

hands, which cannot, without considerable violence, be opened; although, when the fit ensues at any other time, her hands, though closed, can be easily opened.

The particulars of this lady's case Dr. Ringland learned from herself some months prior to her then approaching confinement—her fourth—and which took place early in December, 1854. Immediately after the birth of the child, which was mature and healthy, she had one of her customary fits, which was followed by a second, immediately after the expulsion of the placenta. The following is a brief description of the first fit witnessed by Dr. Ringland.

Without any previous indication whatever, she suddenly seemed to faint, and lay in a state of apparently total unconsciousness. She, however, was quite aware of every circumstance that occurred around her, and could afterwards detail the conversation which had taken place in the room. Her limbs remained in whatever position they were in at the time of the attack, or in any other to which they were subsequently changed. There was no alteration in the colour of her lips, in her complexion, or in the appearance of her skin, which remained of the natural temperature. Her eyelids were closed, but when raised, continued open until closed again. The pupils contracted well on exposure to light. Her pulse was about 100, but very feeble. There were no apparent heavings of the chest nor movements of the nostrils. Repeatedly during the existence of the fit, but more violently towards its close, there were convulsive twitchings of the muscles of the face, spasmodic clenching of the fingers, and forcible supination of the hands on the forearm. There were no convulsive movements of the lower extremities, although such occasionally occurred, as she informed Dr. Ringland, and were always present during the first few months of the existence of the fits.

No restoratives were applied during the fit, as she had previously intimated to Dr. Ringland that the employment of the most simple of these had always produced violent and prolonged hysteria paroxysms, which never presented themselves when interference was not had recourse to.

After the lapse of about five minutes she gave a deep sigh, then opened her eyes, looked about her, and feebly held out her hands. On this signal, which is well understood by her attendants, she was without delay raised into a sitting posture, and after a brief interval of quiet she was perfectly restored.

Had not her attendants, as she informed Dr. Ringland, at once placed her in the erect position, she would have relapsed again and again into the fit. She, too, is so conscious of this necessity, that instantly on the subsidence of the fit she holds out her hands, as described, thereby indicating her desire for the requisite assistance. Should she at this time be handled roughly, or should the tender part of the spine or the coccyx be touched, she at once relapses into the fit.

She is not able until after the lapse of considerable time, and not even then without the greatest effort, to utter a single syllable, the peculiar condition excited throughout the system appearing in her case to attach itself more firmly to the tongue than elsewhere.

After the subsidence of the attack she is greatly distressed with tremors of the whole body, which last sometimes for only a few minutes, but at times continue for several hours.

Dr. Ringland, before concluding, made a brief summary of this singular case, directing attention to its leading characteristics and points of interest; especially to the previous existence of spinal irritation; the occurrence of the attacks in summer as well as in winter; the existence of consciousness during the fits; the erect position being necessary at the close of the fit, and neglect in this respect causing relapse; the loss of speech being prolonged after the subsidence of the other symptoms; and finally, to the fact that restoratives induced hysteria.—*Dublin Quarterly Journ. Med. Sci.*, Aug. 1855.

13. *Severe Inflammatory Croup*.—Mr. MARTYN communicated to the Western Medical and Surgical Society of London, November 16, 1855, an interesting case of severe inflammatory croup, in which alcoholic stimulants, freely administered, rescued the patient, a child aged four years, from imminent death. It had just recovered from the effects of scarlatina. The croupy symptoms

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became fully established in the course of twenty-four hours from first being observed. The fever was very high, and the obstruction to the circulation through the lungs very imminent, and the characteristic symptoms of croupy inspiration alarming. These symptoms were treated, as usual, with promptness and the ordinary remedies. The patient was put under the influence of tartar emetic and calomel, and a large blister was applied to the neck. The next day the symptoms continued as before, but towards evening the third stage, or that of collapse, became established. The face became dusky, and the skin covered with a damp perspiration, the mouth and lips purple and congested, and the efforts at respiration alarming. Under these circumstances the antimonial and mercurial treatment was omitted, and recourse had to stimulants. He was ordered half an ounce of brandy, diluted, and a less quantity at intervals of an hour, or oftener, if it could be swallowed; this was accompanied by the administration of the chlorate of potassa every hour, in combination with good nourishment. The next day, though the breathing was very laboured and difficult, the child was decidedly relieved. He continued to mend under the above treatment by brandy, though for some days the chest symptoms rendered his recovery doubtful. In the remarks which Mr. Martyn offered on the case, he considered that the time for the successful use of tartar emetic, &c., soon passed away, and that exhaustion soon waits upon the patient and demands the opposite kind of treatment. He considered that brandy was in every way preferable to any of the other stimulants used in the third stage of croup, as ammonia, senega, and the like; it had the advantage of being acceptable to children, and of producing more decided and permanent effects than any other stimulant. He was then led to make a few remarks upon the general lowering and evacuating treatment adopted in all acute diseases, the effect of which, in conjunction with the spare and starving diet, soon reduce the patient to such a state of exhaustion as to render him unable to combat the symptoms of disease. Should we not, then, recognize this element in all such diseases more readily than we do, and be ready at an early stage to administer alcoholic stimulants as soon as the evacuates employed have had fair play? Surely it is too late to delay their administration until exhaustion has too truly developed itself. Such stimulants do not augment inflammation, but maintain the vital powers whilst the natural sources of power, as nutrition, are cut off; and if stimulants do not directly combat inflammation, they surely, by supporting the system, give opportunity and fresh impulse to those vital forces that are always tending to subdue inflammations.

14. *Investigations regarding the Formation of Cavities in Tuberculous Lungs.*—The prevailing opinion with regard to the mode in which cavities form in tuberculous lungs is, that after the deposition of the morbid product, secondary ulcerative destruction takes place, by which a breaking up of the pulmonary tissue is effected. Dr. HENCO RUTLE analyzes ten cases of phthisis pulmonalis, in which cavities were found, and concludes that they take their origin in dilatation of the bronchi; and that the ulcerative fusion of the parenchyma surrounding a tubercular deposit is, in the majority of instances, preceded by bronchiectasis. He finds that in proportion as the cavities diminish in size, the more unable we are to discover any limits between the mucous membrane of the bronchus leading into a cavity, and the membrane lining that cavity. The author is of opinion that the microscopic appearances of the membrane are not compatible with the view of its adventitious character. Moreover, the relation of the bronchus to the cavity is regarded as corroborative of Dr. Rühle's doctrine: "The cavities are always in direct communication with the bronchi, and only one bronchus opens into each of the cavities here alluded to, and the communication is not on one side, but the axis of the bronchus coincides with that of the cavity." The author does not inform us at what time the ulcerative process commences, but states, generally, that it ensues early, and that, although non-tubercular bronchiectasis may be accompanied by ulceration, the tubercular deposit possesses a peculiar power of exciting the ulcerative process in dilated bronchi.—*B. & F. Med.-Chirurg. Rev.*, Oct. 1855.