of a single hospital, suggest that the association of aortic hypoplasia and aneurysm, though rare to be sure, may yet be worth looking for in the future, especially, perhaps, in those cases of aneurysm which are least susceptible of explanation by ordinary causes, such as aneurysms in women and young persons.

As for aneurysms in women, I have consulted the considerable number of reports of cases which are to be found in the works of Hope, Stokes, Walshe, Balfour, and others, and in the Transactions of the Royal Medical and Chirurgical Society and of other societies, but without meeting with any mention of hypoplasia. One thing, however, is very striking about aneurysms in women: they go from bad to worse more rapidly than in men and are much more prone to end in rupture. External rupture in particular is nearly as common in women as in men, notwithstanding the relative great rarity of aneurysm. Stokes relates three cases of external rupture, two of which were in women. Crisp tabulates six, four in men and two in women. The records of St. George's Hospital contain three in men and again two in women. We thus have 14 several cases of external rupture, six of which were in women.

Now women are notoriously more liable to hypoplasia than men and the suggestion presents itself that some degree of hypoplasia, not necessarily to be seen unless looked for, may be the reason for the more untoward course of their aneurysms. And so it may be with children and young persons when they suffer from aneurysm, though here also the published reports are almost absolutely silent as regards hypoplasia. Still, there is on record at least one case which may be quoted as showing an association of hypoplasia with aneurysm. This case is included by Mr. R. W. Parker in his Table of Cases of Spontaneous Extracranial Aneurysm in Persons under 20 years of age.¹ The patient was a boy, aged 16 years, who died from the rupture of an aortic aneurysm into the pericardium. "The walls of the aorta were as thin as paper, soft, and easily torn, but free from every kind of morbid deposit."

In another way the association of aneurysm and hypoplasia is of sinister omen—I mean as regards the prospect of cure by the deposition of fibrin. Arterial hypoplasia has long been credited with a leading place in the rather scanty morbid anatomy of hæmophilia, a disease which modern clinical pathology has proved to depend essentially upon deficient coagulability of the blood. It must be admitted that hypoplasia does not always or even generally imply hæmophilia, but at least it constitutes an ominous link between aneurysm and the possibility of a most undesirable condition of the blood.

In conclusion, I have only to say that this short paper will have served its purpose if it succeeds in drawing attention to an occasional morbid alliance the practical importance of which four cases are all too few to establish.

hesterfield-street, W.

A PECULIAR CASE OF SCARLATINA HÆMORRHAGICA.

BY VIVIAN CHASTEL DE BOINVILLE, M.B.,
CH.B. EDIN.

THE following case, on account of the peculiar nature of its course, may be of interest to the readers of THE LANCET, and Dr. N. E. Roberts, visiting physician to the City Hospitals, Liverpool, has sanctioned its publication. The patient was a boy, aged four and a half years, who resided in Liverpool and was admitted to the Grafton-street City Hospital on June 21st, 1902. According to the mother's statement he fell ill on June 16th. The admission thus took place on the sixth day after the onset of the disease, which was characterised by the usual feeling of malaise, headache, and sore-throat, with a cough and pain in the chest, rapidly followed by a diffuse scarlet rash. On admission this rash was still visible but was fading and the fauces and throat generally were congested and foul. During the 24 hours following admission the temperature ranged from 101° to 102·4° F., falling gradually in the course of the next six days to 99·6° on the 27th. On

the evening of this day, the twelfth from the onset of the disease, it rapidly rose to 103°, when grain doses of sulphate of quinine were administered every four hours. The temperature then again fell, reaching normal on July 1st.

Thus far the case had assumed a not unusual course. The patient during this period of observation was pale and rather weak, the pulse was somewhat feeble, but there was no reason to expect anything but a favourable recovery. The cervical glands were not swollen. There was neither thus far nor subsequently any albumin or blood to be detected in the urine. On July 2nd, however (and this is the special point in the case), just as desquamation was setting in bleeding from the anterior nares commenced. Hæmorrhagic spots, a dozen or so, and measuring about three millimetres in diameter, appeared on the anterior aspect of the scalp. Similar spots presented themselves in the neighbourhood of the knee-joints. The evening temperature rose to 99·6° and the patient became generally feeble and, in fact, showed a tendency to collapse. Perchloride of iron applied as a styptic to the nose only partially checked the hæmorrhage during its actual application. On the following day an eczematous rash appeared on the buttocks and the spots thus formed bled on the slightest friction. Tincture of hamamelis was no more successful than the former styptic in allaying the obstinate epistaxis. Iron was administered internally and brandy was cautiously exhibited. Posturing and other methods were of no avail in checking the bleeding. It must be remarked that the total quantity of blood lost was very small. The cause of anxiety was the symptom *per se*, suggesting a markedly impoverished or poisoned state of the blood, not an actual loss in quantity. Desquamation, which had commenced on the hands and feet, became entirely arrested. The patient grew progressively weaker and the temperature rose higher—never above 103·2°, however, which it reached on July 6th. Tepid sponging was now employed. On the 7th, at 3 A.M., the thermometer recorded 103°. Tepid sponging was again resorted to, causing the temperature to fall to 98·9°. At 10.30 A.M. the patient vomited, the vomit containing a little unaltered blood. At 11 A.M. he died in a state of collapse.

The interesting feature of the case is, of course, that the hæmorrhagic symptoms did not appear at the onset of the disease as in an ordinary case of scarlatina hæmorrhagica, but at a period when convalescence was to be expected. In other words, a profound toxæmia set in at a time when it was to be supposed that antitoxin in the ordinary course of events would be forming and immunity becoming established. Can it be that nature had, as it were, surpassed herself in her process of healing, that the antitoxins had become excessive, and that a "reactionary anti-toxæmia," if one may use such a term, had set in? Or can it be that, after the supposed toxins had been sufficiently eliminated to permit of a fall of temperature and partial recovery, a fresh supply of toxins hitherto combined with other material or otherwise rendered inert, had suddenly become let loose in the blood and set up a secondary toxæmia?

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VERBAL OBSESSIONS.

BY JAMES SHAW, M.D., M.CH. R.U.I.

MAGNAN¹ defines an obsession as being a mode of cerebral activity in which a word, thought, or image rises into consciousness—involuntarily and without discomfort when physiological, but forcibly and with painful persistence when pathological. Verbal obsessions are those in which isolated words—mostly obscene or blasphemous—constitute the morbid besetment. They should be distinguished from coprolalia, obscene speech; from the blasphematory mania of Verga,² which he described as a special variety of obsession taking the form of oaths, blasphemies, or indecent utterances; and from the onomatomania of Charcot and Magnan,³ in which a word cannot be recollected without a painful searching of the memory, or a word or phrase is ever present in consciousness and *must be emitted at intervals*, its utterance being repressed for a short space

¹ Annales Médico-Psychologiques, Mars-Avril, 1896, quoted by V Bourdin.

² THE LANCET, April 20th, 1901, p. 1124.
Annales Médico-Psychologiques, Mars-Avril, 1896.

³ Transactions of the Royal Medical and Chirurgical Society, 1884.

only at the cost of extreme and constantly increasing mental pain. In my cases the besetting words were never uttered. The words differed from psychical or psychomotor hallucinations in that they were never spoken of as "voices in the head" nor as "voices" at all. Verbal obsessions may constitute the leading feature of a sort of obsessional aberration, as in the second case below, or an early symptom of a form of insanity, an obsessional melancholia, which appears to me to be as much an entity as hypochondriacal melancholia is. The first case exemplifies the induction of obsessional melancholia by verbal obsessions.

CASE 1.—The patient was an unmarried female, aged 46 years, and had ceased to menstruate for two years. She had always been "nervous," her father had suffered from neurasthenia, and her brother was "nervous." 14 months prior to my first seeing her she had had, as I was informed by her medical attendant, a slight vulvar trouble resembling balanitis in the male. This had been followed by what appeared to have been an attack of influenza, for which she had not sought medical advice. She had become depressed during that attack or soon after it and the depression had been increased by business worries and a monotonous solitary mode of life. When I first saw her the state of her mind had changed very little for about six weeks. Her face was pale with a worried, anxious expression. The left pupil was slightly larger than the right; both reacted to light. Her right hand-grasp was 40 and her left hand-grasp was 20; her pulse-rate was 96. She picked her dress with her fingers incessantly and her feet were in constant motion. Neither these movements nor prolonged walking induced fatigue. Her voice was low, her speech was slow and hesitant, her memory was good, and her consciousness was clear. She had no hallucinations. She said that she was guilty of a great and unpardonable sin. On close inquiry it was elicited from her that the sin was that certain words came into her mind incessantly in spite of herself. These words she did not, and would not, utter. She said they were irrepressible (in her mind), obscene, blasphemous, unutterable, and that the distress occasioned by them caused her to refuse food, prevented her sleeping, and had driven her to make two suicidal attempts. She recovered eventually, convalescence having been preceded by some blurring of consciousness and much increase of motor agitation.

CASE 2.—This case was that of a married male school teacher, aged 33 years. His brothers and sisters were all "nervous," and one sister, also a patient under my care, was irritable, eccentric, incoherent of speech, and possessed of queer ideas almost amounting to delusions. The patient had had influenza four years before my visit and about three years before the latter he had been much worried by an inimical female fellow-teacher. After this quarrel he became weaker and less sociable. Nine months prior to my visit his condition was rendered worse by the death of his brother (from Bright's disease) and his undertaking the cares of the funeral. During the last three months he had deteriorated considerably and had not taught for three weeks. His pulse-rate, when I examined him was 96; his temperature was 98.4° F.; his right hand-grasp was 85 and his left hand-grasp was 90 (he was partly left-handed); his cutaneous sensibility, tested with a feather for touch and pain, was good on the forehead and hands, although he complained of feelings of numbness. He wandered about restlessly, putting his hands to his head, shaking his hands and gesticulating in a peculiar way, sometimes as if he were writing words in the air. There was tremor of the fingers. His demeanour and facial expression denoted mental pain, but motiveless laughter was frequent. Consciousness and memory were good, though the patient could not fix his attention. He said that obscene words arose in his mind and he could not repress them. This caused him great anguish, as he and all his family were very religious. He said also that when he looked at anything he could not get the image of it out of his mind (visional obsession). He fancied that fixed or heavy objects, such as pieces of furniture, moved, and he would put out his hand to steady them. This might have been caused by fine ocular tremor. There was, however, no visible nystagmus. On one occasion he asked to have pictures removed from a wall on which there were none. He exclaimed frequently, "Oh, Lord," "Oh, Lord," fell often on his knees and prayed aloud to be delivered from his evil thoughts and their cause—the obscene words. These words he never uttered. He could not sleep without hypnotics and they, when their

somniferous effects passed off, increased his agitation. An attempt was made to obtain asylum treatment for him. He was detained a few weeks in a workhouse hospital and then discharged slightly less agitated but with his obsessions as well marked as ever. In that condition he remained when I heard of him two years after.

Taking these two cases as types of two forms in which obsessions are prominent it will be seen that the prognosis as to mental recovery is much less favourable in the aberration almost purely obsessional than in the seemingly more formidable obsessional melancholia with its blurring of consciousness, greater mental pain and diminution of self-control, difficulty of inducing fatigue, and its presentation of a distinct fixed idea or so-called faith-delusion of having committed an unpardonable sin.

Liverpool.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et nobiliorum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium

RADCLIFFE INFIRMARY, OXFORD.

A CASE OF TUBAL PREGNANCY; LAPAROTOMY; RECOVERY.

(Under the care of Dr. T. L. KENNISH and Mr. R. H. ANGLIN WHITELOCKE.)

AT the present day it is acknowledged that laparotomy is the best treatment in ectopic gestation in almost all cases. The mortality from the operation is surprisingly low—for instance, Professor Mayo Robson had 22 recoveries in 23 cases and Dr. J. W. Taylor¹ had 41 recoveries in 42 cases—that is, a mortality of less than 3 per cent.

The patient was a married woman, aged 28 years. She had had scarlet fever, St. Vitus's dance, and rheumatic fever. Before marriage, which took place on Dec. 27th, 1897, she had been irregular in her menses, but since then and up to the first week in October, 1900, she had always been quite regular. She had had no children or mi-carriages. In the third week of December, 1900, she was suddenly seized with severe pain in the left side of the abdomen and was repeatedly sick and fainted. A medical man saw her immediately and gave her morphia hypodermically to relieve the pain. Two days later, as the patient did not improve, another medical man saw her in consultation. Her account is that the diagnosis was "inflammation and stoppage of the bowels." At the end of 15 days (Jan. 2nd) she was conveyed to a neighbouring hospital where she remained until the end of February. Soon after her admission to the hospital she came on unwell—she had not been regular since the first week in October—and passed first a large clot and then several small ones for over a week, the discharge continuing irregularly, not more than two days clear, until two days before leaving the hospital at the end of February. Three weeks after entering the hospital she was, she said, "put under ether and operated on for hæmorrhoids." The bowels were very constipated from the beginning. She had to have repeated enemata; and in the first week the urine was withdrawn with the catheter. After removal to the hospital the pain and sickness continued for six weeks. She was evidently very ill, her relatives being sent for in the belief that she was in imminent danger. She left the hospital on Feb. 25th, 1901, and was taken to her sister's home. Dr. Kennish was in bed at the time with influenza and his locum tenent saw her on the day that she went home. He believed that she was suffering from pelvic cellulitis. Dr. Kennish saw her for the first time on March 13th and after hearing a history of amenorrhœa for two months, followed by collapse and sickness, with later the passage of clots (cast?), and menorrhagia, the symptoms appeared to him to be pathognomonic of extra-uterine pregnancy, with rupture of the sac; and this was confirmed by a subsequent examination.

¹ Extra-uterine Pregnancy, 1899.