

of the condition will be more thoroughly appreciated by both the profession and the public.

Duchess-street, W.

Clinical Notes: MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF PARAMYOCLONUS MULTIPLEX WITH FIBRILLARY TREMORS.

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THE patient, a male, aged 32 years, was admitted to Bradford Royal Infirmary under the care of Mr. T. Wilmot. The patient had not worked for about 15 months. He gave up work on account of general weakness. For about 12 months he had had violent twitchings of his muscles. They began in the muscles of his leg but rapidly involved the shoulder muscles. The contractions caused no pain. He was able to get about but could only walk slowly and with great care. He had never fallen. For the last five months he had been almost constantly in bed. Otherwise he had nothing to complain of. There was no history of fits or of any nervous disease in the family.

On admission the patient was found to be a well-nourished man. The temperature was 98·4° F. and the pulse was 80. As he lay in bed he was suddenly seized with extremely rapid muscular contractions of the muscles of all his extremities and of both platysmas. The face, with the exception of the platysmas and the depressor anguli oris, was not affected. In the arms the muscles most affected were the deltoid and triceps, in the back the trapezei and latissimi dorsi. Occasional twitchings were seen in the flexors of the forearms, but they were not nearly so frequent or so violent as those of the muscles of the shoulder girdle. When the patient sat up slight twitching could also be seen in the erector spinae. In the legs the quadriceps extensors were much the most affected. The hamstrings were affected to a much less extent. Contractions could also be seen occasionally in the tibiales antici. In both quadriceps extensors fine, fast, fibrillary tremors could be frequently seen though they were not constant. The same tremors, though to a less extent, could be seen in both deltoids. The contractions were extremely rapid, quite painless, and generally symmetrical, though at times, especially the contractions of the muscles of the forearm and leg, were limited to one side. The right platysma was more affected than the left and here frequently numerous contractions followed one another and seemed to end in a short tonic contraction. Voluntary movement for a time inhibited the contractions, but in a few seconds they began again—e.g., the patient could touch his nose with his forefinger accurately, but if he continued to do so the movements commenced again and soon became more violent than before. The patient's gait was normal though slow. While walking the movements of the legs ceased but those of the trunk continued. Romberg's sign was negative. The movements quite ceased in sleep. There were no paralysis, no rigidity, and no wasting of any of the muscles. The superficial and organic reflexes were normal. The knee-jerks were markedly exaggerated. There was no ankle or rectus clonus. Sensation was absolutely normal. There was increased motor and electrical excitability of the quadriceps extensors and the deltoids, otherwise the electrical reactions were normal. The cranial nerves were quite normal; there was no nystagmus. The fundi oculorum were normal; the mental condition was quite normal; the heart, the lungs, &c., were also normal. The patient was treated with galvanism to the spine and a mixture containing belladonna and arsenic. On June 26th the movements were as before but he had become somewhat excited. His pupils were moderately dilated and very sluggish to light. He had also developed an erythematous rash on his back. He was taken off the belladonna and put on bromide. On July 2nd the pupils reacted; the movements were as before. His mental condition was normal. On the 5th the patient went out at his own desire *in statu quo*.

I am indebted to Mr. Wilmot, medical officer to the

Bradford Royal Infirmary, for permission to publish this case.

Bradford.

NOTE ON A CASE OF UPWARD AND BACKWARD DISLOCATION OF THE CLAVICLE.

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THE patient, a spare, well-grown man, 55 years of age, whilst crossing the road was knocked down by a hansom cab. He remembered being struck on the head and was assisted to his feet in a dazed condition and accompanied to his home by a friend. He sustained a scalp wound which bled profusely, but was unaware of any injury to his shoulder until the following morning, when he found that his left shoulder was painful, and in order to relieve the pain somewhat he had to support his elbow. He was able to raise his arm slightly, but this movement caused great pain.

On examination the left shoulder drooped forward and there was a depression in place of the prominence caused by the forward convexity of the clavicle. The articular facet of the acromial process could be distinctly felt, while the acromial end of the clavicle projected backwards under the skin covering the suprascapular fossa. The distance from the acromial end of the clavicle to the coracoid process measured on the left side four inches and that on the right side three inches. There were some swelling and bruising of the part. The sternal articulation of the clavicle appeared to be in no way affected. Reduction without a general anaesthetic was found to be impossible, the acromial end of the clavicle being apparently entangled amongst fibres of the trapezius. Under chloroform reduction was effected, but the bone could not be retained in the proper position.

The patient was admitted into Middlesex Hospital on April 27th, 1906, under the care of Mr. A. Pearce Gould, who, on April 30th, wired the outer end of the bone into position. Mr. Gould made a curved incision so as to enclose the projecting outer end of the clavicle within the concavity of the incision. The end of the bone was found to have separated the fibres of the trapezius and to have become entangled within them. The bone was disentangled and holes were bored in the acromion process and the outer end of the clavicle respectively; a soft wire was then passed through, twisted tightly, and the ends cut short were battened down. The patient made an uninterrupted recovery and when discharged on May 17th could use the arm well, the movements daily improving. When he returned from the convalescent home three weeks later he could raise his arm as high above his head as on the uninjured side.

The most usual dislocation of the clavicle is at its outer end, with the acromial facet resting on the upper surface of the acromion process. In this case the outer end of the clavicle had passed much further back across the whole length of the acromion and was resting on the spine of the scapula. The whole of the coraco-clavicular ligaments must have been torn across. I cannot find a similar degree of displacement recorded by any of the surgical authors to whose works I have access.

I am much indebted to Mr. Gould for allowing me to publish this case and for his help in these notes.

Reviews and Notices of Books.

Physiology of the Nervous System. By J. P. MORAT (Lyons). Translated and edited by H. W. SYERS, M.A., M.D. Cantab. With 263 illustrations (66 in colours). London: Archibald Constable and Co., Limited. 1906. Pp. 680. Price 31s. 6d.

THE French treatise on physiology by Professor Morat and Professor Doyon is well known to all physiologists in its native garb. The translator has selected the volume dealing with the nervous system and perhaps wisely, for Professor Morat's name first became well known to English physiologists more than two decades ago by the joint work done