prisoner, who was examined and cross-examined in court upon the subject, had placed them in the trunk and sealed over the surface rather elaborately. He admitted that he had repeatedly taken the bodies out and rearranged them in the box. His account was, however, that his wife had committed suicide after killing the children, and that he, going home and finding them dead, became so alarmed at the possible consequences to himself, that, instead of raising the alarm, he disposed of the bodies in the way stated. For the defence it was contended, first that the deceased was a person likely to commit suicide; and, second, that the prisoner came of such an insane stock as to render it likely that, in face of a terrible and unexpected calamity, he would be likely to act in a way different from that of a normal person. The judge permitted to the defence the utmost license in calling evidence which was inadmissible, and thus counsel for the prisoner was allowed to prove that a brother of the deceased had at one time been attended for meningitis, and had subsequently disappeared, having, as it was supposed, drowned himself; that the prisoner's father twice attempted suicide; that an aunt of the prisoner threw herself out of a window; that an uncle of his had been in an asylum; and that the prisoner himself had been regarded by some of his associates as somewhat weak-minded. On the other hand, his employer said that prisoner was a clever chemist and a good business man; and three medical men called for the defence all admitted that the prisoner was not insane.

The jury, after a consideration of ten minutes, found the prisoner guilty, and he was sentenced and subsequently executed.

Central Criminal Court, July 26th, 27th, 28th, and 29th, Mr. Justice Ridley.—*Times*, following dates.

The defence was ingenious, but it was manifestly a forlorn hope, and had no prospect of success. The case is of value, however, as illustrating the extraordinary latitude allowed by the Court to a defence founded upon insanity. Repeatedly counsel for the defence admitted that the evidence he was tendering was inadmissible, and asked the judge to admit it as a matter of indulgence, a request which, after a little demur, was granted.

THE PREVENTION OF THE INHALATION OF FOOD DURING FORCED FEEDING.

By H. DE M. ALEXANDER, M.D.Edin., Senior Assistant Physician, Royal Asylum, Aberdeen.

In forced feeding regurgitation of the food, with consequent flooding of the pharynx, is a necessary prelude to food-inhalation. The regurgitation may arise from the liquid food running back along the sides of the tube, or on account of the patient forcibly vomiting the food by the contraction of his abdominal muscles, or, lastly, it may arise from purely reflex causes. Simple regurgitation is liable to occur in feeding patients suffering from the various insanities associated with delirium, in cases of stupor, and in all cases where marked physical debility is present. Regurgitation owing to forced vomiting on the part of the patient occurs generally in melancholia, mania, and in hysteria. Vomiting and regurgitation, due to reflex irritation of the vomiting centre in the medulla, are often seen in the toxæmic insanities.

Attention to the following details appears to me to diminish the risk of the occurrence of food-inhalation during the process of feeding debilitated or resistive patients with either the œsophageal or nasal tube:

Feed the patient in bed, with his head elevated on one moderately hard pillow, the edge of which should be fitted into the nape of his neck. It is advantageous in some cases to raise the head of the bed on blocks.

The patient's mouth should not be too widely opened, and the tube should not be passed so far as to enter the stomach (Maurice Craig).

It is easier to pass the tube with the head slightly flexed, as with the mouth

open and the head flexed the œsophagus is straightened (Starling); but, after the tube has passed into the œsophagus, the assistant holding the head should be instructed to keep the chin up, as with the head in the extended position there is less chance of any regurgitating food entering the mouth.

In a strong patient, should food regurgitate into the mouth, mere pinching of the tube by the operator until the contents of the mouth have been swallowed is sufficient; but, should the same circumstance arise in a feeble subject, it is safer to withdraw the tube, at the same time elevating the patient to a sitting posture before again passing the instrument.

In order to prevent the patient voluntarily ejecting the food by the contraction of his abdominal muscles, the operator, or an assistant, should apply the palm of his hand to the patient's epigastric region while the muscles are still flaccid, and exert just sufficient pressure to prevent their contraction. This manœuvre is, as a rule, successful in women and in the majority of men, unless the latter be possessed of an exceptional muscular development.

In vomiting and regurgitation due to reflex causes, gastric lavage with a weak solution of Condy's fluid, or with a solution of bicarbonate of soda (one drachm to the pint), about half an hour before feeding, gives the most satisfactory results.

BIFIDITY OF THE SPINOUS PROCESSES OF VERTEBRÆ.

By P. Campbell Smith, L.R.C.P.

Dr. Ch. Féré has done me the honour of asking me to publish an observation to which I drew his attention some months ago, and which he has confirmed—the occurrence in degenerates of bifidity of one or more spinous processes, especially of the lumbar vertebræ. Since receiving my letter Dr. Féré has seen a dozen cases, of which eight were in the lumbar region; they were associated with a certain degree of hypertrichosis, which he has described (1) as "the faun's tail." One of his patients was a neurasthenic, the remainder were insane. In a period of several years I have met with hardly as many cases as Dr. Féré has seen in a few months; but he has many more degenerates under observation than fall to my lot. None of my cases have been accompanied by hypertrichosis. One of them was in the dorsal spine, the remainder in the lumbar, and especially the lower lumbar. In most instances one vertebra only showed the condition; sometimes two or even three were affected, and these were always adjacent, except in one case where two contiguous spinous processes and one at some distance were bifid, all these being in the dorsal region. About half the patients were insane, the remainder, if I remember rightly, being all more or less neurasthenic. I do not think that any conclusion can be drawn from Dr. Féré's figures and my own as to the proportion of cases occurring in the sane and the insane respectively, but I have no doubt that, like other signs of degeneracy, the condition occurs most frequently in the insane. As to its association with neurasthenia, I have already stated (2) my belief that neurasthenia is a congenital state, and there are grounds for holding that it is itself a stigma of degeneracy.

In his letter to me M. Féré refers to the best position for investigating this condition. I have usually examined my patients while they were sitting up in bed—an attitude that involves some flexion of the trunk—and have trusted rather to palpation than to inspection in the first instance. Dr. Féré has adopted the plan of placing the patient on his side with his trunk flexed.

(1) *La Famille Névropathique*, 2me ed., p. 274 et fig. 13.—(2) *Brit. Med. Journ.*, 1903, vol. i, p. 781.

A NEW SAFETY BATH TAP.

Considerable attention has been paid to the construction and fittings of baths, lavatories, etc., for public institutions, the general principles adopted being simplicity of action and safety from accidents. It is certainly an advantage to be able