences of pressure. There being direct communication between the spinal subarachnoid channel, and the cerebral ventricles, how is it that when the fluid was all drawn away in this case no convulsions ensued? and this procedure has been observed several times without mishap. Does this part of the enveloping sac membrane from its large area alone secrete the fluid, or does the whole arachnoidal surface contribute its proportion? and if so why in such excess above normality? The question may also be prompted, Why is there usually talipes in these cases? Is that condition purely accidental or is it due to defective tissue growth dependent upon the spinal abnormality cutting off nerve-supply to a given set of muscles? I confess my inability to suggest any better method of treating, radically, hydrorachis; but, except in the matter of injection, we have made no advance in our knowledge of it during the last fifty years. This is a reproach to our modern surgery, which boasts, and with perfect justice, of feats so brilliant that they become almost incredible as compared with the surgery of the past half century. Of this I am quite convinced, that something will dawn upon the intellect, as a more certain and effective means of dealing with this disease. An interest has sprung up which will eventuate in some satisfactory operation. Can we in any way imitate sloughing which produces spontaneous cure? To say that hydrorachis is an incurable disease would be considered unsurgical, but I am by no means convinced that some better method may not yet be discovered than we at present adopt. The old plan of a seton must be condemned, so I think must tapping and pressure, experience teaching that no reliable good ensues from these measures. It is to be hoped every successful case of cure by injection, no matter what the agent used may be, will be published, so that tabulated results may lay the foundation of something like a sound basis whereon to act, and which will inspire confidence in dealing with this *bête noire* of surgery.

Southport.

ON Wednesday morning Dr. Edwardes, of Hounslow, was found dead in his chair. It is stated that there was evidence present of death having been caused by prussic acid.

CASE OF FEIGNED SKIN DISEASE.

By T. COLCOTT FOX, M.B. LOND.

A. S—, aged nearly sixteen years, a furtive-looking general servant in London, presented herself at the Skin Department of the North-West London Hospital on the 28th of November. The catamenia commenced at the age of thirteen, but had since been irregular, and for the past year absent. She was fairly well nourished, but pasty-looking, and her finger-nails were markedly grooved. She applied on account of three excoriated patches which appeared on Nov. 21st, close together on the front of her left leg, and had, she stated, given her great pain, and caused her to lie awake sobbing at night, so that her mistress had no longer the heart to keep her at work. The suggestion had been made that the sores were caused by the dye from her black stockings, and the girl said that she had dressed the places with "Moore's ointment." One sore was perfectly oval, another nearly heart-shaped, and the third triangular, with a horn at each angle at the base. The patches measured about $1\frac{1}{2}$ in. by $1\frac{1}{2}$ in. to 2 in., and the long axis was in the direction of the limb; they were simple uniform weeping excoriations, with hardly any attendant inflammation. Suspecting the nature of the lesion, I ordered a simple dressing and a saline aperient, and talked of admitting the girl into the hospital if more sores appeared. On Dec. 5th she returned with a transversely oval sore just above each mamma (a very characteristic site in feigned cases, but not quite symmetrically situated. There were two others above the left ankle-joint, and one on the outside of the right calf, all longitudinally oval simple excoriations, with a well-defined border, except on one sore, where the abrasion was not complete at one end, and only papulation existed, suggesting a cantharides application. There was a dark-brown blood scab on some. She was admitted to the wards. On Dec. 6th a transversely oval patch appeared just below the left mamma; and another, longitudinally oval, covered with a slight scab, on the right hip. The girl from time to time, for twenty-four hours after admission, had prolonged fits of hysterical sobbing. On the 12th a sore appeared on the right shin near the ankle, and another on the right mamma, between the site of a former excoriation and the areola. There was a remarkable uniformity in the size of the patches throughout. As to the agency at work, I never could detect any evidence of the formation of a bulla, and the patches were too superficial for causation by an acid; moreover, repeated examination of the clothes, bedding, &c., at convenient times and unbeknown to the patient, failed to furnish any clue. On the 16th, no more excoriations having appeared, I taxed the girl with producing the eruption artificially, and, after prolonged denials, she confessed that she had done so, partly by her nails, but mostly by continued rubbing with the tops of her fingers. Probably the malingering was not altogether motiveless, and she desired a rest from her household labours. She proved to be very troublesome and disobedient in the ward, and I learnt from her father that she was an incorrigibly bad girl and a constant source of worry. The case is of interest as establishing an agency which has hitherto only been suspected as possible. Whether the skin in these cases is peculiarly sensitive to injury is a point for further investigation.

Harley-street.

LARGE ASYLUMS FOR THE INSANE.

By H. RAYNER, M.D.,

SUPERINTENDENT OF THE MALE DEPARTMENT OF THE HANWELL COUNTY ASYLUM.

It appears to me to be desirable to draw attention to a danger which threatens the welfare of the insane poor of England and Wales. This danger arises from the conversion of asylums of a size that is efficient and economic, into larger asylums that are less economic, and I fear less efficient. Moreover, valuable opportunities are being lost by the building of large, cheap asylums for the detention of lunatics, in place of efficient hospitals for their treatment

and cure. These errors are being committed from the prevalent belief that large asylums are the cheapest. The following figures abstracted from reports prepared for other objects will, I hope, tend to correct this mistake, and prevent further mischievous consequences. The thirty-sixth Report of the Commissioners in Lunacy for the year 1881 yields the following statistics in regard to the English county asylums. (The borough asylums are excluded as being under different conditions.) The asylums I have divided according to their number of inmates into four groups: the first, in which there are less than 450, being considered too small; the second, above 450 and under 600, being taken as the most favourable size for economy and treatment; and the two other divisions being made only to show the increase of cost with the increase of size.

Names of Asylums.	Number of beds.	Average weekly cost per patient.	Number of patients to each medical officer.
Northumberland, Notts, Derby, Cumberland, Berks, Bucks, Cambridge, East Riding, Hereford, Denbigh, Suffolk.	Less than 450 beds	s. d. 9 7½	181
Dorset, Oxford, Salop, West Riding, Cornwall, Wilts, Chester, Monmouth, Burntwood, Leicester, Carmarthen, Glamorgan, Northampton.	450 to 600 beds	8 10½	228
Lincoln, Norfolk, Sussex, Parkside, Warwick, Hants, Stafford, Rainhill, Devon, Gloucester, Chartham, Somerset, Worcester.	600 to 800 beds	9 3½	265
Beds, Durham, Whittingham, Essex, Wandsworth, Brookwood, Lancaster, Wadley, Prestwich, Wakefield, Banstead, Hanwell, Colney Hatch, Barming Heath.	Upwards of 800 beds	9 5½	345

This table shows, as might be expected, that those asylums are dearest which are not sufficiently large to justify the necessarily complex and expensive staff of such institutions; and it also shows that beyond this is a class much more economic, and, if judged by the proportion of medical attendance supplied, much more efficient than the larger asylums. A Parliamentary return for the year 1877 yields the following statistics:—

Names of Asylums.	Size.	Total number of beds.	Total cost.	Average cost per bed.
Northumberland, Notts, Derby, Cumberland, Oxford, Berks, East Riding, Suffolk, Denbigh, Cambridge, Carmarthen, Hereford.	Not more than 450 beds	4580	£ 785,570	£ 171·5
Northampton, Burntwood, Bucks, Glamorgan, Cornwall, Dorset, Monmouth, Stafford, Salop, North Riding, Chester, Wilts.	450 to 600 beds	6307	963,122	152·7
Gloucester, Hants, Devon, Worcester, Beds, Essex, Lincoln, Parkside, Rainhill, Somerset.	600 to 800 beds	7099	1,303,166	183·5
Barming Heath, Wandsworth, Hanwell, Colney Hatch, Lancaster, Durham, Whittingham, Brookwood, Wadley, Prestwich, Wakefield, Banstead.	800 beds and upwards	16,428	3,215,717	196·9
Banstead (Asylum for Chronic Cases).	—	1700	276,422	162·9

This report includes all the county asylums of which the returns were available, and shows that the asylums of from 450 to 600 beds are the most economic in construction, larger asylums being dearer in proportion to their size; even

Banstead, constructed in the simplest manner, with a special view to cheapness, being more costly. A second Parliamentary return for the year 1877 shows that in—

Asylums of	The average cost of repairs of building per bed per annum.
Not more than 450 beds	£1·74
450 to 600	1·85
600 to 800	2·48
Upwards of 800	2·91

In this respect the cost would seem to bear a direct relation to the increase of size.

Statistics are proverbially unreliable, and I have considered these carefully, from other points than the one given here, with the result that, making all due allowances, I consider the above figures to approximate closely to the truth. Assuming that they do so, we may make the following summary of results, in comparing the moderate-sized asylums (450 to 600 beds) with the large asylums (of 800 beds and upwards). In the large asylums a patient costs 6½d. more per week, and each bed costs £44·7 more in construction and £1·06 annually in repairs. This is equivalent to saying that if 40,000 patients (and the number for England is close upon this) were lodged in large asylums, they would cost £1,760,000 in construction of buildings, £40,000 annually in repairs, and nearly £60,000 annually in maintenance, more than the same number in asylums of the size I advocate.

The current economy is of small importance compared with the question of efficiency, and this depends to a very great extent on the personal influence of the medical superintendent, an influence which I believe cannot be delegated to a junior officer, however efficient and zealous.

The primary importance of the personal influence of the physician was emphatically expressed by W. Tuke in 1792, and was fully recognised by the Commissioners in Lunacy in their report for 1857, in which they point out “the evils of very large buildings on account of the loss of individual and responsible supervision, the loss of the patient’s individuality, and the tendency of the rate of maintenance to run higher.” I could quote many other authorities in support of this opinion, but that I might appear to be proving a truism.

Then arises the question, Over what number of patients can an average superintendent exercise the maximum of personal influence, and at the same time exert such a general control over the asylum that every detail of management may be used to the greatest advantage for treatment and economy? I answer that the number should be not more than 600, and that the balance of advantage lies in a somewhat smaller number than this.

I do not doubt that efficiency may be and is obtained in the larger asylums, but, as the preceding figures show, at a much greater cost, which must be still further increased if the number of medical supervisors in them is to be made proportionate to that in the medium-sized asylums.

Believing as I do that the curability of insanity is in an almost direct ratio to the care bestowed on it, I cannot help expressing an emphatic protest against the enlargement of asylums of useful size, or the building of large dementia repositories in place of lunatic hospitals.

Hanwell.

TWO CASES OF

INTRA-VEINUS INJECTION OF FLUIDS

FOR SEVERE HÆMORRHAGE.

By WM. COATES, M.R.C.S.,
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PROMINENCE having lately been given in THE LANCET to the subject of intra-venous injections for the purpose of combating the effects of severe hæmorrhage, in connexion with which Mr. Jennings has contrived a new instrument, I wish to supplement what has already been written by the history of two cases in which I have performed this operation, both of them cases also interesting in these particulars, that the hæmorrhage necessitating the operation occurred a long time after delivery without any definite cause, and that they were the first occasions on which Mr. Jennings’ syphon has been employed.