Great credit is due to the Sisters in charge of King's Ward (males) and Murray Ward (females) for the careful search for the head of the worm which they have made in every case. In the former ward the treatment has been successful in the last thirteen cases; and in the latter, where the cases are not so numerous, in three successive cases.

There appears to be a belief that oil of male fern is less successful against *Tænia mediocanellata* than against *Tænia solium* and the *Bothriocephalus latus*. This series of cases, so far as it has any bearing on the point, does not support such a view. None of the very various toxic symptoms described as having occasionally followed the administration of this drug were observed.

TRYPANOSOMIASIS.

The *Lancet* publishes the following synopsis of a paper on the above subject read by Professor Erich Martini (Berlin), staff surgeon in the German navy, at the International Congress of Medicine at Lisbon. After a general reference to human diseases in which spirochætæ were found and to the effects of trypanosomiasis affecting the lower mammals, birds, fish, &c., he proceeded to consider the latter disease in the human subject under the two headings of African trypanosomiasis and kala-azar. African trypanosomiasis was known as trypanosoma fever in its early stages and sleeping sickness in its later stages. It was conveyed by the glossina palpalis, and was an exclusively African disease. Kala-azar and other febrile cachexiæ caused by the same parasite occurred principally in India, but have been seen in Africa as well

The first account of sleeping sickness was published in 1803 by Dr. T. M. Winterbottom, who had observed it in Sierra Leone. It has occasionally been conveyed to America by imported negroes, but has never spread there. The parasite was discovered by Dr. J. S. Dutton and Mr. R. M. Forde in 1901. The preliminary latent stage might vary from two to eight years; the onset of the sleeping sickness stage was followed by death in from four to eight months. No method of immunisation was possible and prophylaxis depended entirely on the use of mosquito nets, wire gauze, and gloves as a protection against the glossina. Treatment consisted only in the use of palliative measures. Kala-azar (*Anglice*, black fever) was so called because in the early stages the patient's skin was sometimes pigmented. A considerable number of observers have taken part in elucidating the pathology of the disease.

The Neurasthenic Nurse.

By a Patient.

A good deal has just lately been written about the neurasthenic nurse, but not, as far as I have seen, from the patient's point of view, which, after all, may be worth something. It was a decided shock to me to be told that the trouble I was suffering from might be caused by neurasthenia, and needed a rest cure—that after nursing a good many Weir-Mitchell cases, I was to be one myself. Still, when you have been ill for some time anything seems worth trying, and I started off gaily for a home. I had been head of a successful home for such patients for some years, so that it did not occur to me to think twice about the matter. I do not intend to speak of the treatment; most nurses are acquainted with the details, and in itself it is very endurable, but all depends on the way it is carried out.

Massage is delightful, done as I had it, by skilful and kindly hands, and those two hours were the bright spots of the day. Much milk one can easily get used to if one tries. Being debarred from visitors and letters is the greatest deprivation, but that can also be put up with cheerfully when you know there is a good time coming at the end of six weeks, and when worn out the advantages of leading a cabbage-like existence are obvious.

What I want to remark from "one who knows from the inside" is the vital difference the personality of the nurse makes to the cure of the neurasthenic.

The medical man, of course, plays a very important part in directing the cure, but he is at most a visitor and however much you may appreciate his visits they are few and far between. He may be all that is skilful and kind, and yet so dependent is he on the nurse for the success of his case, that no Weir-Mitchell patient is likely to get better unless she, and outside circumstances, help him.

To take the least important first. The situation of the home should be considered. Quiet is a great essential and a very noisy thoroughfare is not suitable. The patient's room should be far from the irritating noises of operating theatre, ward kitchen, and household work.

The present system of receiving these cases in ordinary homes seems to me a mistake. From circumstances, operation work must be attended to whatever happens, and the rest case must do the best she can till the rush is over. At the same time it is not mentally restful to lie and listen to the various prepara-

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