ual condition—she had, in fact, a form of mild religious melancholia. After this had lasted several weeks, she began to experience difficulty in swallowing. She would rise from the table suddenly, alarmed and gasping, and exclaiming that she could not swallow and was choking. She got so bad that she would not take anything but liquid food, and not nearly enough of this. She believed that her throat was gradually closing, and, of course, suspected cancer. In this case I took a plan the opposite of that followed by Skey, as far as the use of an instrument was concerned. I assured her that if any local obstruction existed I could remove it with one application of a probang.

I also very confidently excluded cancer, placed her upon iron, valerian and quinine, and in a few days returned and passed an instrument down her throat. I refused, however, to repeat this operation, telling her that I was absolutely convinced that she would have no more difficulty. Tonics and full feeding were continued, and in less than a week the difficulty in swallowing had disappeared.

As most cases of real stricture of the œsophagus are cancerous, traumatic, syphilitic or congenital, and as history, cachexia, and the use of instrument of precision, will, in general, readily determine these facts, the diagnosis of hysterical dysphagia is usually not difficult.

A resort to nasal feeding, as practiced in hospitals for the insane, will, sometimes, from its unpleasantness, lead a hysterical case to regain swallowing power, and, at the same time, may be the means of giving her much needed nourishment.

In one group of local hysterias, the presence of pain is the predominating feature. Copland* enumerates the situation in which hysterical pains are most frequently felt, as follows: "*a*, The head, often attended with the clavus hystericus; *b*, below the left mamma, or at the margin of the ribs; *c*, in the region of the stomach and spleen; *d*, in the course of the descending colon, and in the left iliac region; *e*, above the pubis; *f*, in various other parts of the abdomen or in the abdomen generally; *g*, in the region of the kidneys, sometimes extending in the course of the ureters; *h*, in one or more of the dorsal or lumbar vertebræ; *i*, in the sacrum; *k*, in the hip or knee joint. Although these are the most frequent situations, pain may be felt so seriously in others as to alarm the patient, as in the pharynx and larynx, in one or both mammæ, or in the region of the liver." Of these locations, omitting the consideration of headache, the most common seats of hysterical pain, in my experience, are the spine, the breasts and inframammary region, the left iliac, or ovarian region, the sacrum or coccyx and the joints.

Before turning to a few illustrations of special forms of hysterical pain, let me stop for a moment to discuss the nature of hysterical pain in general.

Dr. Charles Fayette Taylor, in a brochure on *Sensation and Pain*,* has given us a condensed philosophical explanation of such pain, drawing largely from Carpenter, Bain, Spencer, Bastian, Maudsley, Tuke, Huxley and others. The pith of the matter is, that many of our sensations are centrally initiated, the memory of previous objective sensations: "Pain is different from ordinary sensations, in that it requires an abnormal condition for its production, and that it cannot be produced without such an abnormal condition. Hence it is impossible to remember pain, because the apparatus does not exist for causing such a sensation as pain after the fact, or when it is to be remembered. Memory is a repetition, in the nerve-centre, of energy which was first caused by the sensory impulse from without. But centrally initiated sensations may be mistaken, in consciousness, for pains, depending wholly on a certain intensity of excitability in the cerebral mass."

The "hysterical spine" is one of the commonest forms of hysterical trouble; in fact, a large percentage of all cases of hysteria complain more or less of spinal irritation. Spinal periostitis, spinal caries and perhaps some cases of spinal meningitis, are organic diseases which may give rise to tenderness on pressure along the spine; but in the vast majority of cases of "spinal irritation," you have to deal with neurasthenic or hysterical patients. So much has already been written about spinal irritation, by Skey, Anstie, Reynolds, Hammond, and a host of others, that I would not take up your time with a reference to the subject were it not that, even yet, almost every week I find practitioners inclined to regard cases as organic spinal trouble, *because* of the presence of great spinal tenderness; whereas, for my part, I regard this symptom as almost diagnostic of the absence of real spinal disease. Faradization of the spine with metallic rheophores, taking sparks from the spine, or the alternate hot and cold douche, with iron, zinc and quinine internally, have proved the most effectual remedies in my hands.

HOW TO SHRINK HYPERTROPHIED TONSILS BY CAUSTIC APPLICATIONS.

Prof. Chisholm, of the University of Maryland, begins a paper on the above subject by saying: I unhesitatingly prefer excision of the enlarged gland in every case in which the patient will permit the use of the knife. It is by far the quickest, surest, and best means of securing permanent and complete relief.

In my personal experience of tonsil-cutting (and I have taken off a great many), I have never seen any trouble from hemorrhage. In fact, I have never seen any bleeding which gave me any anxiety whatever. Cases have been reported in which

* A Dictionary of Practical Medicine. By James Copland, M.D., F.R.S. Edited, with additions, by Charles Lee, A.M., M.D. In three volumes. New York: Harper & Brothers, 1859.

* Sensation and Pain. By Charles Fayette Taylor, M.D. A Lecture delivered before the New York Academy of Sciences, March 21, 1881. New York: G. P. Putnam's Sons, 1881.