

was on the 13th November, 1880. Next morning the dose was increased to one-fifth grain, and in an hour the patient had quieted down and kept quiet until next day, when he became violent once more. He took one-fifth grain on the 15th and the same dose the day following, when it was not found necessary to prescribe any more of the drug, the patient having become perfectly quiet and manageable, remaining so until the next period of attack, some six weeks later. Again the hyoscyamine had the desired effect and cut the paroxysm short. These two cases are, perhaps, as typical as any we can enumerate. In the case of recurrent mania, chloral had often been tried, but beyond controlling the mania for the time being, did not seem to exert any beneficial effect, and did not shorten the duration of the attack. Hyoscyamine acts very speedily and the patient seems at first like one intoxicated. In a short time there is mild delirium, and if not watched the patient is apt to crawl about the floor and grasp at imaginary objects. In all the cases under our care where hyoscyamine was given, marked dilatation of the pupils resulted. The after effects are merely a little dryness of the mouth and difficulty in distinguishing objects owing to the dilatation of the pupils.

We have tried the drug in a fair number of cases and have come to the following conclusions in regard to it:

If any sedative is *really* required in the treatment of mania, hyoscyamine is the drug most applicable to the majority of cases.

It cannot be claimed to have any curative effect, but as a controlling agent is very valuable.

We believe it cuts short attacks of recurrent mania, and in many cases of acute mania will give much needed rest.

Not having any faith in the use of chloral in the treatment of acute mania we are glad to welcome hyoscyamine as a sedative which leaves such trivial after-effects.

Chloral seems to *lengthen* attacks of mania, hyoscyamine to shorten them.

There is at present one drawback in the use of this preparation, and that is the great cost of the article. The present price places it beyond reach for ordinary use. [Especially in public hospitals.—Ed.]

Selections: Medicine.

STERTOROUS BREATHING IN APOPLEXY AND THE MANAGEMENT OF THE APOPLECTIC STATE.

BY ROBERT BOWLES, M.D., FOLKESTONE.

In the investigation of the causes of stertorous breathing in apoplexy, I found that they were mechanical, and could at all times be so changed as to alter altogether the nature of a case, and often to make the difference of recovery or death; and, moreover, that the principles involved applied not only to apoplexy, but to many abnormal conditions allied to it. The subject having been now before the profession for twenty years, one is surprised to find how little attention appears to have been directed to it in our medical schools. Younger members of our profession to whom I have spoken, certainly do not realize its importance; and yet the value of a knowledge of it in the management of the apoplectic state is far greater than bleeding, blistering, calomel, crotonoil, and the rest.

The removal of the causes of stertor so immediately changes the aspect of a case, that the question of blood-letting is at once solved in the clearest and surest manner. The truth is, two separate conditions of the apoplectic state have been jumbled together and treated as one: the cerebral affection, and the condition of suffocation consequent upon it. Stertor, in one sense, is but a croup in the pharynx, or apoplexy *plus* suffocation, as croup is laryngitis *plus* suffocation. We feel it necessary to relieve croup by a serious operation; whereas stertor is left to itself, although it may be relieved by merely changing the position of the body.

On referring to the literature of the subject, I have been astonished to find how difficult it is to draw any conclusions from the descriptions of the disease, or the treatment to be adopted. Authors are not agreed; and one of our most distinguished neurologists, in an article on Apoplexy, in a recent important work on medicine, with infinite labour, appears to arrive at the conclusion that, in apoplexy, we can know nothing, we can foretell nothing, and we can do