

given. If the volume of a meal be put as low as one pint a dose equal to 90 minims of the B.P. dilute hydrochloric acid must be added in order to raise the acidity of the gastric contents to 0.1 per cent. HCl. But a pint is a very small volume for a meal, and if there be much protein in addition a correspondingly larger quantity of HCl must be added. Crohn,³ in his investigation of this subject, came to the conclusion (1) that single doses of HCl given before meals are useless; (2) that small doses are always useless; and (3) that only by giving large doses throughout meals can any appreciable percentage of HCl be assured in the gastric contents. Bastedo¹² expresses a similar opinion and speaks hopefully of the effects of acidol, a proprietary preparation of betaine hydrochloride, which may be taken as a solid and which liberates free HCl on solution. Pepsin should, of course, be given at the same time, and, from clinical experience, one is forced to the hopeful conclusion that even small percentages of HCl may lead to very material improvement in symptoms.

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LOSS OF SPEECH FOLLOWING AN ANÆSTHETIC.

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I CAN find no record of loss of speech following an anæsthetic in any book or periodical available to me, and in publishing the following case my hope is that further light may be thrown on it by someone who has met with a similar experience.

The patient, aged 43, ruptured the right quadriceps femoris muscle on Oct. 1st, 1920. He was a heavy, well-built man, but of rather a so-called "neurotic" temperament. An operation was performed on Oct. 13th to unite the severed ends of the muscle. The urine and heart and lungs appeared quite normal, but the patient was very nervous about the anæsthetic. A hypodermic injection of morphine gr. $\frac{1}{8}$ and atropine gr. $\frac{1}{160}$ was given half an hour before the operation.

The anæsthetic was commenced at 10.45 A.M., and the operation was completed at 1.6 P.M. Gas and ether were given, followed by chloroform and C.E. mixture, the quantities used being 2 ounces of ether and 3 ounces each of chloroform and C.E. mixture. The patient took the anæsthetic well, and never appeared to be very deeply under or abnormal in any way.

The same evening, after recovery from the anæsthetic, he could not answer any questions or speak a single word and, on being spoken to, he rolled his eyes and head in a drunken fashion. The following day he could utter a few words, but showed marked incoördination of speech and was unable to write sense, on attempting to write to his wife, though apparently knowing quite well what he wished to write. There was no personal or family history bearing on the case. There were no other signs of paralysis and he appeared to understand all that was said to him. On Oct. 15th (two days after the anæsthetic) he still spoke with difficulty, like a drunken man, and was slightly emotional, his lips quivering and his facial expression indicating a great effort to suppress weeping when spoken to as to whether his wife was coming to see him.

The neurologist reported that he appeared to be recovering from a condition of "post-anæsthetic" stupor, the reaction to interrogation being delayed but fairly good, although associated with a certain degree of mental stress, which was manifested in muscular movements of the face and in general irritability. He considered that the condition was possibly due to minute hæmorrhages or some congestion and was probably not hysterical. There was a certain degree of motor aphasia but no sensory aphasia. The lesion appeared to be cortical and to be confined to the dorsal part of the third frontal gyrus.

The ophthalmic specialist reported that both discs were normal. The urine, blood pressure, and temperature were normal throughout. Speech slowly improved, but on Oct. 19th (six days after the anæsthetic) there was still rather laboured staccato speech and the patient did not sleep well. There was still a grimacing effort at certain words, but when interested in any subject speech was now quite free and easy.

Since then the patient's condition has steadily improved, but his speech is still rather slow and deliberate, 50 days after the operation, and he states that he finds it more difficult to talk to strangers than to those he knows well.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

SECTION OF TROPICAL MEDICINE.

THE first meeting of this newly-formed section of the Royal Society of Medicine, which took place at 1, Wimpole-street, on Nov. 30th, under the temporary presidency of Sir LEONARD ROGERS, was very well attended and fully representative. An organising committee was appointed to prepare nominations for the offices of President, honorary secretaries, and council, and to draw up regulations for the conduct of the section. The following were unanimously elected to form the committee: Professor L. S. Dudgeon, Sir Robert Hill, Sir William Horrocks, Professor R. T. Leiper, Sir Humphry Rolleston, Dr. E. Wilkinson, with the President of the Section.

THE INCIDENCE OF FILARIASIS IN BRITISH GUIANA.

Dr. F. G. ROSE opened a discussion on this subject based on his experience of the prevalence of infection by *Filaria bancrofti* during five years' work in the colony. He dealt with his subject under three headings: (1) The incidence and economic aspects of filariasis; (2) preventive measures; (3) problems of filarial periodicity and ætiology, clinical and pathological features of the disease, and treatment by vaccine therapy.

1. *Incidence and economic aspects.*—His estimate of the incidence of filarial infection in the colony, whose total population was about 300,000, was derived from a relatively small number of inhabitants, including hospital patients, and he regarded his calculation of the percentage of persons in whom micro-filariae were found—namely, 21.2 per cent.—as only a rough approximation of the true filarial index. Moreover, the incidence of infection necessarily varied in proportion to density of population. Examinations for the presence of micro-filariae in the blood of cases of lymphangitis and elephantiasis were not uncommonly negative owing to obstruction to the passage of embryos into the circulation or due to the death of the parent worm. The adoption of the improved method of Smith and Rivas with 10 c.cm. of blood collected in 2 per cent. acetic acid, washed and recentrifuged several times, would greatly facilitate the finding of embryos and yield a more accurate and higher index than he had obtained by the ordinary method of examining 20 c.cm. of blood. It was, indeed, not unlikely that at least 40 per cent. of the population were at some time or other infected with the parasite. His results showed the age-incidence to be highest in young adult life and for the sex-incidence of filariasis 19.5 per cent. proved to be males and 23.3 per cent. females. Particulars were given of the general population, its racial proportions and distribution among the three divisions of the colony, whose area covered 90,000 square miles. Of the various towns Georgetown, the capital of Demerara, with 50,000 inhabitants, was by far the most populous in comparison with other places of 5000 to 10,000 and in contrast to extensive sparsely populated or wholly uninhabited parts. Infection was most prevalent in the more densely peopled towns and districts. From the health point of view malaria, enteric fever, and dysentery presented the chief problems; but filariasis was undoubtedly on the increase, notably outside Georgetown, where 20 to 25 per cent. of the school children showed some form of filarial manifestation. Among adults the racial incidence of elephantiasis was highest in the Portuguese and those of mixed blood, especially the females, and among children the blacks suffered most. It was still uncertain what part filarial infection played in contributing to the very high infant mortality-rate of over 200 per 1000, and the large number of stillbirths—factors which went far to explain the low increase of 50,000 in the colony's population during the past century. Dr. Rose emphasised the important influence of secondary streptococcal infection on filarial lesions in the causation of lymphangitis and lymphadenitis,