

REPORTS OF SOCIETIES.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

TUESDAY, JANUARY 24TH, 1882.

A. W. BARCLAY, M.D., President, in the Chair.

On Hernia of the Ovary. By ROBERT BARNES, M.D.—The author said that scanty advantages had been taken of the opportunity which the ovary, brought to the surface of the body, offers for physiological observation. He cited in abstract some of the most marked cases of hernia of the ovary which have been published, notably those of Goucy, Pott, Desault, Lallemand, and Poquet, Deneux, Veboux, César Hawkins, Oldham, Holmes Coote, Oettingen, Meadows, and Lawson, Courty, Leopold, Beigel, Boinet, Rheinstädter, and Raffo, and related two cases observed by himself. The first case was admitted by him into St. George's Hospital in 1877. The patient, a single woman, aged 41, had always enjoyed good health. At 24, she sustained a rupture in the left groin and wore a truss; at 38, she observed a second swelling behind the first. The swelling and tenderness of the ovary were observed before and during the menstrual periods. Corresponding sphygmographic observations showed distinct rise of tension preceding the flow, and subsiding when the flow set in. The ovary was removed. A description and illustration of it were submitted by Dr. Goodhart. Dr. Barnes referred to Dr. Chambers's case in the *Obstetrical Transactions*, in which bodies simulating ovaries turned out to be testicles. He discussed the etiology of hernia of the ovary and uterus, citing Cruveilhier's views. He referred to the frequent complication of anomalies of development of the genital organs in association with hernia of the ovary; also with extra-uterine gestation. He enumerated the varieties of hernia of the ovary, and referred to the supposed greater frequency of inguinal hernia when the ovary was concerned; to the greater frequency of congenital hernia; the complications with intestine and epiploon; the dependence of hernia of the uterus upon pre-existing hernia of the ovary, citing Cruveilhier's theory and the confirmatory conclusions of Puech, Deneux, and César Hawkins. The author then discussed physiological points, illustrated by the observation of the herniated ovary; how the ovary swelled concurrently with increased tension of the vascular system before menstruation; how the round ligaments swelled. He discussed the order in which the phenomena of menstruation occurred, arguing that the ovarian nismus was the *primum mobile*, that nervous and vascular tension followed, and lastly, the menstrual flow; resting greatly upon sphygmographic observations. He suggested that the recent practice of oöphorectomy on Battey's principle would supply opportunities for deciding this and other questions; and proposed that sphygmographic observations should be made upon the subjects of this operation. He then discussed the diagnosis and treatment of hernia of the ovary, contending that it furnished a legitimate motive for Battey's operation *quoad* this affection at least. The paper was illustrated by sphygmographic tracings by Dr. Fancourt Barnes; by drawings of the amputated ovary by Dr. Goodhart; and by a cast of the parts by Dr. Harper.—Dr. ROUTH said that such cases as those described by Dr. Barnes were important, not only as indicating the symptoms of ovarian hernia, but as contributions to the history of menstruation, which no doubt began in the ovary. He had, however, observed some symptoms to which Dr. Barnes had not referred, in cases in which the ovary had fallen into Douglas's pouch; especially on the left side. In one case, that of a young lady, who had a displacement of the ovary into the left side of Douglas's pouch, where it had become adherent, pressure on the ovary caused sexual excitement. This, if observed in hernia of the organ, would be an additional means of diagnosis. Another symptom observed in these displacements was, that pressure on the ovary produced a feeling of sickness like that arising from pressure on the testicle.—Mr. HULKE said that cases of hernia of the ovary were rather frequently met with by surgeons. Of course, care was necessary in making a diagnosis. In 1871, 38 cases of hernia of the ovary were recorded and classified by Englisch of Vienna (see *Biennial Retrospect* of New Sydenham Society, 1871-72). Of these, in 27 the hernia was inguinal; and in 9 of these the displacement was on both sides. In most of the inguinal cases, the hernia was congenital. As regarded the absence of any process of peritoneum in one of Dr. Barnes's cases, this might have existed and have become atrophied. In congenital cases, it appeared that the ovary was almost always accompanied by the Fallopian tubes; while, when the hernia was acquired later in life, the ovary generally came down alone. In many of the recorded cases, a distinct tubular process of peritoneum was described. As regarded operation, each case must be judged on its own merits. He had seen

cases where a lightly fitting truss produced no discomfort to the patient, while in others it could not be borne.—Mr. LANGTON referred to the difficulty of diagnosis. At the Truss Society, among more than 4,000 cases of inguinal hernia in women, there were 67 cases of hernia of the ovary. Of these, 42 were congenital, and in 25 the displacement occurred at various ages. The ovary was reducible in 29 of the congenital cases, and in 27 of these the patients were quite relieved by the use of a truss; the other two did not report themselves, and were probably cured. Of the cases in which the hernia occurred later, 8 were reducible and 17 irreducible; the proportion being the reverse of that in congenital hernia. The conditions of the ovary during the menstrual periods varied. In some, there was swelling of the ovary with effusion of fluid, which became absorbed; but, when the hernia had been first observed between the ages of one and twelve, no such excitement of the ovary was developed. The application of a truss gave relief in most cases; in none were there any indications for operation.—Dr. HEYWOOD SMITH said that it was very rare to find sexual excitement produced by pressure on the ovary; pressure generally caused pain of a sickening character. Might not the sexual excitement in Dr. Routh's case have been caused by irritation of the pudic nerve, in consequence of the adhesions to the pelvis?—Dr. BARNES thought that the remarks of Mr. Hulke and Mr. Langton tended to confirm the opinion of Cruveilhier that most cases of hernia of the ovary were congenital, and that the displacement was most frequent on the left side. He had not met with any cases in which distinct sexual excitement was produced by pressure on the ovary. He thought that the greater frequency of displacement in Douglas's pouch on the left side was caused by the round ligament and the ovary being more lax there than on the right.

OPHTHALMOLOGICAL SOCIETY OF GREAT BRITAIN.

THURSDAY, JANUARY 12TH, 1882.

WILLIAM BOWMAN, F.R.S., President, in the chair.

A Case of Acute Vascular Disease, with Retinal Hæmorrhages.—Dr. STEPHEN MACKENZIE read a very carefully recorded history of a case of this nature. The patient was a young blacksmith, aged 28, not overworked, getting meat three times a week, and vegetables daily, and in large quantity on Sundays. Four days before admission, he was attacked with swelling, pain, and bleeding of the gums, and abundant purpuric spots on the skin. At night, he vomited bloody fluid, and became delirious. On admission into the London Hospital, he was well nourished; there were numerous hæmorrhagic extravasations into the skin, but no subcutaneous or intermuscular extravasations; the gums were spongy, bleeding, and sloughy; there were extensive hæmorrhages into the retina, and some vitreous extravasations. There was a high degree of anæmia (corpuscles, 24.9 to 27.5 per cent.; hæmoglobin, 25 to 22 per cent.), and the temperature was high (maximum, 105.0° Fahr.). The disease ran a rapidly fatal course; antiscorbutics were of no service, and transfusion caused a rally of but very short duration; death occurred within a week of the onset. The body decomposed so rapidly after death that the necropsy threw little light on the nature of the disease, revealing only subarachnoid and subperitoneal hæmorrhages. The case was brought forward on account of the rapid and large retinal hæmorrhages, and also to raise the question of its nature. Dr. Mackenzie, after passing in review the most important vascular diseases attended with retinal hæmorrhage—namely, scurvy, idiopathic anæmia, hæmophilia, and purpura hæmorrhagica—said that he thought the case fell under the last head, though it was peculiar in that there was a condition of the gums similar to that seen in scurvy. This seemed to him to indicate that spongy gums had not the specific significance usually attached to the condition—a view which was supported by a case of idiopathic anæmia, in which the gums were swollen and bleeding, brought before the Society by him in the previous session.

Case of Double Optic Neuritis, following Purpura.—Mr. LAWFORD communicated this case, which had been under the care of Mr. Nettle-ship, at St. Thomas's Hospital. The patient was a girl, aged 12. During the greater part of the summer of 1880 she suffered from purpura; the purpuric eruption appeared in crops, a new crop being discovered on rising in the morning; she had several severe attacks of epistaxis, but no hæmorrhage from other sources. When admitted, on March 16th, 1881, there had been no purpura for many weeks; she had experienced some pain in the right eye, which was followed by loss of sight. She was sent to the hospital by Dr. McDonald, because she had lately begun to experience a similar pain in the left eye; at that time, the right eye had perception of light only, while the left had $\frac{3}{8}$ and 1 Jäger. The ophthalmoscope revealed neuritis, with fine striated hæmorrhages, on the disc on the right side, and commencing neuritis on the left side.

A week later, the swelling of the left optic disc had increased; the right disc was clearing rapidly. There was some disturbance of vision of colour in both eyes. Four days later, vision had greatly improved in the right, while it had markedly deteriorated in the left eye; the right disc was nearly clear, and the left was beginning to clear. From this date, vision in each eye rapidly improved—so that, on May 7th, she could read *Jäger* with either eye. She was examined on the day of the meeting: vision was then normal in both eyes, and ophthalmoscopic examination revealed no definite deviation from the healthy state. Optic neuritis was quite rare, if known at all, with purpura; and, in this case, it might be doubted whether any causal relation existed. The strict coincidence in time and degree between the changes at the discs and the state of vision, together with the history of pain referred to each eye shortly before the failure of sight, probably pointed to the disease being a localised papillitis, rather than a descending neuritis. In reply to a question from Dr. Stephen Mackenzie, Mr. Lawford said that there was no heart-disease.—Dr. STEPHEN MACKENZIE, in reply to several questions, stated that there was no evidence of any infective process in his case, and that he did not attach any great diagnostic importance to the high temperature; it was commonly met with in various forms of severe anæmia. In Mr. Lawford's case, he was led, by the manner in which the spots appeared in crops at night, to regard it as a case of peliosis rheumatica; the neuritis followed so long after the purpura, that he doubted whether there was any good reason for connecting the two, though it was worthy of note that, in his case, Mr. Waren Tay had observed some swelling of one disc.

Epithelioma of the Cornea.—The patient, a man aged 50, had been under the care of Mr. JAMES E. ADAMS. In September 1877, Mr. Adams shaved off from the conjunctiva a small, hard, lobulated growth, which sprang from the lower and inner part of the ciliary region on the right side, and overlapped the cornea. No further trouble occurred until the spring of last year, when a tumour appeared at some distance from the site of the former one. It grew rapidly, and, on September 3rd, 1881, the globe was extirpated. On microscopical examination, the growth proved to be undoubtedly an epithelioma, though it showed no tendency to penetrate the deeper tissues.—The PRESIDENT observed that, though he had himself frequently been forced to excise the globe in these cases, he still felt that repeated removals of the growth, with the careful application of such an escharotic as chloride of zinc, was a justifiable line of treatment, since it was possible sometimes thus to eradicate the growth.—Mr. ADAMS said that he had applied nitrate of silver after the first operation; but now somewhat regretted that he had not used a more powerful escharotic. At the time, he regarded the excision of the growth merely as a palliative measure.

Two Cases of exceptionally high degree of Spasm of Accommodation.—Mr. JAMES E. ADAMS described two cases. The first was that of a young lady, aged 13, who had suffered from diphtheria three months before her eye-troubles commenced. When seen, there was slight dragging of one foot, but no other signs of paralysis; here the eyes, naturally hypermetropic, became apparently myopic to a high degree. Not the slightest alteration of refraction took place in the dark; but, after instillation of atropia for three hours, the refraction returned nearly to its original condition. This condition of spasm had arisen shortly after resuming arduous studies. The facility with which the surgeon might fall into error in such cases was, Mr. Adams remarked, obvious, unless atropia were used. The second case, that of a French priest aged 20, was chiefly remarkable for the length of time required to bring the ciliary muscle under the influence of atropia.—Mr. ADAMS FROST referred to the history of diphtheria in the first of these cases. He suggested that there might have been some paralysis of accommodation, leading to violent effort to overcome the paresis; after recovery from the paresis, the spasm might have remained.

Hard Chancre on the Conjunctiva of the Lower Eyelid.—Mr. WHERRY (Cambridge) described the case of a young shepherd, aged 23. On the conjunctiva of the right lower eyelid, a little to the outer side of the centre, was an ulcer with an indurated base; there was a good deal of chemosis, but the eye was otherwise healthy; the lymphatic glands in the parotid and submaxillary regions were large and hard. There was no history of the mode of infection. About five weeks after the affection of the eye began, well-marked secondary symptoms occurred.—Mr. NETTLESHIP said that he had seen a case in a little girl, aged three years, which was almost the exact counterpart of this case, and was published in Mr. Berkeley Hill's treatise. She had a painless swelling on the inner surface of the lower lid, followed by indolent enlargement of the lymphatic glands, and a roseolar eruption. There was no history, in this case, either of the mode of infection.—The PRESIDENT remarked that a foreign body, which entered the sulcus, between the lower lid and the sclerotic, was very apt to be retained there;

and he suggested this fact might account for the site of the chancre being exactly the same in the two cases referred to.

Diabetic Cataract.—Mr. NETTLESHIP read the case of a woman who had suffered partial dislocation of the lens in one eye, owing to an accident; and when first seen, three years later, was suffering from diabetes. There was then partial cataract in each eye, but more advanced in the injured one. Afterwards, the displaced lens made much slower progress towards complete opacity than the other. The question was: whether the rupture of the suspensory ligament by injury prevented the diabetic state from having so great an influence on the lens in the injured as in the sound eye.—The PRESIDENT suggested that as, when the lens lost its natural connections, the normal processes of nutrition went on less rapidly, so, under the same condition, it might be less affected by any morbid state.

New Perimeter.—Mr. MCD. MCHARDY exhibited and explained a new perimeter, made for him by Messrs. Pickard and Curry. He claimed that it combined most of the advantages of other perimeters; that it was more portable; and especially that the automatic recording apparatus, introduced last year by Dr. Stevens, was here rendered simpler and more effective.

Specimens shown by Card:

Fibro-sarcoma of Lacrymal Gland.—At the last meeting of the Society, Mr. HENRY POWER and Mr. JULER showed a patient with a tumour of the lacrymal gland. The tumour was removed on December 22nd, 1881, and proved, on microscopical examination, to be a fibro-sarcoma. The patient, who was in attendance on this occasion, also presented slight ptosis of the left eyelid; the cicatrix was firm, and there was no evidence of recurrence.

Glioma of the Retina.—This patient, a girl aged four years, was exhibited by Mr. HENRY POWER and Mr. JULER. A whitish lobulated tumour grew apparently on the lower and outer part of the ciliary processes, and protruded into the vitreous body, behind the lens. The retina was extensively infiltrated with deposit, which extended to and included the disc.

HARVEIAN SOCIETY.

JANUARY 5TH, 1882.

HENRY POWER, M.B., F.R.C.S., President, in the chair.

Cases of Removal of Osseous Tumours from the Auditory Canal.—Mr. FIELD related several cases, in which he had operated successfully on ivory exostoses (hyperostoses), by means of the American dental engine, drilling through the growth—thus making a permanent opening. In other cases of pedunculated osseous tumours, exostoses, made up of soft bone, he usually removed them with stump forceps, such as are used by dentists for the upper jaw. In all cases, the patients regained their hearing satisfactorily. In the case of multiple growths, operations were, as a rule, unnecessary; for a triangular space was left, between the apices of the tumours, which, growing from opposite sides of the canal, became wedged together—so that the aperture was not completely closed up. Five patients, with ivory exostoses, were accustomed to bathe regularly in the sea. From this fact, he was led to conjecture that this disease, instead of being invariably due to gout, rheumatism, or syphilis, or being influenced thereby, is more often the result of a chronic inflammation of the walls of the external meatus, such as might be produced by sea-bathing, or from the presence of pus in the canal.—Dr. STEPHEN MACKENZIE asked if serious brain-symptoms ever followed these operations.—Dr. BROADBENT mentioned a case of double exostoses, in which severe giddiness and sickness occurred when the mucous membrane was congested.—Dr. CLARKE and the PRESIDENT spoke; and Mr. FIELD, in reply, said he had never met with a case in which serious brain symptoms had followed the operation.

Encysted Dropsy of the Peritoneum.—Mr. KNOWSLEY THORNTON read a paper on this subject. He said that the disease was very rare, but he had met with two cases, in his hospital practice, in the last three months; and this showed that it was necessary to diagnose it from other abdominal enlargements. He alluded to the small amount of information on the subject to be found in either the general or special text-books. He quoted at some length a case in Mr. Spencer Wells's work on *Diseases of the Ovaries*, which very closely resembled one of his own; and alluded to the opinions of Drs. West and Peaslee, and showed how misleading the statements of the latter were—the errors arising, in his opinion, from an attempt to generalise from very imperfect data. He pointed out that it was important to distinguish this disease from the much commoner condition in which partial collections of fluid occurred in the peritoneum, around malignant growths. His own cases were then fully recorded. Case I was that of a woman, aged 45, believed to have an ovarian tumour, which was also supposed to have ruptured into

the peritoneum, while she was under the author's observation. Suppression of urine led to tapping of the peritoneum, which gave temporary relief; but she died with uræmic symptoms without further operation. The *post mortem* examination revealed very advanced granular disease of the kidneys, a large spleen, and an encysted dropsy, which had become general by breaking down of adhesions. The ovaries were healthy. Case II was that of a young girl, in whose abdomen a doubtful collection of fluid existed. It was a very difficult case for diagnosis; but, on the whole, the author leaned to the view that it was a case of flaccid cyst of the broad ligament. Abdominal section showed that it was an encysted dropsy of the peritoneum. The fluid was removed, the sac carefully sponged out, and the incision closed without drainage. The patient made a good recovery, the intestines gradually reoccupying the space where the fluid had been; and, when she was last seen, there was no appearance of reaccumulation. In his concluding remarks, Mr. Thornton urged the importance of the faithful record of rare cases, and pointed out that the knowledge of this disease was still too limited for it to be possible to lay down rules as to diagnosis. He would accept Peaslee's statement, that "encysted" dropsy of the peritoneum was always preceded and caused by peritonitis. The causes of the peritonitis were, however, very various. With regard to treatment, he thought it right to open the abdomen, and sponge out the sac, in any case in which the condition was diagnosed in a patient free from kidney-disease. Drainage was not necessary. He urged the advantage of incision, as compared with tapping; and spoke strongly as to the value of Listerism in abdominal section. At the Samaritan Hospital, in 1881, he had had forty-one cases of ovariectomy; he had not once drained, and had only had two deaths, both occurring in young patients, the subjects of malignant tumour.—Dr. BROADBENT mentioned a case of peritonitis, with dropsy, limited to the great omentum.—Dr. HARRIS also stated that he had seen a case of localised dropsy following child-birth.—Dr. HAYES said, after Mr. Thornton's success, he would be encouraged to operate in these cases, though he felt the whole difficulty lay in the diagnosis.—The PRESIDENT spoke; and Mr. THORNTON replied.

BORDER COUNTIES BRANCH.

OCTOBER 28TH, 1881.

S. GRIENSON, M.R.C.S.Eng., in the chair.

Amputation of the Hip-joint.—Dr. MACLAREN read a short account of three cases of amputation at the hip-joint. The first patient, a boy aged 10, had acute necrosis of the upper end of the femur. He died twenty-six hours after the operation from exhaustion consequent upon extensive intrapelvic suppuration. The second case, a boy aged 17, was one of chronic osteitis and subperiosteal suppuration of the femur. He made a good recovery. The third, a lad aged 20, had hip-disease of six years' standing. A large portion of the pelvis was subsequently removed. He made a slow recovery, and all the sinuses had not yet healed. He was able to go about and work at his trade. The method of removing the limbs was circular incision in two cases, anterior and posterior flaps in the other, all at the upper third; then an incision along the femur, and disarticulation. The advantages of this operation were: easy control of hæmorrhage; a small cavity in the centre; division of important structures, further from the trunk than by the old method; and diminution of shock. Davy's lever was used to control hæmorrhage in two of the cases, and answered admirably. In the other, which was a right limb, it could not be placed upon the common iliac artery; and Lister's tourniquet, supplemented by digital pressure, was employed.

The Treatment of Scarlet Fever.—Dr. HENRY BARNES, in introducing a discussion on this subject, first spoke of the prophylactic measures necessary for preventing a patient suffering from this disease from becoming a source of danger to others. The most essential of these were thorough isolation, and efficient disinfection. The unsatisfactory character of the experiments for the inoculation of the disease were referred to; and a hope was expressed that the infective germs might, at some early period, be identified and cultivated—so that the good results obtained by Pasteur, in splenic fever, might be also forthcoming in regard to scarlet fever. The medical and hygienic treatment was then considered. In mild cases, the necessity for great precautions against cold, and the risks of secondary complications, were insisted upon. The good effects of the blanket bath, and inunction with oil, in allaying irritation, reducing pulse and temperature, and conducing to the greater comfort of the patient, were pointed out. In discussing the treatment of graver cases, the unfavourable symptoms which the author had met with in different epidemics were alluded to, and the plan of treatment which he had found most successful in obviating these symptoms was described. The antiseptic salts of soda, especially

the hyposulphites, were prescribed in some cases with decided benefit. The indications for the use of quinine, pilocarpine, chlorate of potash, carbonate of ammonia, and other remedies, were detailed, and especial reference was made to the external use of cold water, in the form of either cold pack or of cold affusion. The applications to the throat which had been found most useful were, sulphurous acid and glycerine, liquor sodæ chlorinatæ, solution of nitrate of silver (five grains to one ounce), and the liquor calcis saccharatus—the latter especially in those cases where there was any tendency to the formation of false membrane. When the urinary secretion was scanty or suppressed, a condition which might continue sometimes for four or five days, the internal administration of benzoic acid produced good results. The sequelæ of the disease and their treatment were also shortly alluded to, special prominence being given to the treatment of the tubal nephritis.

REVIEWS AND NOTICES.

OBSERVATIONS ON THE LOSS OF SENSIBILITY, OR ANÆSTHESIA, IN FUNCTIONAL CONDITIONS, AND ON CORD DISEASE, ETC.
BY DAVID DRUMMOND, M.A., M.D. Newcastle-on-Tyne, 1881.

THIS essay, a reproduction of papers presented by Dr. DRUMMOND at different times to the Northumberland and Durham Medical Society, represents an attempt to treat of the various anæsthetic and analgesic phenomena met with in hysteria, and in diseases of the spinal cord, in a systematic way; and contains, therefore, as might be expected, many interesting and suggestive observations upon a class of affections in regard to the pathogenesis of which we have at present but little information.

In a brief physiological introduction, the author gives his adhesion to the opinion that the same terminal organs in the cutaneous and afferent nerves serve in common for tactile and painful impressions; and, further, that these are the same organs and channels which respond to thermal impressions.

In treating of sensation-conduction in the spinal cord, the theories advanced by Brown-Séquard, Schiff, Woroschiloff, and Wundt, are discussed; and, in order to explain the fact familiar to clinicians, that pain is more frequently abolished (analgesia) in nervous affections than the sense of touch, a hypothesis is suggested, founded on the theory that pain-exciting impressions are from habit accustomed to travel certain definite paths in the afferent regions of the spinal cord; that such impressions, when forced into a new channel owing to some obstruction, ascend through the unaccustomed paths with difficulty, and arrive at the sensorium so modified as simply to excite tactile sensations; while, since the whole of the afferent channels are habituated to their passage, no such opposition is offered to the conduction of tactile impressions.

In discussing the etiology of the affection, the opening passage is calculated to excite comment. "I would premise that an overwhelming majority of the cases of anæsthesia, using the term in its fullest sense, are of the hysterical variety. My observations on this point have led me to the conviction that analgesia—impaired sense of cutaneous pain—is the commonest phenomenon of hysteria, and its most faithful and frequent index, not excepting the globus, emotional manifestations, inframammary neuralgia, etc." If it be true that the hysterical condition can be recognised by the loss of cutaneous sensibility more certainly than by any other manifestation, the observation is to be looked upon as of considerable clinical importance; although the author, in describing in succeeding pages the modes of investigating sensibility, wisely adds a word of warning as to the necessity of much discrimination in this regard, and particularly insists upon the necessity of distinguishing between painful impressions originating in muscles and those arising from irritation of the skin.

Hysterical hemianæsthesia is spoken of as exceedingly rare, the analgesia frequently met with being either general or irregular in its distribution. Several interesting cases of the former variety of the affection are, however, mentioned.

In distinguishing hysterical anæsthesia from the organic variety, particular emphasis is laid upon the presence, as indicative of a functional origin, of analgesia affecting the skin, whilst a strong Faradic current causes pain by inducing contraction in the muscles; and, again, in hysteria it is not unusual to meet with abolished tactile sensibility, whilst thermal impressions are still appreciated. In organic anæsthesia, thermal and tactile sensibility, in their presence or absence, are generally associated. Subjective symptoms—paræsthesiæ—are, Dr. Drummond states, rare in functional cases; a statement referring, it is to be supposed, to true paræsthesiæ, and not to those peculiar morbid sensations that usually pass under that name, and which result merely