All the patients were of a well-marked rheumatic diathesis and nervous temperament. Two of them suffered from undoubted organic cardiac disease; in the third there was a strong suspicion of the same; and in the fourth the organ was weak, with most probably a dilated right side.

Suffocation by Food—Tracheotomy—Recovery. By EDMUND BANCKS WHITCOMBE, M.R.C.S., Assistant Medical Officer, Borough Lunatic Asylum, Birmingham.

F. J., an epileptic, 26 years of age, was reported by his attendant, on December 2nd, 1875, to have got a piece of crust in his throat while eating his dinner. He takes food ravenously, is in the habit of snatching it from other patients, and cramming it into his mouth, and on several occasions I have had to use a probang to remove food from the æsophagus. I went immediately, and found him lying on his back, on the floor, to all appearance dead; his face was cadaverous, lips livid, the lower jaw dropped; he was pulseless, and completely insensible; the mouth was surrounded with masticated food, there was no attempt at inspiration.

Having no other instrument at hand, with an ordinary penknife I made an incision into the trachea, half an inch below the cricoid cartilage, large enough to admit the little finger; and then, with my left hand, removed two large pieces of meat which were impacted in the larynx. Artificial respiration (Silvester's method) was immediately resorted to, and in a few seconds a faint gasp was the only indication of life.

As there was slight bleeding from the wound, and no satisfactory result from the foregoing proceedings, I put in a tracheotomy tube, continuing the artificial respiration, and in about twenty-five minutes respiration was fairly re-established, one pulse was just perceptible at the wrist, and the patient was able to drink a little brandy and water. The tube was now removed, the patient placed on his side in bed, and iced water applications were made to the wound. In the evening he had completely rallied, the edges of the wound were drawn together by strips of plaster, and he took milk freely.

On the 4th he was allowed to get up, the wound had nearly healed, he was bright and cheerful, and apparently unaffected by the operation.

He is now (December 31st) in his usual state of health, and it is noteworthy that the record of his fits shews an unusual diminution during the present month.

Remarks.—Cases of suffocation by food are not so uncommon, perhaps, as to justify special notice of a single one; but the great aim of the medical profession being to save life, and as cases of recovery after suffocation are rare, I have thought

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this may be of much practical value, especially to those having care of the insane. The ravenous propensities of many of the insane, and the liability of epileptics to attacks of their malady during meals, render this class of patients peculiarly liable to suffocation by food; and such cases will occur in spite of the precautions taken in asylums, such as the careful cutting up or mincing of meat, &c., and the feeding of patients by attendants or nurses. When such a case does happen, it is obvious that every effort should be made to resuscitate the patient, of course within a reasonable time. The usual appearances of death (suspended respiration, imperceptibility of the heart's action, and the cadaveric hue) must not be taken as conclusive that death has actually taken place, nor must time be lost in endeavouring to find out that such is not the case; but means must be taken promptly to admit air into the lungs. This can only be accomplished in two ways, viz., by removing the obstruction by the fingers or forceps, or, by admitting air through an artificial opening, by tracheotomy or laryngotomy.

The latter I believe to be the safer and most efficient mode of procedure. When a mass of food is drawn into the larynx during an inspiration, a spasm of that organ holds it firmly and tightly, preventing the expulsive efforts of the lungs from ejecting it, and rendering removal by the fingers or forceps difficult and prolonged; but once let in more air by an opening in the larynx or trachea, the spasm ceases, and the removal is easy and complete. Immediately this is done artificial respiration should be resorted to, and continued uninterruptedly until respiration is restored, or until the case is proved hopeless. It is difficult to determine how long this should be kept up, with any chance of success, but in the foregoing case at least fifteen minutes elapsed before any good sign was visible.

Dr. Richardson, in an address before the Midland Medical Society, in November last, on "The Treatment of the Dying," mentioned a case of choking in which animation was suspended for a much longer period, and which was attended with such success that the patient revived, although only for a short time. It must not be forgotten that fainting may occur, and thus enable the patient to endure for a longer time the deprivation of air.

In my case I found much benefit from the tracheotomy tube, which I retained until respiration was re-established, and which had the effect, also, of checking the hæmorrhage

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which took place. After its removal the bleeding returned, and I was fearful lest this should prove fatal by trickling into the trachea; however, by placing the patient on his side—a suggestion I am indebted for to my colleague Mr. Green—the blood flowed externally.

Suffocation by liquid food is fortunately of rarer occurrence than by solid, though, perhaps, not so immediately fatal. In such cases, however, I should now be disposed to open the trachea, and endeavour to remove the fluid by means of a syringe, as, I believe, by such a procedure life may occasionally be saved.

I have been asked why I did not treat this case on the principle enunciated by Dr. Marshall Hall for the relief of the epilepsy. My only reason for not attempting this experiment was that the case did not appear a fair one for trial, as the patient is hopelessly imbecile, and of such filthy habits that, had an artificial opening remained in his trachea, he would have been likely to suffocate himself through it.

Report of a Case of Acute Insanity ending fatally in eleven days, supposed to be due to Syphilis, and of the morbid appearances found. By CEDRIC HURFORD, B.A., M.D., Resident Medical Superintendent, Moorcroft House Asylum, Hillingdon, Middlesex.

In the "Journal of Mental Science," July 1st, 1875, is recorded an interesting case of acute insanity ending fatally in a week, by Dr. Ringrose Atkins, of Cork. The similarity of the case to mine has induced me to place the following before the profession, trusting it too may prove of some interest:—

W. M., aged 21, was admitted August 21st, 1874. Tall, dark complexion, thin, but body fairly nourished; is said to have always been weak-minded; fond of pleasure and extravagant habits, which he indulged in freely. Maternal aunt is said to have died insane. Had no employment, the Stock Exchange being his chief resort. Contracted syphilis about 12 months ago, for which he was treated by a medical man; latterly, however, he took large doses of iodide of potassium on his own responsibility. About two months ago he became very eccentric in manner, would sit gazing fixedly for some time without speaking, but making a peculiar grunting noise. About a month ago he was placed in charge of a medical man, but his manner continued strange and peculiar, finally culminating in an attack of mania, with refusal of food, within two days of his admis-

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