and two holders, and while I am using one holder, the other, with tubing attached, is being sterilised.

I use a fresh needle for each case, and the needle will slip into the vein with ease if lubricated with a little sterile vaseline, and for this purpose I use a five cubic centimetre serum flask, filled to the shoulder with vaseline, which is autoclaved at 120, and after the vaseline has solidified a few drops of izal are introduced into the neck of the flask, which is then covered with a sterilised rubber teat. The needle, immediately after removal from the steriliser, is dipped into the vaseline before use. After use the holder and tubing should be washed through with a small glass urethral syringe to remove the blood before placing in steriliser.

If the patient objects to venipuncture, which is seldom the case, I use the glass tube depicted in Fig. 2 with which I can easily collect one cubic centimetre from the finger. The tube is made from No. 4 glass-tubing with one end drawn out into a capillary tube and the other end sealed and a bulb blown near the drawn-out end with a small hole blown in its side (see Fig. 2). The tube is held with the hole in the bulb uppermost and the blood will flow into the bulb by capillary attraction and then collect in the sealed end, the displaced air escaping through the hole in the bulb. After filling, the drawn-out end is sealed in the flame and the hole in the bulb is sealed with wax.

Brook-street, W.

Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A NOTE ON SOME NON-TUBERCULOUS THROAT COMPLICATIONS OF PHTHISIS.

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TUBERCULOUS laryngitis is by far the most important of those complications of phthisis which affect the upper respiratory tract, so much so, indeed, that it is apt to overshadow all the others and to receive the exclusive attention of the laryngologist as well as of the physician. Nevertheless, other complications are very frequently encountered and are of sufficient importance to claim some consideration. A "pre-tuberculous" condition of the larynx has often been described, and this expression seems to mean an abnormal condition, consisting of anæmia, congestion, or swelling of the larynx of a phthisical patient but without as yet any true tuberculous deposit, and it is implied that this is a precursor of tuberculous infiltration. The use of this expression appears highly unscientific, for there are no grounds for the view that there is any distinctive state of the larynx which is always, or frequently, followed by tuberculosis. There is also a very general opinion that pallor of the larynx is a characteristic feature of tuberculous laryngitis, but this opinion requires qualification. Many consumptives are anæmic, and in such cases the larynx, as well as the fauces and other mucous membranes, are, of course, pale; in other cases the colour is quite normal, and very frequently the tuberculous larynx is in a state of hyperæmia as the result of coughing and irritation; in fact, it may be stated that tuberculous larynges are reddened quite as frequently as unduly pale. It is true that the swollen infiltrated arytenoids are often pallid, and that the margins of tuberculous ulcers are characteristically anæmic, and this may have given rise to some misconception; but very often tuberculous infiltration is decidedly red and congested, especially on the cords, ventricular bands, and epiglottis.

Simple chronic pharyngitis and laryngitis are extremely common among consumptive patients and not infrequently give rise to mistakes in diagnosis, for there is naturally a tendency to diagnose tuberculous laryngitis in a phthisical patient who complains of hoarseness and discomfort in the throat. The frequency of simple inflammation of the larynx may be explained by the strain of constant coughing and by the contact with irritating

sputum which contains numerous micro-organisms and their products in addition to the tubercle bacillus. In the absence of other distinctive signs a uniform redness of both vocal cords should not be diagnosed as tuberculous, but if one cord be affected markedly in excess of the other tuberculosis may be strongly suspected. The subjects of active phthisis often complain of much dryness and discomfort in the throat, especially at night, even when there is no obvious nasal obstruction. This appears to be the result of the nocturnal pyrexia and the consequent rapid respiration which makes nasal breathing insufficient. A drink of hot milk or a demulcent lozenge diminishes the sense of discomfort. Patients in quite an early stage of phthisis sometimes complain of painful sensations about the throat which on examination appears perfectly normal. The cause of this is obscure; it may, perhaps, be that the pain is referred from the pulmonary disease to the most sensitive part of the respiratory system. Be that as it may, the symptom is not very uncommon, and I would suggest that the patient who complains of pain about the larynx for which no cause can be found should be submitted to a careful examination of the chest.

Pachydermia laryngis is also disproportionately common among the subjects of pulmonary phthisis; indeed, Gougenheim¹ considered the majority of cases of pachydermia to be tuberculous. I personally consider the affection as an extreme form of chronic laryngitis and due to the same causes; it is therefore natural that it should be frequent in the larynges of consumptives exposed to the mechanical irritation of coughing and the chemical irritation of the sputum without, of necessity, any entrance of the bacillus tuberculosis into the tissues. The firm white, almost cornified, appearance of a typical case is very different from the soft semi-translucent granulations of tuberculous laryngitis. On several occasions I have removed the pachydermatous thickening from the posterior commissure of consumptive patients and have failed to find any sign of tuberculosis on microscopical examination.

It is well known that in cases of tuberculous laryngitis the voice is readily lost and is generally much weaker than it would be with a similar extent of lesion due to another cause, such as syphilis. But apart from any laryngeal affection, functional aphonia is very common among consumptive patients. The feeble respiration, the general weakness, and the tendency to catarrh and discomfort of the throat all conduce to this affection, which is found in male as well as female consumptives, though more frequently in the latter. It is so frequent that an examination of the chest is advisable in every case of intractable functional aphonia. True paralysis of a vocal cord is also a recognised complication of pulmonary phthisis. It is due to pressure on the recurrent laryngeal nerve, and is therefore of the abductor type. Paralysis of the left cord is the result of pressure on the left recurrent laryngeal nerve by enlarged bronchial or tracheal glands, but the right nerve passes very close to the apex of the right pleura and is thus sometimes directly involved in an infiltration of the lung on this side. This is, perhaps, the commonest cause of paralysis of the right vocal cord, therefore the possibility of pulmonary phthisis should always occur to the mind of the observer who discovers this lesion on laryngoscopic examination.

Thus, other complications of pulmonary phthisis occur in the throat besides tuberculous laryngitis, and deserve recognition; and in a few cases where the first complaint is of the throat a correct estimate of their significance may direct the attention to the pulmonary disease.

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NOTE ON A CASE OF JACKSONIAN EPILEPSY TREATED BY TREPHINING.

BY W. BERNARD SECRETAN, M.B. LOND., F.R.C.S. ENG.

THE following are notes of a somewhat unusual case of Jacksonian epilepsy, in which cessation of the fits was brought about by operation.

The patient was an anæmic woman, aged 24 years. Her occupation was that of a clerk. About 16 years ago she fell down a flight of steps on to her head. She was not stunned at the time and was apparently able to get up by herself and

¹ Atlas de Laryngologie et de Rhinologie, p. 16.