attack of rigors to-day. Twelve inoculations were made.

Jan. 18th. She was much worse, delirious; pulse 180. The skin was hot and dry; the tongue dry and coated brown. She refused her food; passed her urine and fæces under her. I ordered her Hogarth's essence of meat; ammonia, chloric ether, and bark.

Jan. 19th, 20th, and 21st. She was improving, but still very weak; pulse 150. Two large bed-sores had formed, one on the sacrum and the other on the right hip. She was inoculated in twelve places.

Jan. 24th. The arms had not taken, but the legs had.

Jan. 27th. She had become jaundiced, and vomited her food again. The bed-sores were increasing. From this time till Feb. 5th, she gained a little strength, but the pulse kept very high the whole time. From that date she began to get worse, and died on February 9th.

Remarks. This is the first case treated by syphilisation in this country which has died; but the patient was, I consider, in such a bad state when Dr. Boeck first commenced to syphilise her, that she most likely would have died; and it was a curious fact that, as soon as the inoculations commenced to take well, her health began to improve. The pulse became quieter, and she gained flesh; and I thought she would quite recover. From Jan. 5th till about the 18th of the same month, she had a great deal of mental excitement, also great grief, crying all day long. This caused a loss of appetite. From Jan. 18th, she did not improve, although the cause of her mental anxiety was removed. Her pulse was below 120. On the 21st, the large bed-sores made their appearance, and she became jaundiced on the 27th. On the chest, it will be perceived, I could obtain no positive results from Dec. 20th; and, the last inoculations on the arm showing that the disease was gradually being overcome, I do not consider that the woman's death was due to the disease under which she was labouring; but that, if we could have removed all cause for mental excitement from her, and kept her mind in a comfortable state, and prevented the bed-sores from forming, this case, instead of terminating fatally, would have been successful. To Professor Boeck my best thanks are due for his great kindness in treating this case of mine during his sojourn in London; and I do not think that he thought when he left town, that any other than a successful result would follow this mode of treatment.

Increase of Insanity. Dr. Stiff, Superintendent of the Lunatic Asylum, Nottingham, in his last report, just issued, makes the following pertinent remarks: "The admissions, 109, are 20 in excess of the previous year, the females predominating. A certain amount of this increase is probably coincident with that of the general population of the county, and the remainder may be accounted for by other circumstances. In the first place, persons formerly considered proper to be confined were comprised under the heads of lunatics, insane, or dangerous idiots; names of narrower and more definite signification in practice than that of unsoundness of mind, substituted in recent Acts of Parliament. Persons suffering from acute and chronic diseases of the brain, the delirium of drunkenness and of typhus fever, the aged becoming childish and troublesome, imbecile children, and even those labouring under delirium in their last illness, are occasionally certified as proper cases to be taken care of in the Asylum. The apparent undue increase of insanity of late years may, therefore, in part be ascribed to an extension of the term defining it, rather than to any spread of the malady itself."

# Original Communications.

## IMPAIRED VISION FROM MENTAL WORK.

By Haynes Walton, Esq., Surgeon to St. Mary's Hospital, and to the Central London Ophthalmic Hospital.

*Impaired Vision and Partial Paralysis of some of the Muscles of one Eye, arising out of Excessive Mental Work. Treatment by Medicine, etc., and by Operation. Recovery.*

This case is interesting in itself, and instructive as one of a class. It is rather out of the ordinary course of ophthalmic practice, required thought respecting the treatment, and imposed much responsibility in operating.

Nearly two years ago, an Asiatic, 20 years old, was sent to me by a surgeon, because the sight of the left eye was imperfect. He was here for education, and had been a very laborious student. Possessing high mental power, and having a strong desire to distinguish himself more and more at the examinations of his college, he knew no bounds in working. Now, he was feeble, and his circulation very languid. He had difficulty in applying himself, and the mind quickly fatigued, obliging him to desist. His appetite was small. His religion forbade stimuli.

The ocular defect consisted in inability to read small type, and mistiness of sight, and occasionally double vision. There was slight ptosis, and the pupil was a little dilated and inactive, but there was no palpable loss of action, or paralysis of any of the other muscles supplied by the third pair of nerves, although there must have been alterations in the optic axes at times, through irregularity in the muscles, to produce the double sight.

There was nothing abnormal in the interior of the eye, beyond the physical state, so often associated with near sightedness, if such can be so called.

Before I speak of the treatment, it may be well to allude to the chief source of the nervous motor supply to the orbital muscles; that is, the third nerve, called also motorius oculi. It presides over five out of the seven muscles; the upper and smaller division being given to the rectus superior, and to the levator of the eyelid. The under supplies the rectus internus, the rectus inferior, and the oblique superior. More than this; for, through the filaments to the ophthalmic or lenticular ganglion, a centre of supply of nerves, motor, sensory, and sympathetic to the eyeball, it gives filaments to the ciliary muscle, and to the sphincter pupillæ of the iris.

Then there are pathological peculiarities connected with this nerve, that must be known to be able to understand what may happen. The nerve-trunk may be entirely diseased, and all the muscles dependent on it quite paralysed, in which case there will be complete ptosis, or dropping of the upper eyelid, and fixed eversion of the eyeball, external squint, because it is pulled outwards by the rectus externus, which is not paralysed, because supplied by the sixth nerve; and dilatation of the pupil; and loss of the accommodating power of the eye. But there may be slight general paralysis, in which case the symptoms are less marked. Then only some of the branches of the nerve may be affected, when the muscles supplied by them will suffer, and some of which may be more affected than the others. To speak, therefore, loosely of paralysis of the third pair of nerves, and in a general way,

does not give a correct idea of the nature of the paralysis. It is necessary to define the degree and extent of it. In the case before me the levator only was markedly, but yet slightly paralysed, and the dilatation of the pupil was not very marked; and these, together with loss of power in the ciliary muscle, could not, as I suspect, have been the whole causes of the imperfection of the sight.

I commenced my therapeutic measures by forbidding a continuation of study, and gave full directions about all that I deemed necessary as to food, exercise, amusement and sleep, and prescribed a tonic course of medicine.

The restoration of vision was the first improvement noticeable. He could read as well as with the other eye, and the general mistiness had disappeared. The ptosis then was removed, and the double vision was only very occasional. So then, after all trace of disease of the motorius oculi nerve had passed away, for there was no longer evidence of any paralysis of the parts supplied by it, as I could determine, the symptoms of double vision remained. At this time, also, about six weeks from the commencement of my treatment, my patient's general health was much improved, but he could not yet study, as several trials proved that his brain was too weak, and I advised him to travel about with a friend, to see new places, and to amuse himself. It is hard to induce a student with this intense passion for study, to give up his work altogether. A few weeks of recreation much recruited the mental power, but repair was not yet complete, and a trip to India was resolved on.

A year later this gentleman again presented himself to me. He had been in India all the while, and had abandoned study. He had married, but never consummated, from inability, although when in England, and also on his voyage to India, he thought himself virile. His mental power was now as good as ever, and the eye was well except in one particular, the double sight. After reading for less than an hour, double vision came on, and so troubled him that he was obliged to desist for a while, or to cover one or other of the eyes. He was now aware that it was the result of slight eversion of the eye. Without reading, he could manage by merely looking sideways at an object in a certain position to produce the optical defect. I examined him more carefully than ever. The double image was lateral and vertical, being to the side, and above the object looked at. It seemed clear that a weak internal rectus muscle, arising out of defective nerve-force, whereby there was occasional eversion, was the chief origin of the disturbance. Mr. Z. Laurence, who saw this gentleman, came to the same conclusion. Under certain tests I could detect a defective internal rectus. I determined to try the effect of general treatment, alcoholic stimuli, and galvanism. These measures were used for nearly three months, and with no result. The question of dividing the external rectus was now entertained and discussed. The chief objection was the risk of producing internal squint, because ordinarily the eyes were parallel, and therefore the balance of muscular power was almost perfect. After weighing all the points, and making deductions from the result of my operations on the recti muscles, into the details of which I shall not enter, I operated under chloroform.

It was rather mortifying to find, when the effects of the chloroform had passed over, that my patient squinted inwards, and that there was constant double sight in a new direction, with other confusion of vision. A far worse state was established. A very few days, however, shewed an amelioration and gave hope for the cessation of the new trouble. Parallelism of the optic axes was then daily more nearly established, and at last acquired, when double vision was quite lost. There was ultimately normal sight.

## SUCCESSFUL REDUCTION OF DISLOCATION OF THE HIP, BY MANIPULATION.

By G. N. Collyns, M.R.C.S., Moreton Hampstead.

On March 26th, 1866, A. C., aged 17, a well developed muscular youth, whilst struggling with another lad, slipped and fell, his antagonist falling on him. On attempting to rise, he found that he could only rest on his knee, and was unable to stand. Assistance having been procured, he was removed to his home in a cart, and put to bed. His parents, not considering that anything serious was the matter, did not send for a medical man until the following morning, (the accident having happened at 9·30 p.m.) when, finding that he was in great pain, and that there was considerable swelling of the right hip, they requested Mr. Nosworthy to see him, who, not feeling quite satisfied as to the exact nature of the injury, asked me to examine him. On putting him in the upright position, the shortening of the limb with inversion of the foot and knee were sufficient to convince us that dislocation of the hip upwards, on the dorsum ilii, had taken place; and, on careful examination, we detected the head of the bone in its new situation. Having settled this point, we had next to determine what treatment to adopt, and not being provided with pulleys, etc., I suggested that we should make trial of Dr. Reid's plan of reduction by manipulation; we accordingly put our patient under the influence of chloroform, and placed him on a hard mattress on his back; I then, kneeling on the bed, flexed the leg on the thigh, carrying the knee upwards and inwards, till the thigh, being fully flexed, touched the front of his chest; then placing one hand on the knee and grasping the foot with the other, I forcibly abducted the limb, and brought it into a straight position. Whilst abducting the limb, I distinctly felt the head of the bone rotate, and we had the satisfaction of hearing it return into the acetabulum, with a loud crack.

Remarks. The facility with which reduction was accomplished in this case, after a delay of fourteen hours, is, I think, worthy of being recorded, as it may be the means of inducing others to adopt the same mode of treatment, which certainly possesses many advantages over the old one of pulleys, girths, etc., inasmuch as it can be done without any delay, and without a number of assistants, and with much less trouble and expenditure of time; in this case, the reduction was accomplished in two minutes.

Death from Chloroform. Dr. J. Smith, Surgeon Dentist to the Edinburgh Royal Infirmary, in the *Edinburgh Monthly Journal* affirms that fatal deaths from chloroform are, for the most part, to be attributed to the fault of the administration. "We find," he says, "deaths associated with chloroform naturally separating themselves into the two distinct divisions of those arising from avoidable and those due to unavoidable causes, the avoidable causes are numerous and varied, while the unavoidable are of a range very limited if not invariable in their nature. The former class tells, of course, not so much against the administration as the administrator of this agent. The remainder forms an interesting series, probably all belonging to cases whose condition, altogether apart from anæsthesia, was unsuspectedly near to death, and where the chloroform acted merely as the touchstone of their hold on life."