luxated joints accompanied, it may be, with spontaneous fractures, or to be capable of preventing the exhibition of the typical characters of arthritis deformans, this is tantamount to admitting in a roundabout way a causal relationship between the nervous lesion of tabes and tabetic arthropathy. Such an admission must necessarily end in an unreserved acceptance of the simpler view of the occurrence of Charcot's disease as the direct effect of tabes without the intervention of arthritis deformans.

5. Tabetic arthropathies have special clinical characteristics and accompaniments which mark them off from arthritis deformans. These are the occurrence of the joint lesions at a particular and comparatively early stage of tabes—viz., after the prodromal stage and before the onset of ataxic symptoms,—a special sequence of the joint affections, the lower limbs suffering before the upper, rapid destruction of joints without pain or fever, rapid luxations, and equally sudden and spontaneous fractures. Four examples of fractures from slight causes in association with tabetic symptoms have occurred in my practice at the London Hospital, and these I will take an early opportunity to bring before the Clinical Society. In one a lesion of the knee-joint was associated with a "spontaneous" fracture of the tibia and fibula about three inches below the affected articulation. Fractures of this kind do not occur in connexion with arthritis deformans, and though scarcely referred to in the course of the debate, supply one of the strongest arguments in favour of the tabetic nature of Charcot's disease.

Since the knowledge of tabetic arthropathy became current knowledge, I have not unquestionably, to use Charcot's language, "assisted at the development of an ataxic arthropathy" in addition to the case above referred to; but in the pretabetic times I have met with one or two cases of swollen, crackling, flail-like joints, occurring suddenly in middle-aged individuals, which were diagnosed as chronic rheumatic arthritis, but which in all probability, preceded as they were by so-called "rheumatic" pains in the limbs, were typical examples of Charcot's disease. This unavoidable confusion, occurring doubtless to bygone as well as to existing observers, still casts its shadow across the path that leads to the recognition of Charcot's disease as a genuine tabetic lesion; and it may be necessary to defer a final judgment on the questions raised in the debate until further observations have been made in this country; and until the advance of physiology and pathology has dispersed the mists which still becloud the relations of the nervous system to the bones and joints in health and in disease.

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A CASE OF MIGRAINE, WITH PARALYSIS OF THE THIRD NERVE.

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WILLIAM P——, aged seven, was admitted into the Birmingham General Hospital on August 31st, 1884, complaining of sickness and pain over the right eye and in the right cheek-bone. The right eye was shut. He had been suffering from sickness for three days, accompanied by headache, but without localised pain. A year ago he was in this hospital with a similar illness. On referring to the case-book I find that on November 7th, 1883, he was admitted complaining of pain above the *right* ear; for four days previously he had complained of seeing double. There was some ptosis of the right eyelid. There is no mention of vomiting, and there was a "very slight discharge" from the left ear, which ceased immediately after admission, and there was some "weakness of the action of the left facial nerve, especially in the lower part." Hearing was not affected on either side. He has never had measles or scarlatina; he had whooping-cough slightly. His conduct at school has been good, but he has never been bright; in fact, he frets because they call him a dunce. His mother has never noticed any facial paralysis or any discharge from the ear, except that which occurred on his previous admission, and which she attributes to the use of an instrument to examine the ear (during which he complained of pain), and for the removal of a quantity of wax. She says she has had no miscarriages; she is a stupid woman, and has had constant neuralgia for two or three years past. The father is a sharp man. There is no history of syphilis. One child died of convulsions; three others, excluding the present patient, are alive and healthy.

Present condition (Sept. 2nd, 1884): Patient is a well-nourished, fresh-complexioned, pleasant-looking child. He makes no complaint of pain and has not vomited since admission. There are ptosis of the right eyelid and paresis of the internal rectus. He sees double, and when walking covers his right eye. There is no tenderness of the scalp. There is slight want of symmetry in the naso-oral folds, so that the mouth appears a little drawn to the right side, but the upper part of the face is quite normal. The tongue is protruded straightly. He can walk well; there is no giddiness. The thoracic and abdominal organs appear healthy; his tongue is clean, and his bowels are regular. Hearing on both sides is unaffected. There is no paralysis of the soft palate. Temperature 99°, pulse 96, respiration 26; urine 1018, acid, free from albumen. On Sept. 6th Mr. Eales examined the eyes at my request, and found no evidence of any paralysis of the oculo-motor muscles, nor any changes in the fundus of either eye.

Unfortunately, this case came under my observation quite at the end of the attack, so that my account of it is not very complete, but I think it is sufficient to justify the diagnosis of recurrent migraine with paralysis of the third nerve. Such a diagnosis may appear hazardous, and perhaps would not have been made by me had I not met with a very well-marked case of a similar kind previously. Two years ago I published in THE LANCET[1] a remarkable case of recurrent migraine, in which during the attacks there were all the phenomena of paralysis of the left third nerve: ptosis, complete paralysis of the upper, lower, and internal recti, dilatation of the pupil, and paralysis of accommodation. Owing to the recurrent nature of these attacks I was enabled to study the case fully, having had many opportunities of observing them in all their stages. A very noticeable circumstance with regard to that case was that the recovery after the paralysis was incomplete, the superior rectus remaining permanently paralysed while the other recti were enfeebled. The pupil remained slightly larger than that of the opposite eye, and there was a persistent degree of ptosis of the eyelid. As is well known, a great variety of nervous phenomena have been recorded in connexion with migraine; affections of vision, taste, smell, and hearing, aphasia, partial loss of consciousness, vertigo, cramps, transient hemiplegia, numbness and tingling of the fingers; and Horner has described a form of ptosis which he attributes to paralysis of the unstriped muscular fibres of Müller which are supplied to the orbicularis palpebrarum. Dr. Wilks mentions paralysis of the third nerve among the symptoms of migraine, but cites no case, nor can I find any recorded but my own. The rarity of the condition is shown by the absence of all mention of it in Dr. Liveing's comprehensive monograph on this form of headache, and in Galezowski's more recent paper on the ophthalmic phenomena of migraine.

Birmingham.

THE SURGERY AND PATHOLOGY OF TENESMUS OF THE RECTUM.

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A SHORT time ago, attention was called in a contemporary journal to the treatment of spasmodic contraction of the sphincter ani by digital dilatation, a *modus operandi* concerning which most of our standard surgical text-books afford but scanty information. Maisonneuve was probably the first to bring it into notice; and Holmes, in the last edition of his "System of Surgery," speaking of an "operation that has lately been recommended in France," condemns it as "unsurgical," at the same time admitting the evidence of its success. So far back as 1877 we find Erichsen, after recommending the trial of belladonna by

[1] Vol. ii., p. 345.