the patient's, and not the physician's. Only so much is abstracted as appertains to the peculiarities the case exhibits as one of particular fits stopped by a definite procedure.

1861.—He (the patient) rarely has genuine fits; but he has sensations which would go on to fits if they were not prevented. Before he knew how to stop them, each sensation invariably resulted in a full fit; and it would now if he had not timely assistance.

Description of the full fits.—He used to have them once a fortnight, and had never two together. The left leg would begin to draw up and the nerve worked, and it went up and up the spine; and then he became insensible. The first shock was from the base of the great toe; it next passed to the inner side of the foot. After he became insensible, or about that time, his son said that the arms and legs were violently worked; the face also worked, it became of a *dark pale*, and the tongue was generally bitten. He remained insensible about half an hour—once two hours; but even after the lapse of that time he was not quite himself, and wandered. However, he shortly went into a deep sleep for two or three hours.

Description of the partial fits.—About three years ago he tried to stop the fits by tying a string round the toe, and that would sometimes, though rarely, stop them. Afterwards he tied a string round the ankle, but he never applied anything higher. One morning he asked to have his leg rubbed, and has since been able to stop the fits. When a fit begins, he falls if there is nothing to catch hold of. He is, however, raised, and the leg, which becomes flexed, is rubbed. The following is copied, with a few verbal alterations, from Dr. Hughlings Jackson's case-book:—"His son tells me, partly by words, but chiefly by demonstrations, how he proceeds when the attack comes on. His father being standing, and holding by something, the son kneels in front of the leg, pushes his head against the knee, and holds the heel to the ground, and rubs the calf violently. When he gets the leg straight, it is all right. He occasionally asks some one to help him to get the heel down. The muscles of the calf sometimes stand out quite hard and stiff, and the leg works and twists all manner of ways. The patient says he has a pain like a cramp from the middle third of the leg behind, and it goes higher, but how much higher he cannot say. If the leg can be kept down, there is, the son says, no working about the knee. Whilst all this is going on, the patient feels very ill, and his nerves are all at work. He feels as if shaken to pieces. Occasionally he is jerked all over, and especially when the fit is leaving; it gives then several jerks, and goes away. He often has a slight jerk in the leg without anything further."

At one visit he remarked to the effect that by touching the foot at or about the crossing of the tibialis anticus tendon, the jerking and the seizures can be brought on; but touching that spot on this occasion produced only a "feeling of something like an electric shock to the little toe." The following extract from Dr. Hughlings Jackson's notes is also of much interest:—"He is quite clear that when the fits used to be severe [he means the fits described above as full fits], he did not lose power in any of his limbs; but now that the fits are stopped, the left leg is 'paralysed' after each attack. He can, he says, bear no weight on it after the seizure, and on getting along by help he drags the foot with the toe on the ground. The leg gets well gradually in about an hour."

May, 1865.—Dr. Bathurst Woodman, then resident medical officer of the London Hospital, was a witness at the Old Bailey on a trial on which the patient C— was a witness too. Dr. Woodman on that occasion saw an attack which was so strange that he would have suspected malingering had it occurred in an out-patient. C— cried out suddenly "Rub my leg." His son (C— always goes about with his son, so that skilled assistance may be had promptly when a fit begins) knelt down and began to rub it violently, the father urging him on. Dr. Woodman felt the lower part of the thigh, the muscles of which were lax; he then felt the calf, and found the muscles firm. From the first the leg was in continual agitation. Soon C— said, "Rub away, it's getting higher;" and now, on feeling, Dr. Woodman found that the previously lax muscles of the thigh were firm and rigid. After some time the man said, with a sigh of relief, "It's all gone now." He was shortly called into one of the offices, and as he walked away Dr. Woodman noticed that the left leg was dragged with a slight swing. He told Dr. Woodman that it was always so after a fit, and he complained that the hand and the arm of the same side were numb and weak, although he could make almost any movement with the limb.

The patient goes to the London Hospital now and then. He is what, for want of accurate knowledge, is called a hypochon-

driac. One day he attempted suicide, and was afterwards locked up for a night in a police cell. Dr. Hughlings Jackson thinks there is much truth in the view Dr. Copland takes of hypochondriasis—namely, that it is due to a fault in the ganglionic nervous system.

Clinical Records

OF

THE PARIS HOSPITALS.

HÔPITAL NECKER.

FOUR CASES ILLUSTRATING THE TREATMENT OF ANGIO-LEUCITIS BY COMPRESSION.

(Under the care of Dr. GUYON.)

THE following cases will doubtless be found of interest, as evincing the results of a special mode of treatment not generally employed in inflammation of the lymphatics. In Mr. Chas. Moore's paper on Angiopleuritis contributed to "Holmes's System of Surgery," no mention whatever is made of compression in the treatment of the disease; and Mr. Erichsen, in his "Science and Art of Surgery," only casually alludes to the proceeding as being applicable in the later stages of adenitis. Among the French, Velpeau was the great promoter of this mode of treatment. He commended it when the angiopleuritis was superficial, and extended more in surface than in depth; and particularly when the purulent collections had been opened, and the tumefaction and inflammatory doughiness began to assume the character of oedema. The different points of this great surgeon's practice may be found carefully summed up in the paper which he contributed to Costello's "Cyclopædia of Practical Surgery." With the exception of Velpeau, much attention has not been given by French surgeons to this means of treatment. Nélaton and Vidal, in their respective treatises on Surgical Pathology, merely indicate the proceeding as being worthy of a trial. The authors of the "Compendium" state that it is one which must be set aside; and Follin, in his work on "Surgical Pathology"—the most recent of the French treatises,—alludes to it as having been completely abandoned.

Dr. Guyon, who has taken Civiale's well-known service at Necker, and who was one of Velpeau's favourite pupils, has been tempted to make use of this means in his recent investigations on the treatment of angiopleuritis. Whether the good effects which have attended this trial be due to other causes—such as rest, &c.—may be a question; but, judging from the *ensemble* of these cases, benefit has doubtless ensued from the employment of compression.

The details of the cases we owe to Mr. Edward Alling, Dr. Guyon's house-surgeon.

CASE 1.—On February 14th a man aged fifty-nine was admitted into the wards. For a few days previously he had been suffering from a wound on the middle finger, and on Feb. 11th he had noticed some slight swelling. On being admitted, intense inflammation of the lymphatics was found. The whole of the forearm was tumefied and red; there was much oedema, and so much pain that it became a question whether the case was not one of diffuse phlegmon. The hardened red lines, however, which ran up towards the axilla left no doubt on the subject. The same evening compression with a roller was applied.

Feb. 15th.—The progress of the disease has been arrested; the inflammation has lost much of its intensity. A fresh bandage applied.

16th.—The redness has disappeared, except on one or two spots which affect the appearance of patches, of from five to six centimetres in diameter, on the posterior surface of the forearm. Compressive bandage.

17th.—The size of the patches has much diminished. A small abscess which had formed in the situation of one of these patches was opened, and gave issue to matter of a reddish colour.

19th.—The patient may be considered as cured.

24th.—He left the hospital, in good condition.

CASE 2.—On Feb. 15th a man aged sixty-five entered Dr. Guyon's wards, with a vast sub-aponeurotic abscess situated on the anterior surface of the leg and dorsal surface of the

foot. The abscess was immediately opened, drainage tubes were applied, and the wound rapidly cleansed.

Feb. 21st.—The indurated red lines of angeioleucitis were observed, together with tumefaction of the inguinal ganglia. Mercurial inunction applied to the part.

24th.—The adenitis has much increased. The whole of the leg is extremely swollen, red, and painful. Numerous ribbon-like red lines extend along the thigh. The drainage tubes are taken off, and compression applied with a roller.

25th.—The redness has lost its deep hue, and has diminished in extent. A new bandage applied.

26th.—Both the redness and swelling have considerably diminished, but patches of angeioleucitis are observed above the situation where the bandage ends. Another bandage applied, and made to extend over the thigh.

27th.—Bandage taken off.

28th.—A very slight redness is all that is left of the disease.

March 6th.—The patient left the hospital completely cured.

CASE 3.—The patient, aged seventeen, was admitted into the wards on Feb. 18th. He had been suffering for a month from a whitlow situate at the extremity of the middle finger. There was at the time of his admission some slight inflammation of the lymphatics, which gradually increased till Feb. 23rd, when large patches having the appearance of erysipelas were seen to extend over the forearm and around the elbow. The subcutaneous tissue tumefied, mostly in the situation of the posterior surface of the elbow-joint. Mercurial inunction, followed by the application of poultices, was the treatment adopted.

24th.—The disease has lost somewhat of its intensity.

25th.—The condition of the patient is much the same. Compression applied with a roller.

26th.—The angeioleucitis has abated in a remarkable degree. A fresh bandage applied.

27th.—The amendment continues.

28th.—The disease has almost entirely disappeared. The compression left off.

March 6th.—Cured.

CASE 4.—A man aged twenty-nine, admitted March 21st. On March 1st the right middle finger received a scratch; on the 5th an epitrochlean ganglion was observed to be swollen; next the arm became red, and the redness then extended very rapidly. On the 12th the application of six leeches gave no relief to the patient.

On admission, there was swelling of the entire posterior half of the arm, from the elbow to the armpit. The whole of the part was red and painful. Amidst the general swelling two indurated points were noticed, one near the upper part, the other near the lower part, of the affected region; both being about as large as a nut. No fluctuation whatever. In the evening compression was applied by Mr. Alling.

March 22nd.—The patient feels great relief, and has slept the whole night. The arm has lost much of its redness, and is less swollen. In the situation of the lower induration the skin is withered, and peels off. Use of the bandage to be continued. The same evening the bandage, which had become loose, was retightened. At the same time it was noticed that the inflammation had diminished both in extent and intensity. The indurated points had softened.

23rd.—The amendment continues. The posterior half of the inner surface of the arm is the only point which has retained a reddish hue.

24th.—The indurated points were incised, and gave issue to a small quantity of creamy pus. The two abscesses are connected by a band of indurated tissue, from four to five centimetres in width, and formed almost exclusively by the skin, thus giving evidence that the case was one of inflammation of the lymphatics, and not of subcutaneous phlegmon.

HÔPITAL LA PITIÉ.

NATURE AND TREATMENT OF ANTHRAX.

(Under the care of Professor RICHEL.)

M. RICHEL devoted one of his recent clinical lectures to the consideration of the above subject, *apropos* of a patient who was then in his wards. The case was that of a man, aged forty-seven, in miserable condition, and reduced to a state of complete emaciation through distress and starvation. Three tumours covered almost the whole of his back. One of them, as large as the open hand, occupied the situation between the scapula and the spine; another, of equal size, occupied nearly

a corresponding situation on the opposite side; the third, even larger than the other two, extended over the lower part of the back. Only the last of these tumours showed signs of profound inflammation. It bulged slightly, was surrounded by a reddish circle, and the neighbouring tissue was somewhat tumefied.

M. Richet does not agree with those who divide anthraxes into two kinds—the benign and the malignant. With the surgeon of La Pitié there is no such thing as malignant anthrax; because the idea of malignity involves that of contagion and inoculability, and this is not the case in so-called malignant anthrax. M. Richet simply divides these tumours into simple anthrax, and anthrax complicated with diffuse phlegmon. To this latter kind the term “malignant” is wrongly applied. It is far from being malignant, since it heals invariably when properly treated; whereas charbon, with which it has been compared, heals only when destroyed *in toto* and from the outset. With regard to the etiology of anthrax, M. Richet establishes a difference between those tumours which are observed on debilitated subjects (the common inmates of hospital wards), and those which develop in robust, well-nourished people. A third category of patients would comprise those affected with diabetes.

In considering the treatment of anthrax, M. Richet said he would distinguish three groups of surgeons: those who believe in the malignity of anthrax; those who do not; and those who retain a neutral position. The supporters of the first opinion are for removing the whole of the tumour. Now, according to M. Richet, a small anthrax may be excised; but how could we remove a vast tumour extending, for instance, over the whole lateral surface of the neck? Total ablation must be out of the question in these cases; and this mode of treatment M. Richet designates generally as *ferocious*. Another group of surgeons (those who remain neutral) institute a medium sort of treatment, which is yet very severe. First they incise the tumour, and then they apply caustics. Some have recourse to perchloride of iron, others to tincture of iodine; others, again, employ more energetic caustics, such as the actual cautery, &c. These cauterisations generally succeed; but they are invariably attended by most marked deformities. M. Richet condemns the use of the tincture of iodine or of perchloride of iron, as they paste the lips of the wound, and thus act as an impediment to the escape of pus. The third group of surgeons—those who are convinced that the disease is simply inflammatory—are not agreed with regard to the surgical means which are to be employed in anthrax. On the one hand may be mentioned M. Alphonse Guérin and the late Velpeau; on the other, M. Nélaton and M. Richet. M. Guérin, acting on the subcutaneous method, introduces the tenotome, and divides the tissue compressed by the anthrax. M. Richet condemns this practice. Velpeau used to make a crucial incision, and then a circular incision, carrying the bistoury around the tumour. M. Richet thinks that this method savours somewhat of total ablation, and therefore condemns it with the others. Nélaton's method is that which he considers best. It consists in splitting the tumour with several incisions which radiate like the petals of a flower. With regard to M. Richet's own practice, the following are the rules which he lays down, and with which he concluded his lecture:—If the anthrax is of a simple kind, and is confined to the skin, the surgeon need not interfere. Such cases heal spontaneously. When the subcutaneous cellular tissue is involved, and passes thus into diffuse phlegmon, incisions must be made according to M. Nélaton's plan. The subcutaneous tissue must be carefully divided down to the muscles—which may be felt with the extremity of the finger through the wound. Hæmorrhage may be easily arrested by the application of some lint, and by slight compression. Poultices and tepid baths must then be employed. The general condition of the patient must not be neglected. If he is weak and emaciated, a restorative treatment must be adopted. If he is a robust man, he must be bled, purged, or even submitted to the administration of tartar emetic, &c. Pursuant to these principles, the Professor opened only one of the three tumours above described—namely, the lower one, which showed signs of profound inflammation.

AMONGST the forty-seven candidates who passed the last preliminary examination at Apothecaries' Hall was Mrs. Isabel Thorne, who was in the first division.

THE ESSEX HALL ASYLUM FOR IDIOTS, COLCHESTER, has become entitled to £1000 under the will of the Rev. W. H. Crawford; and £100 under that of the Rev. E. Ward.