

epileptic fits. There was a mark of an old scar, due to the removal of an enlarged gland five years ago, on the right side of the neck, and some enlarged glands could be felt in the neighbourhood of it. There was no tenderness of the neck. On examining the pharynx by means of a finger introduced behind the soft palate a distinct projection forwards produced by the consolidation of the bodies of the cervical vertebræ could be felt. The head had become fixed eighteen months before admission and could only be slightly moved. The patient could feed herself with the left hand but by degrees lost power in it. Gradually she lost power in her legs, first in the right and then in the left, dragging them as she walked. On June 16th galvanism to the spine was ordered, but as she seemed to get worse under the treatment it was stopped. Mr. Cotterell saw the case towards the end of June, 1895, and found the girl was the subject of an old cervical caries, with a certain amount of consolidation and welding of the bodies in front. There was no evidence of any post-pharyngeal abscess or acute mischief of the vertebræ. As the paralysis was rapidly becoming worse laminectomy was decided upon, with the idea of relieving the pressure upon the cord. This operation was accordingly performed by Mr. Cotterell on July 1st, the laminae and spines of the fourth, fifth, and sixth cervical vertebræ being removed. The dura mater bulged somewhat posteriorly when the laminae were taken away. The most careful search in front of the spinal cord failed to find any button granulations or evidence of dead bone. The dura mater was not opened. The skin and muscles were brought together with sutures and the wound healed by first intention. The subsequent progress of the case was briefly as follows. On July 3rd she moved the left hand. On the 7th she moved the left hand and arm and held it up. On the 10th she moved slightly the right hand. On the 15th she could raise the right hand and arm above the head. On the 16th there was still more power in the right hand and arm. On Aug. 5th she sat up for an hour; both hands were cold. On the 8th the right hand was cold and the left hot. She had regained power in both legs. Soon afterwards she was discharged, but came to the hospital for examination on Oct. 25th. She had full power over the limbs and sensation was normal. There was no pain or tenderness of the neck. She could move the head, but only slightly. On Oct. 30th she was readmitted, and massage was ordered to the neck as there was still some stiffness; this disappeared under treatment. On Feb. 6th, 1896, Dr. de Watteville kindly tested the muscles of the right arm and forearm for us, and the following is his report: "Reaction of degeneration in all the muscles of the arm and forearm. Some of the intrinsic muscles of the hand still unexcitable to faradaic currents of fair strength. The nerve trunks begin to react to induced currents better than the muscles themselves."

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

RUPTURE OF THE TERMINAL EXPANSION OF THE EXTENSOR COMMUNIS DIGITORUM.

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THE Clinical Note by Dr. F. G. Wallace in THE LANCET of Feb. 29th under the above heading describes a small accident of a somewhat rare kind of which I have met with two cases. These may be worth recording, as they extend over a longer period of time than the case of Dr. Wallace, and in each case recovery took place, the power of extension of the ungual phalanx being regained long after all treatment had ceased.

In the more recent case a man about fifty-five years of age fell while ascending some steps, and putting out his right hand to save himself injured his ring-finger. I saw him within an hour or two of the accident and found the same condition as that described by Dr. Wallace—viz., that the terminal phalanx of the right ring-finger could not be extended beyond an angle of about 130°, and there were some swelling and pain in the joint. The finger was placed in a splint, and at the end of a fortnight this was removed and reapplied, as the joint was in the same faulty position and distinctly inflamed. After three weeks,

no improvement being manifested, the patient refused to wear the splint any longer on account of the inconvenience occasioned by it in his occupation, which involved architectural drawing. Two or three months later the joint was still inflamed slightly and no more extension was possible than at first. When I last saw this patient, eight months after the accident, the joint had practically recovered its power of extension without further treatment. A similar result occurred in a similar case, the patient being a younger man, the power of extension of the finger being completely regained after several months, when all treatment had been suspended.

Blackheath.

AN ADDITIONAL SIGN GIVEN BY PLEURAL EFFUSION.

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ALTHOUGH as a rule the signs given by a collection of fluid in the pleura, whether serous or purulent, are definite enough to allow of an easy diagnosis, cases sometimes occur where the presence of lymph adherent to the visceral or parietal pleura, or thickening of the pleura itself, gives signs which so closely resemble them that the differential diagnosis becomes a matter of some difficulty; it is in such cases that I venture to think the presence or absence of the physical sign about to be described may be of use. The patient should be standing or in the sitting position, with the head and neck inclined forwards so as to render the skin and muscles of the back somewhat tense. The observer stands on the left side of the patient and, placing the left hand flat and fairly firmly on the lower part of the thoracic wall just below the nipple, percusses sharply either with a finger of the right hand or with a pleximeter on the ribs of the same side, striking them just posterior to the angles, when if no fluid be present a very slight vibration of the rib which is struck posteriorly is felt by the left hand in front, but if there be fluid in the pleura the vibration of the rib is much greater, and if the quantity of fluid be at all considerable the difference between the sensations experienced by the left hand when examining the sound and affected sides is most marked. This description as to position of hands, &c., applies, of course, to cases where the effusion is of some quantity, but by changing the position of the left hand and the spot where the rib is percussed posteriorly I have been able to elicit and demonstrate this sign where the quantity of fluid was small; it requires a little practice, but when once the sensation is thoroughly appreciated it is easily recognised again. In cases of bilateral effusion there is not, of course, the advantage of a sound side for comparison, but even in such experience may tell the physician whether or no the vibration obtained is greater than it should be. My own experience in this matter has been entirely confined to children, whose chest-walls are generally lightly covered and therefore favourable for the manifestation of this sign, but I hope that those who have the opportunity of trying it may find it of some service with adult patients also.

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SUBLUXATION OF THE JAW IN A GENERAL PARALYTIC.

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SEVERAL cases of subluxation of the jaw occurring during epileptic fits have been recorded in THE LANCET and elsewhere, but, so far as I am aware, never as occurring during a seizure in the course of general paralysis.

A man aged thirty-eight years was admitted into the West Riding Asylum, Wakefield, in May, 1893, suffering from general paralysis. In May, 1895, being then in the second stage, he had a series of slight epileptiform seizures, during one of which he sustained double dislocation of the jaw forwards. It was reduced with considerable difficulty, an anæsthetic being necessary to overcome the spasm of the muscles, which were above normal. His jaw also is massive. Since then he has several times dislocated the jaw and the reduction has been comparatively easy.

Wakefield.