she occasionally wants to get up into the trees to roost. On admission, she had other birdlike propensities, not convenient to indoor life.

In cases already given, there were delusions or perversions of the instincts with respect to dying. In some, the feeling existed with the patient that she could not die; in others, that they had died; or in another, that she should live for ever.

I have at present a case in which the patient has the delusion that she has no blood; that her head is made of wood. She strikes her head forcibly, to prove her assertion by the sound; and she entreats others to do the same, or to run a lancet into her to satisfy themselves. This patient also believes she is under the influence of witchcraft.

A patient, very lately dead, asserted that her heart had stopped; that she was dead, and about to be buried, at which she expressed great terror.

I had formerly a patient who at last died in reality, but who maintained perseveringly for seven years that she was a corpse; and she had her distinct theory on the subject. She argued that, though her case was unique, that did not prove its impossibility. "I know such a case never was heard of before," she would say; "but my case is exceptional." Her belief was, that she died on a certain day and hour, which she named; but, owing to the negligence of the nurses, who did not tie up her jaw at the proper time, "she was left a-speaking"; and "so her jaw never dropped", and consequently "she could not get to the grave". She greatly blamed my predecessor in office, that he did not cut her head off. She repeatedly entreated me to do this for her. For years, day and night, she was in a constant state of mental agony, rocking backward and forward on her seat, and moaning, "I have not got to die, I have not got to die. It's nothing but the bitter cold wind that's speaking." This patient ate pretty well, though she declared she never did. "How can a corpse eat?" she used to say. At times she could be diverted for a short period, occasionally would play a rubber, and enter well into the game. At times she was chatty, and would relate her previous history. She was a nurse in an asylum for the insane. Her memory and reasoning faculties were clear up to within six months of her death. The disease then began to affect the motor functions. She became unable to articulate clearly; this gradually increased; and before death she became quite unintelligible. She died during my temporary absence from the asylum.

Another extraordinary anomaly, having reference to the bodily state, occurred in a patient whose name was Martha Stevens, but who persisted for years in calling herself Molly Dodd. She had, it would appear, completely lost all idea of her personal identity. She called her son, who came to see her after a long absence at sea, Martha Stevens's young man. She spoke of knowing Martha Stevens formerly, but said she died. She appeared to relate the history of her early life as that of Martha Stevens; but the latter events of her life were always spoken of as connected with her state as Molly Dodd.

A patient lately received has the idea or delusion that the various parts of her body do not belong to her. This form of insanity has been specially named *melancholia metamorphosis*. She asserts that her head was taken off, and a horse's head put on her. She complains much about her legs, and says that they are great ugly legs, which belonged to an overgrown boy; that her own legs were nice little legs; and she appears horrified when she casts her eyes downwards on her limbs. She says her hands have been changed at the wrists; that her arms are somebody else's, and that they do not correspond, and

there is no feeling in them. This confusion of parts is the source of great mental anguish to her.

With respect to all such false perceptions and delusions, it is common to hear them attributed to peripheral excitants of various kinds; that is, to look upon the mental phenomena therefrom as arising from eccentric causes. In a very large number, there is no evidence of such; but in cases (and which, I think, are exceptional), such peripheral excitant would appear to be present. Instances have been recorded in which an insane person has suddenly recovered her mental faculties on removal by operation of a diseased organ, or by the natural termination of a peripheral disease, as the breaking of an abscess. Such cases are very striking when they occur; and one is apt, therefore, to exaggerate the frequency of their occurrence. A patient lately discharged, who on admission had the delusion that she was pregnant, was found to have tapeworm, which was brought away by the use of the oil of male-fern. She regained her strength, with the return of which her delusion vanished. The patient who, while pregnant, believed she gave birth to one hundred children, and who, after delivery, reduced her ideas to tens, is also an example of the presence of peripheral or eccentric excitants; but the evidence in the last case is equivocal, since the delusion did not cease entirely. In far the greater majority the cause of the delusion is centric—in other words, cerebral.

[To be continued.]

RESUSCITATION OF STILL-BORN CHILDREN: ACTION OF ERGOT.

By EDWARD GARRAWAY, ESQ., Faversham.

Do accoucheurs ever fail in their endeavours to establish the respiratory function in still-born children? or am I the most unfortunate of men? One reads of numbers of instances in the various medical journals of infants being resuscitated by the Marshall Hall and Silvester methods of treatment, but never of an instance of failure. Now, I have been defeated—perhaps it is not expedient to say how many times; of course, too, I have had my successes (see, in particular, the JOURNAL of September 28th, 1861.)

Mrs. C., a healthy, small, but well proportioned young woman, aged 22, was taken in labour with her first child, at 6 A.M. I saw her at 9; the liquor amnii had escaped, and the head was presenting in the ordinary position; the os was dilated to the size of a half-crown; the pains were vigorous. By 1 P.M., the head was well down on the perineum, which proved rather rigid, and, at the same time, the pains began somewhat to abate. At 6, the perineum being on the stretch, and the labia separating, the pains became utterly ineffective, and I therefore gave my usual quantity of ergot, in two doses (two drachms boiled in eight ounces of water down to four ounces). Vigorous pains speedily followed; and for nearly half an hour labour seemed progressing; but now, the influence of the ergot being exhausted, the pains ceased. I never give more than the quantity above mentioned of this drug; so, after a little repose, I had recourse to the forceps. Careful manipulation, however, with one blade, aided by strong pressure on the abdomen, sufficed to deliver the head. This was accomplished without the slightest uterine effort, or even feeling of pain, on the part of the mother. By hooking my finger into the axilla, and again pressing hard upon the abdomen, the child was partly dragged and partly pushed out of the uterus, still without the slightest pain. As the feet were drawn out, a rush of air took place into the vagina—a phenomenon, as far as my

observation had hitherto gone, usually succeeded by more or less hæmorrhage. On compressing the uterus the air rushed out again; and, although there was no feeling of contraction or pain in this organ, it seemed slowly to close upon the placenta. No friction nor compression of the uterus would induce pain; and, as the funis began to tear under traction, I passed my hand into the vagina and easily removed the placenta, which was not attached. The uterus, somehow, without any apparent contraction, seemed gradually to accommodate itself to circumstances; and it is remarkable that literally not one drop of blood was lost.

I never before met with a case in which from beginning to end of the expulsion, or rather extraction, of the child and after-birth, not one single effort was made by the uterus, the mother being quite easy and comfortable during the process, whereas previously the house had resounded with her cries. There was no physical exhaustion; the pulse was quiet: and I can in no way account for the uterine inertia.

Ranking's *Abstract* contains the history of a case of resuscitation of a new-born infant by Dr. S. Reed. The case, extracted from the *Lancet* and the *Pacific Medical Journal* of October 1862, was briefly this. The doctor arrives at a patient's house, finds the labour completed; the accoucheur, who had attended for him, having departed twenty minutes, leaving behind a still-born babe and a sorrowing family. He hastens to the bedroom, detects a slight fluttering about the child's heart, at once begins forcing air from his own mouth into the chest of the infant, alternately inflating the lungs and depressing the ribs, compressing the nostrils, and so on, meanwhile keeping the child warm in flannel. "In forty minutes it gave a sigh; in twenty more it began to breathe, and was handed to the thankful mother."

Now, in my case, the child was born asphyxiated. I did not abandon it in twenty minutes; but, discovering in twenty seconds not a slight fluttering about the heart, but a decided pulsation, went vigorously to work after Dr. Reed's fashion. Over and above the attempts at inflation, the warm bath and cold douche, Dr. Marshall Hall and Dr. Silvester's plan were had recourse to, and for thirty minutes I persevered, the heart's action getting fainter and fainter, and not one gasp rewarding me for my pains. Meanwhile the mother, who ought to have been flooding, but was not, requiring my attention, I gave up the recovery of the child as hopeless.

In this case sickness accompanied almost every pain until the decoction of ergot was given. This was the first thing retained upon the stomach. Its effect was quick and powerful, militating against Dr. Graily Hewitt's theory that the action of ergot upon the uterus is through the vomiting it induces. Dr. Graily Hewitt, however, does not venture to lay this down as a law, but diffidently submits his views to the profession for confirmation or otherwise. The question is a most important one, and might be settled in a few months if every accoucheur would take note of his cases in which ergot is given. If sickness only were needed to excite uterine action, safer emetics might be used; for I suppose all men's minds are not yet quite assured of the innocuous action of ergot upon the fetus, if delivery be long delayed after its administration. We all use antimony and ergot, but regard the two drugs as perfectly dissimilar in action. We avail ourselves of the former, by its nauseating effect, to induce dilatation of a rigid parchment-like os; of the latter, to excite expulsive pains; but at present we should not think of giving ergot to dilate—by the vomiting it may possibly induce—a rigid os, nor should we administer antimony when uterine effort fails in the last stage of labour.

This fact, I think, I have noted; that ergot manifests a much more powerful effect upon a full uterus than upon an empty one. I have rarely been disappointed with it as an aid to the expulsion of the fetus, and seldom satisfied with it as an inducer of contraction in *post partum* hæmorrhage, notwithstanding it is invaluable in a case of anticipated flooding, if given as the head is emerging from the lower outlet.

Reviews and Notices.

THE PRINCIPLES AND METHODS OF MEDICAL OBSERVATION AND RESEARCH, for the Use of Advanced Students and Junior Practitioners. Second Edition; with copious Nosologies and Indexes of Fevers, and of Constitutional, Cutaneous, Nervous, and Mental Diseases. By THOMAS LAYCOCK, M.D., F.R.S.E., F.R.C.P., etc.; Professor of the Practice of Medicine and of Clinical Medicine in the University of Edinburgh. Pp. 403. Edinburgh: 1864.

THE aim of the author in publishing this work has been to teach the student "how to attain to a mental culture and discipline suited to his special and immensely wide spheres of knowledge and labour." He has, therefore, in seven of the lectures of which the work consists, commented on the nature and acquisition of experience in medicine; the combination of theory with experience and observation; the fallacious use of theories; the general methods and objects of clinical study; the methods of clinical examination; clinical observation of general or constitutional morbid states; prognosis, and the order of succession of morbid phenomena; the due estimate of treatment, and the management of the case; the numerical method of research; and the analogical, philosophical, or purely inductive method of research. In the remarks of Dr. LAYCOCK on these subjects, there is a good deal of practical instruction which is calculated to be useful to the student in training him to an orderly method in examining patients, and in forming a proper estimate as to the utility of treatment; and these portions of the work—we refer especially to the second, third, fourth, and fifth Lectures—may be perused with advantage while he is engaged in his studies in the hospital wards; but the more abstruse topics treated of in the sixth and seventh lectures—the relative merits of the numerical and inductive methods—will be more profitably brought before him when his mind has been somewhat relieved from the details of which he is required to obtain such a knowledge as will fit him for the practice of his art. In an eighth lecture, the author speaks of the naming and classification of diseases.

As the portion of the work to which we have just now referred has been some time before the profession, we abstain from saying more about it. But a considerable portion of the volume is now occupied with a new part, in which Dr. Laycock enters very fully on the subject of the Classification of Diseases. He classes diseases primarily as general and local. General diseases, again, are divided into three classes: pyretic, including two orders, fevers and inflammations; constitutional, comprising diathetic and cachectic diseases; and systemic, dividing into orders according to the system of organs affected. Local diseases are arranged in two classes: diseases of the