ceding the evidences of mania, resembled each other in many other points. 1. None of them were primary attacks of insanity. Hence we may draw this inference, which is corroborated by all my experience, that all primary attacks of mania (proper) commence by melancholy; and the converse—viz., that where an outbreak of maniacal violence takes place in an individual without a previous stage of melancholia, such individual has been insane before. 2. These five exceptional cases commenced suddenly. 3. They exhibited great violence for a short period. 4. All recovered; and on recovery all denied having been ill, and dwelt much on the injustice of their detention or incarceration. 5. It is curious—but whether it is an accidental coincidence or not I am uncertain—that three out of the five (and these were all females) stripped themselves naked when first taken.

These cases certainly have characters of sufficient constancy and distinctness to enable us to predicate their future progress; I am not convinced, however, that they constitute in themselves a separate form of disease, or a distinct species.

I know of nothing which marks their character—for example, in the first onset, or in the primary attack. I am not aware of any diagnostic mark which would enable one who witnessed the primary attack to prognosticate that the patient would be liable to repeated secondary attacks of the disease. Nor does my experience enable me to say whether the primary attack is invariably accompanied or not accompanied by melancholic symptoms. This is a point which remains for future inquiry.

If we admit this form of case as distinct, it is nearly the only one out of the multitude of variations which have received distinctive appellations to which I would yield the same distinction.

In different authors, one meets with an almost innumerable variety of forms of insanity, on which separate names have been bestowed. The confusion thus introduced into the subject becomes perplexing in the extreme. Guislain thus commences his ninth chapter: "Vingt-trois formes de manie, sans compter plusieurs formes composées non indiquées, voilà, me direz-vous peut-être, une bagage symptomatologique passablement lourde pour la mémoire." (P. 203.) Before proceeding with the illustrations of distinct forms, it becomes necessary here to explain of what these so-called varieties consist. From a careful examination of all these variously named kinds of mania, I think it will be found that they belong to one of the three following classes.

1. Certain so-called forms will be found to consist of cases in which one particular symptom has been perhaps rather more prominent than the rest; as, for example, cases named kleptomania, erotomania, nymphomania, oinomania, homicidal, suicidal mania, etc.

2. Another large section of these varieties are named from some presumed cause of attack, such as puerperal mania, hysterical mania, phthisical mania, mania *a potu*, none of which have very distinctive characters, according to my experience.

3. Varieties have been formed out of what really are only stages in the progress of insanity. The cases hitherto narrated have all belonged to the acute stage of the disease. The morbid processes, in entering upon the chronic stage, undergo certain modifications in their downward progress. The disease may subside gradually, or it may alternate between activity and inactivity; and it may ultimately cease altogether, but leave the mind in one case enfeebled only, in another nearly annihilated. Out of these progressive stages, more kinds of insanity have been formed.

1. In the worst condition, the patient is demented—imbecility, dementia.

2. In another set of cases, the morbid process appears to terminate, but leaves the mind permanently changed in some peculiar function; as a particular delusion remains, an alteration of disposition, or an eccentricity in habits, etc. Most English writers would call this a state of chronic mania. In France, it constitutes what they call monomania; and some writers have coined names for almost every sort of eccentricity of conduct or behaviour met with. "There is a mania," writes Guislain, "which I call *manie astucieuse, malicieuse*, which resembles this foregoing (*manie raisonnante*), but which presents phenomena of marked character. The patient is guided by a spirit of intrigue; he is a cheat, a sharper, an intriguer," etc.

3. The downward progress in certain cases is not uniformly progressive. The patient, on the whole, declines towards dementia; but periods of activity—flickerings of the morbid process—occur. Thus the chronic mania may be subject to occasional outbreaks of violence—to a recurrence of the acute symptoms generally; and these attacks take place at completely irregular or at more or less regular intervals. We have the following modes in which this may take place.

1. The patient is subject to occasional outbreaks of violence and excitement; but a constant and progressive increase of imbecility goes on.

2. The patient's condition alternates between a state of general depression and one of great excitement. (This form is called *folie circulaire* by French writers.)

3. The patient has repeated attacks, of two or three months' duration every year, for many years consecutively; not entirely recovering sanity in the interval, but free from depression. These cases are what have already been alluded to as recurrent mania.

In the next paper, a few observations on these variations of the symptoms will be considered.

NOTE ON LARYNGOSCOPY.

By George Johnson, M.D., Professor of Medicine in King's College.

It is common to meet with persons who, having had no experience in the use of the laryngoscope, are sceptical as to the possibility of examining the larynx without difficulty, and, in particular, without occasioning considerable annoyance to the subject of the examination. In illustration of the facility with which, in the great majority of cases, the larynx may be inspected, I beg to narrate the following occurrence.

A few days since, after lecturing to my class at King's College on the Use of the Laryngoscope, I announced to them my intention of first showing them my own larynx, by the simple process which I have described in my published lectures, and then I requested that twelve of my pupils would submit to a laryngoscopic examination, with a view to ascertain in what proportion of cases the larynx could be inspected without difficulty.

Accordingly, twelve gentlemen presented themselves; and the result was, that in eleven cases I at once got a complete view of the larynx by a single introduction of the mirror; while in the twelfth case a large and rather nervous tongue somewhat interfered with the examination, and, after three or four attempts, I got only an incomplete view of the larynx.

The whole process of demonstrating my own larynx, and inspecting the larynx of twelve members of my

class, occupied exactly a quarter of an hour. I believe that not one of these gentlemen had ever before been subjected to a laryngoscopic examination. The ease with which the inspection was borne by the subjects of it was not, therefore, the result of habit on their part.

I thought that this mode of proceeding would be an effectual means of showing my pupils that a laryngoscopic examination may usually be made quickly and with ease; and I think that the publication of the result may influence some sceptics who may chance to read the account. To guard myself against a possible imputation of having made an unwarrantable "assumption", requiring to be exposed and corrected in a second edition of *Medical Errors*, I beg to state that I by no means infer from this experiment that an inspection of the larynx may always be made with equal ease in the same proportion of cases.

Rebiews and Notices.

ACUPRESSURE: A New Method of Arresting Surgical Hæmorrhage and of Accelerating the Healing of Wounds. By JAMES Y. SIMPSON, M.D., F.R.S.E., Professor of Medicine and Midwifery in the University of Edinburgh, etc. With Illustrations. Pp. 580. Edinburgh: 1864.

A LITTLE more than five years ago, Dr. SIMPSON described to the Royal Society of Edinburgh a plan for the suppression of hæmorrhage by the temporary compression of arteries by means of metal. This method of treatment, to which he gave the name of *acupressure*, has excited much interest among surgeons, and its reception has been watched throughout by the proposer himself, who now, after a silence of years, comes forth with his matured opinions, first in two lectures in the *Medical Times and Gazette*, and then in the expansion of them in the present work.

After a chapter on the Importance of Surgical Hæmorrhage and Surgical Hæmostatics, the author speaks of the Impediments to the Primary Union of Wounds. In the course of his remarks, he traces the readiness of union in vesico-vaginal fistula, ruptured perinæum, and hare-lip, to the absence of arterial ligatures; and, *vice versâ*, he holds that, when surgical wounds fail to unite by primary union, it is because ligatures have been employed.

"It is, in short, the absence or the presence of these ligatures tied around the ends of the bleeding arteries, that makes the marked and distinctive difference between wounds likely to heal and wounds not likely to heal by the first intention. But then arises the next question,—Why do the ligatures interfere with the primary adhesion of wounds?

"Arterial ligatures prevent the primary union of the lips of wounds in two ways—(1.) By acting as extraneous and irritating bodies, and hence as miniature setons; and (2.) By their necessarily producing strangulation and sloughing of every tied artery at the part of deligation." (P. 22.)

He then proceeds to object to ligatures, that they act as foreign and irritating bodies, and that they strangulate and slough the artery at the point tied.

Again, Dr. Simpson still more strongly expresses his abhorrence of the arterial ligature, by comparing its use to the placing of minute morsels of dead flesh into the raw cavities or on the sides of surgical wounds.

"For thus, in every wound, surgeons (1) artificially produce and make as many small masses of strangulated, dead, and sloughing tissue, and have (2) as many small irritating seton-threads attached to these masses, as there are vessels tied. Further, they (3) retain these small sloughs, and the long threads which are anchored to them, for five, ten, or more days, in the depths and sides of the wound, whose surfaces they wish to cohere throughout. (4.) Each separate arterial slough inevitably sets up around it an eliminative process of ulceration and suppuration, and every ligature-thread inevitably also excites suppurative irritation along its track. Is it a great marvel then that primary union so seldom occurs in wounds so managed? Would it not be a greater marvel, if union by the first intention followed oftener under such adverse circumstances?" (Pp. 45-46.)

In the sixth chapter are described Acupressure-Needles, and the means of applying them.

"*First Method of Application* This was the mode which I generally adopted in most of the first acupressure operations. It consists in passing a long needle twice through the flaps or sides of a wound, so as to cross over and compress the mouth of the bleeding artery or its tube, just in the same way as, in fastening a flower in the lapelle of our coat, we cross over and compress the stalk of it with the pin which fixes it, and with this view pass the pin twice through the lapelle. The only portion of the needle which is left exposed internally on the fresh surface of the wound is the small middle portion of it, which bridges over and compresses the arterial tube at its bleeding mouth, or a line or two or more on the cardiac side of it. And if it were a matter of any moment, this part need not always be left bare; for the needle could be often passed a few lines higher up *between* the vessel and the cut surface, and without emerging on that surface. More or less of both extremities of the needle, viz., its head and point, are exposed externally on the cutaneous surface of the side or flap of the wound. When passing the needle in this method, the surgeon usually places the point of his left forefinger or of his thumb upon the mouth of the bleeding vessel, and with his right hand he introduces the needle from the cutaneous surface, and passes it right through the whole thickness of the flap till its point projects for a couple of lines or so from the surface of the wound, a little to the right side of the tube of the vessel. Then, by forcibly inclining the head of the needle towards his right, he brings the projecting portion of its point *firmly* down upon the site of the vessel, and, after seeing that it thus quite shuts the artery, he makes it re-enter the flap as near as possible to the left side of the vessel, and pushes on the needle through the flesh till its point comes out again at the cutaneous surface. In this mode we use the cutaneous walls and component substance of the flap as a resisting medium, against which we compress and close the arterial tube. But in some wounds a neighbouring bone or other firm unyielding texture forms the best and readiest point of resistance against which to pin and compress the artery by the acupressure needle. In such cases, the end of the finger at the bleeding point is sometimes necessary to assist the needle in duly pressing it down upon or against the open vessel. In both these modifications of acupressure a thick flap, or a vessel situated deeply, requires a proportionally longer needle; and the amount of pressure upon the artery is easily regulated and increased, when required, by the acuteness of the angle which the needle makes in its passage over the arterial tube. The degree of compression required to shut an artery by acupressure is generally by no means great, especially if care be taken to pass the needle as near as