

which she was ill was imperfect. Some writers state that myxœdema extending over some time leads to a permanent dementia. I have had two patients, both of whom had a relapse of the disease due to ceasing to take thyroid extract, who exhibited little dementia after recovering a second time, though the whole disease extended in one case over seven years.

Ideation and the formation of concepts do not appear to be diminished and the association of ideas seems to be good. There is a retardation of thought and the elaboration of an idea is difficult but complete. These patients are coherent and their speech, though slow, is to the point. In a recovering patient one of the earlier signs of improvement was that she began to read novels and she now assures me that she could picture to herself the scenes described therein as well as ever and that she found no difficulty in the understanding and amplifying of such abstract ideas as "speed" and "thought."

Judgment and reasoning power are not defective and once aroused to attention the myxœdematous subject can give a very sound opinion. Thus, I asked a patient, Would you prefer working half an hour every day in the week for 1*l* a day or four hours on one day for 7*d*. and why? She answered that she would work half an hour on each day because she would then gain 7*d*. for three and a half hours' work. It took her five minutes to answer this question but she told me that she had made up her mind long before that but could not get the answer out. On inquiry she explained that she felt the answer "on the tip of her tongue" but failed to voice it. As far as I have observed these patients have no definite delusions but they are inclined to be suspicious. The capacity for work is diminished and they are conscious that their mental processes are less facile and that they readily tire. They cannot follow an argument closely for long and have to put down the book they are reading sooner than when they are well. These patients neither laugh nor cry and any sign of emotion is rare with them. Their affective state, however, is not one of indifference, the maternal instinct is strong, and they usually retain their consideration for others and affection for their relatives. Their sensitiveness is not decreased, for one of my patients having almost entirely lost her hair I chaffed her good-humouredly about it; this I afterwards found she had felt acutely and when she recovered was able to recall the feeling of shame which she had suffered. Their moral sense is in no way blunted. Though these patients are often described as melancholiacs they do not appear to be more depressed than is natural as the result of the consciousness of their condition.

It is essentially in disturbances of volition and action that the peculiar mental symptoms of this condition manifest themselves. A diminution of volitional impulse produces that lack of initiative, that striking immobility of face and body so characteristic of the disease. To originate even the simplest movement requires a very special exercise of the will. An external stimulus to produce a movement must be unusually strong. It is at the commencement of action that the block occurs and noticeably when once action has begun it flows more easily. The execution of the movement itself is slower than usual. Patients describe the tremendous difficulty they had, not in perception or understanding but in action. A loud command elicits a quite inadequate response though their appreciation of the order seems in no way diminished. It is noticeable that these patients are always more "tired" in the morning than in the evening. One tells me that if "a neighbour popped in to see her" it did her good, because at first she could hardly answer a word but after a time found she conversed more easily. Another was asked to get up from her chair, to walk to the end of the ward, to sit down on another chair, and to return (the whole manœuvre in a healthy person taking 30 seconds). It took her three minutes to do this, half the time being occupied in getting up from her chair, so that one wondered whether she had understood the request; she informed me afterwards, however, that she had the greatest difficulty in making a start but that once on the move she could get along fairly easily. To make a simple statement, "Yes" or "No," took a patient five seconds but she always answered correctly; to make a complicated movement such as "clasping the hands behind the back" took 45 seconds. Under treatment these times gradually shortened coequally with quickening of the pulse and rising of the temperature. On admission it took a patient five seconds to say what part of her face I touched;

after 14 days' treatment it took her two seconds. I have not found that, apart from their slowness, the movements made were particularly clumsy, these patients when getting better often writing and sewing nicely. I noted in one patient that the knee-jerk, though well marked, was delayed and the contraction of the quadriceps extensor was prolonged.

I submit then that the changes in the mental condition of those suffering from myxœdema are almost confined to the sphere of action. It seems necessary to suppose that either some toxin in the plasma surrounding the motor cells inhibits the chemical processes which originate a motor impulse or that the absence of some substance from the blood interferes with the discharge. This toxin is neutralised or this essential substance is supplied by the administration of thyroid extract; the patients get well and keep so as long as they continue to take thyroid. I have observed that the simultaneous exhibition of syrupus ferri iodidi appears to assist its action. We see this class of patients described by such terms as dull, listless, apathetic, taking a long time to comprehend and to answer questions, of sluggish ideation, of sluggish mentation, demented, depressed, moping, lethargic, suspicious, of impaired memory, sleepy, torpid, contented, and irritable. I suggest that this proves on careful inquiry to be but part of the truth and that the majority of these cases are sent to an asylum in error and could be as well treated outside one.

Banstead.

A CASE OF ULCERATIVE COLITIS IN WHICH A LEFT INGUINAL COLOTOMY WAS PERFORMED TO CONTROL EXTENSIVE HÆMORRHAGE.

BY HENRY BETHAM ROBINSON, M.D., M.S. LOND.,
F.R.C.S. ENG.,

SURGEON TO OUT-PATIENTS AT ST. THOMAS'S HOSPITAL; SURGEON TO THE EAST LONDON HOSPITAL FOR CHILDREN, SHADWELL, ETC.

THE following case was operated on by me as long ago as May, 1891, and, death occurring a few days after, I exhibited the diseased colon as a card specimen at the Pathological Society of London and a brief account appears in vol. xlii. of the Transactions, p. 115. As reference to this case by subsequent writers¹ and inquiry by others as to further details have been made to me from time to time, I have thought it desirable to record the case in full. It has been referred to as one of the earliest cases, if not the first, in which the colon has been opened for this ulceration. Mr. A. W. Mayo Robson² records a case operated on by him in June, 1891, in which a left inguinal colotomy was performed so as to treat locally the diseased mucous membrane through the artificial anus. Now, in my case the motive was the attempted arrest of a dangerous and exhausting hæmorrhage assumed to have its origin in the sigmoid loop which was tender and unduly palpable. The diagnosis was correct and the purpose was effected, but owing to the feeble condition of the patient he died on the fourth day before there was any opportunity of considering the advantages to be obtained from direct treatment of the ulcerating mucous membrane. This, then, is the explanation why the colon in this case was exposed on the left side, a form of treatment, from the light of our later experience, giving a much lessened chance of effectually dealing with the disease than when the opening is in the neighbourhood of the cæcum.

A man, aged 66 years, was admitted into St. Thomas's Hospital for cataract extraction in the early part of April, 1891. For some months he had been in a state of debility but with no definite symptoms except that about a month before admission he had passed blood per rectum and from time to time had had pain about the left iliac region; he had never been out of England. On admission he was cachectic-looking and his urine was slightly albuminous. About three weeks afterwards (May 2nd) he had diffuse abdominal pain, not very acute, and there was no marked tenderness, except in the

¹ Hale White and Golding-Bird: Transactions of the Clinical Society of London, vol. xxxii., p. 183.

² Mayo Robson: Ibid., vol. xxvi., p. 213.

left iliac region, where there was some increased resistance over the line of the colon. There had been constipation for two or three days, so the bowels were relieved by an enema, a well-formed motion being followed by an acute diarrhoea with plenty of mucus and bright blood. The above symptoms were accompanied by vomiting which occurred several times. The free hæmorrhage from the bowel continuing through the day, the condition of the patient became such that it was imperative to do something to stop it. As stated before there were some fulness and increased resistance in the left iliac fossa with tenderness; no actual tumour was to be made out here or elsewhere in the abdomen. These signs with the bright blood pointed to the part of the bowel involved—namely, the sigmoid flexure, and it was evident that some large vessel was opened. The diagnosis rested between malignant disease and ulceration of the colon and the signs in general suggested that it was the latter condition. I decided to open the abdomen in the left inguinal region so as to explore the sigmoid flexure and to control the bleeding spot.

An incision three inches long was made, the muscle was divided, and the parietal peritoneum was fixed to the skin margin. The sigmoid loop was drawn out and the cause of the hæmorrhage was fortunately discovered. There was a large ulcer about two inches by one inch in the long axis of the bowel and along its free edge; the base of the ulcer appeared to be practically only peritoneum. As it seemed certain that this ulcer would perforate this segment of the gut was brought up out of the wound and fixed there by passing a glass rod through the mesosigmoid and packing it round with gauze. The bowel was not opened. There was no further pain or hæmorrhage and the patient took his fluid nourishment well. On May 7th in the early morning the bowel opened spontaneously at the site of the ulcer; during the day he was not so well, getting gradually more feeble, and he succumbed during the night.

At the post-mortem examination there was found well-marked ulcerative colitis beginning in the cæcum and extending to the lower end of the sigmoid flexure where the changes were most marked. Here the bowel was thickened and contracted, showing many small circular sharply cut ulcers as well as the one large ulcer before mentioned; many of these were evidently of long duration. The rectum was practically healthy. Under the microscope the bowel gave no evidence of malignant disease. Very marked granular contracted kidneys were present.

Upper Wimpole-street, W.

A CASE OF ANEURYSM OF THE AORTA RUPTURING INTO THE PULMONARY ARTERY ASSOCIATED WITH FIBROSIS OF ONE LUNG.

By FREDERICK J. SMITH, M.D. OXON., F.R.C.P. LOND.,
PHYSICIAN AND PATHOLOGIST TO THE LONDON HOSPITAL.

(With a Note on the Lung by Dr. R. N. SALAMAN, Acting
Director of the Pathological Institute, London Hospital.)

THE following case seems sufficiently rare to merit publication. The patient was a soldier, aged 31 years, sent to me by Dr. Alexander of Bromley on Jan. 26th, 1904, on account of shortness of breath and some swelling of the right side of the neck and face; he also complained of a cough and pain in the back. For the following notes I am indebted to my house physician, Dr. H. E. Ridewood. Of the patient's family history nothing need be said. His personal history was that he had been a soldier for many years in India and had had there gonorrhoea with bubo and gleet but had no recollection of syphilis, though it was obviously possible if not probable. He had malaria in 1895 and recently—up to three or four months previously—had been working as a labourer. He drank moderately. The history of his present illness was that he was well enough up to some three or four months ago, when he began to complain of a cough and of shortness of breath. Both these symptoms had gradually but steadily and progressively got worse; he also complained that they were worse in the morning after lying down and

occasionally had caused a distinct feeling as though he would choke. On one or two occasions lately they had actually caused a fainting attack. In addition to these symptoms he had (1) a dull aching pain starting from the right side of the root of the neck radiating upwards into the head, worse at night and on coughing; (2) swelling of the right side of the neck, face, and shoulder, which was worse on lying down; and (3) difficulty in swallowing, all three of which had, like the other symptoms, gradually increased in the last three months.

On admission the patient was a thick-set muscular man of medium height, very obviously suffering from genuine difficulty of breathing associated with a swollen condition of the upper part of the right chest and neck. He was not at all wasted nor cachectic nor, indeed, feeling very ill in himself and had walked up to the hospital and to the ward unaided. His temperature was normal. Examination of his chest gave the following physical signs. Over the swollen area the veins were more obvious to the eye than on the corresponding parts of the left side but they did not pulsate and would not fill from the cardiac side. The swelling itself was doughy but without any pitting on pressure anywhere. He had perceived it himself because he could no longer wear his usual 16½ inch collars. His breathing, which he himself described as shortness of breath, was very typically—so much so that I used him for clinical demonstration of the point—that due to some form of laryngeal obstruction with slight stridor on inspiration, more marked on slight exertion or on lying flat on his back in bed. The cough was dry and brassy in character and the respirations were 40 per minute.

Palpation enabled us to fix the heart's apex beat just above the sixth left rib five inches from the mid-sternal line. The general cardiac impulse was slightly heaving as though the organ were somewhat hypertrophied. On percussion the cardiac dulness was practically normal, extending from the apex in a slanting direction inward to the junction of the third rib with the sternum and bounded by the left border of the sternum. There was an area dull to percussion over the first and second right ribs and the intercostal space between them and extending over the upper part of the sternum even to the first intercostal space on the left side. Auscultation of the heart revealed the following condition. At the apex the sounds were clear and somewhat exaggerated, at the base the second aortic was slightly accentuated, over the dull area the cardiac sounds were very clearly heard, but nowhere was there anything like a bruit nor thrill nor undue pulsation. On auscultation of the lungs the inspiratory breath sounds were exaggerated apparently, but this was, I think, merely a conduction of the tracheal sound; otherwise there was nothing unusual except an occasional rhonchus and a few crepitations at either apex. In view of the post-mortem changes it must be distinctly noted that I could not remember any noticeable difference in the breath sounds on the two sides except the ordinary normal louder sounds on the right.

Features external to the chest—Tracheal tugging was looked for and my house physician thought he could appreciate it but I was unable to do so; he also states that it became more marked in the course of time. The pulse was 84 per minute, of medium tension; the vessel wall was palpable on rolling it under the finger but could not be styled very degenerate. There was no appreciable difference in time or volume between the two radial pulses. The carotids could not be compared owing to the swelling of the neck. The pupils were equal and active for accommodation and to light. There was no paralysis of either vocal cord. To account for the pain in the back nothing could be seen, felt, or heard; an occasional pain down nearly to the wrist on the right arm seemed to own a causation in common with the swelling. The blood, urine, and abdominal organs were all carefully examined but showed nothing pathological. There was some dysphagia which had recently become more marked. The only other point that seems to call for notice was one which Dr. Alexander communicated to me but which I did not notice in hospital, that the left side of the face would swell if he lay on his left side.

The patient was treated with morphine, iodide of potassium, &c., but the treatment presents no features of interest except that he may be said to have improved somewhat. On Feb. 3rd, 1904, he seemed as well as usual. On the 4th he asked for the nightstool but did not use it, for he was at this moment seized with an attack of coughing and then suddenly complained of an acute pain in the cardiac region, his face and lips became blanched, the