6. Supra-renal extract exercises a beneficial effect on the patient.

(1) A paper prepared for the autumn meeting of the South-Eastern Division, held at the Priory on October 6th, 1904. (2) This patient was discharged recovered on December 2nd, 1904.

A Case of Pseudangina Pectoris in an Epileptic.

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THE following case is one which, whilst being interesting as a typical case of pseudangina or vaso-motory angina pectoris, presents further interest in occurring in a patient suffering from epilepsy.

The patient is a married woman, æt. 39, who was admitted into the Canterbury Asylum on February 5th, 1904, with the history of epileptic fits and recurrent maniacal attacks, coming on usually after a fit. This was her second admission; she had previously been under treatment for the same disease in the asylum from March to November, 1903.

She is a small, thin woman of about 8 stone, markedly anæmic, and of a highly neurotic temperament. She has right dorsal scoliosis, and in consequence her thorax is much flattened on the right side in front and projects posteriorly, and on the left side projects anteriorly and is flattened behind. Her lumbar spine is convex to the left, and her pelvis is tilted down on the left side. This deformity gave rise to difficulty during parturition; she was married at twenty-one years of age, and has had three children, the first a year after her marriage, and forceps were required at each birth. All the children were born alive; she has had no miscarriages.

The scoliosis came on when the patient was sixteen years old, and she believes its appearance was due to a fall she received over a chair.

She first began to have epileptic fits after the birth of her first child, at twenty-two years old, and, although the onset is late, the convulsions are typical in character and show no signs of being due to any local lesion.

There is no history of epilepsy in the family, but there is a history of insanity; her first cousin committed suicide whilst insane, but unfortunately there is no record of the type of insanity.

There is no family history of alcohol, syphilis, gout, or rheumatism. The patient has not had rheumatism, chorea, tonsillitis, gout, or influenza, and has been a temperate drinker. She suffers from dyspepsia and flatulency, largely due to the decayed state of her teeth, and constipation; she frequently has frontal headaches, and at times complains of "pins and needles" in her legs. She shows no signs of approaching menopause.

On March 5th, 1904, she was suddenly seized at the dinner-table with sharp pain over the region of the heart and breathlessness. She sprang up from the table screaming, and dropped on to the floor, rolling over and over, clutching at the root of her neck and the left side of her chest with both hands. She described the pain as "a hand squeezing her heart very tightly"; the pain starting in the cardiac region, and shooting into the back between the shoulder blades, up into the neck as far as the ears, and down the left arm to the wrist. She complained especially of the tightness, which was greatest at the root of the neck, and caused her to exclaim she "would be choked to death." Her features were distorted and blanched and covered with a clammy sweat. She tossed on the floor and gasped for air. The acute pain lasted four to five minutes, but, to a lesser degree, the feeling of constriction and the pain over the præcordium lasted about fifteen minutes, leaving the patient fatigued and very frightened.

After the acute pain the patient vomited about a tablespoonful of clear fluid, and eructations of wind occurred.

During the attack the radial pulse was regular, 84, and of a good stroke and volume; the tension was increased, but the pulse could be obliterated by the pressure of one finger, and the artery beyond remained empty and pulseless. There is no thickening of the arterial walls.

The heart's apex beat was in the fifth intercostal space, a quarter of an inch outside the mid-clavicular line, circumscribed and heaving in character; and the area of superficial cardiac dulness began above at the level of the fourth rib, and did not extend further to the right than a finger's breadth to the right of the left border of the sternum, or to the left beyond the apex beat.

The heart sounds were normal at the apex, but at the base the second sound was markedly accentuated in both the aortic and pulmonary areas. There were no adventitious sounds.

Whilst I was examining the chest the patient complained of pain in some of the places where the chest was touched, and after the acute attack had subsided I endeavoured to map out the exact area of superficial tenderness. This was tested by gently pinching or stroking the skin, beginning in an area which was not tender, and working towards the suspected tender area and so marking out its boundary. Pain on slight pressure or gentle pinching started above at the level of the upper border of the left third rib and extended downwards as far as the middle of the fourth intercostal space, where the hyperalgesia became more marked and could be elicited by a slight touch on the skin. This tenderness extended downwards as far as the sixth rib, and was most acute in an oval area about two and a half inches by one inch over the cartilages of the fifth and sixth ribs near the sternum. The cutaneous hyperalgesia did not extend beyond the mid-line of the sternum, but it extended around the left side into the back in a band, and lay between the levels of the second and sixth dorsal spines, there being a circular area of about two inches diameter of acute tenderness at the level of the fifth and sixth dorsal spines near the middle line; it did not extend across the middle line behind.

There was no superficial tenderness on the left arm; nor could I

ascertain the existence of any tenderness in the supra-orbital region, such as is described by Head (1) in true angina pectoris.

The pain was relieved by trinitrine in solution.

The patient has since had one attack of lesser severity, which occurred on April 3rd, and was brought on by excitement. In this attack the pain and cutaneous hyperalgesia were similar in character, course, and distribution to the first attack; and the pain in this instance was relieved by an ammonia and ether draught, which appeared to be as efficacious as trinitrine in its effect.

The heart has been repeatedly examined, and, beyond the hypertrophy, there appears to be no lesion. The second sound at the base is invariably accentuated to some degree.

Her urine is of a normal specific gravity, and contains no albumen, sugar, or excess of phosphates.

The neurotic temperament of the patient, the long duration of the pain, and the restlessness during the pain, together with the absence of signs of arterio-sclerosis and heart disease, make the diagnosis of vaso-motory angina from that of angina pectoris gravior.

That angina pectoris occurs in families with a history of insanity or epilepsy was remarked by Eulenburg (2), who was one of the first to class disturbances of the vaso-motor nervous system as a variety of cardiac neurosis causing angina.

Occurring in a patient the subject of epilepsy, the condition is interesting inasmuch as it suggests that the attack of angina pectoris might be due to a disturbance of the cells of the vaso-motor centre of the medulla oblongata similar to the disturbance of the cells in the cerebral cortex, giving rise to an epileptic fit.

(1) *Brain*, vol. xix.—(2) *Allbutt's System of Medicine*, vol. vi.

A Note on Veronal as a Hypnotic and Sedative in Mental Affections.

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IN appearance veronal resembles trional; it is odourless, practically tasteless, and readily soluble in hot fluids. Chemically it is dimethyl-malonyl-urea: but though related to urea, it is not diuretic.(1)

We have used this drug for some months in all forms of mental disease with very satisfactory results, and from our experience of veronal we have made the following observations:

1. For the insomnia of acute melancholia we have discarded