Klin. Wochenschr., 1889, No. 25) have recorded the occasional occurrence of imperative ideas, and Séglas (Bull. de la Soc. de Méd. Ment. de Belgique, 1887) and Stembo (Berl. Klin. Wochenschr., 1891, No. 28) have noted various intellectual disturbances. The case here detailed presented certain abnormal features. The motor attack first showed itself at a comparatively late age (54). There were no antecedent evidences of involuntary movement (tics vulgaires), and its onset, occurring at the menopause, was sudden, and not, as is usually the case, of gradual growth. The progressive development was rapid, and after a comparatively short duration (two years) led on to psychic disturbance. Hysterical symptoms (globus, bulimia, abdominal and diaphragmatic clonic contractions) accompanied the earlier tic symptoms. The maniacal symptoms rapidly vanished under asylum treatment, and after two months the patient was discharged, with a marked improvement, too, in the symptoms of her primary neurosis. Buringh Boekhoudt and Van der Weyde in endeavouring to explain the phenomena of this malady observe that, taking into consideration the rapidity of succession of movements and vowel sounds, these must in a measure be rendered unconsciously. They are of opinion that some alteration must exist in those inhibitory tracts the office of which is to control and modify verbal and motor representations in their transmission to motor initiatory centres. As children learn to speak by imitation, they assume that the disposition to convert speech (or motor) idea into speech (or motor) action is an innate one, and that thus "every person is a born echolaliac." This leads one to the idea that convulsive tic and its correlated disorder latah, may be the evidence of a developmentary reversion, the affections being closely allied to the microkinetic movements of infants. It must be noted that in certain cases the idea (of phonation or movement) must exist for a definite period in the field of consciousness, as the patients have a premonition of what they are about to say or do. The instance quoted by Frylinck from Guinon of the ballet-dancer who never was subject to involuntary grimacing coram publico, but who on retiring immediately commenced violent facial contortions, proves that for a time these movements can be supervised and controlled without intentional will effort. As every cerebral performance of whatever nature acts as a stimulant to its repetition, we can understand how these movements may become reflex, and thus ensue in rapid succession outside the limit of conscious feeling. It is not, however, all movements or sounds that are reflections of recently-observed movements or sounds, but also from earlier cerebral acceptations of such can they arise, probably as the result of some unknown cortical irritation. The development of such irritation or its intensification may then lead to disturbances of the psychic centres.

Hysteria.

H. Higuier (Wiener. Klin. Wochenschr., 1895, Nos. 1, 2, 3, 5) relates two cases of interest, one of hysteria simulating tabes dorsalis,

https://doi.org/10.1192/bjp.41.175.728 Published online by Cambridge University Press

and another of locomotor ataxy complicated with hysteria. The diagnosis of an involuntary simulation of tabes dorsalis is not so difficult. To establish the existence of actual locomotor ataxy we must endeavour to demonstrate the presence of "tabetic stigmata," especially the loss of pupillary reflex action to light, the optic disc atrophy, Charcot's joint implication (which, though frequently absent, must be included among the earlier symptoms of the affection), and lastly the absence of patellar reflex. The accessory tabetic symptoms are in this relation of less value. When a combination of hysteria with tabes is suspected, however, the recognition becomes more difficult. The hysterical stigmata may cloud the tabetic, and the presence of various anæsthesiæ—hemianæsthesia, pharyngeal anæsthesia, concentric contraction of the visual field, deep epigastric anæsthesia, etc.—may make us overlook the presence of the organic affection. The contraction of the visual field in hysteria is mainly concentric; in tabes it is mostly irregular. The dyschromatopsia of hysteria is wholly unlike that of tabes. The ophthalmoplegia externa of tabes is limited generally to one muscle; in hysteria it embraces associated groups of muscles, is as a rule hardly observable, and is induced by contraction of antagonistic groups, etc. By this careful observation it has been possible to demonstrate in one case symptoms of tabetic implication of one eye and hysteric affection of the other.

Higuier's first case—that of hysteria simulating tabes—was of a young girl aged 15, with slowly progressive symptoms of inability to walk or stand, of loss of patellar tendon reflex, of ataxic gait, neuralgic pains in the legs and along the course of the sacral nerves, girdle pain, loss of sensation and delayed pain perception and vesical and rectal retention. Subacute polyneuritis could be excluded owing to the absence of all true paralytic symptoms, of muscular pains, and of diminution in muscular content, of cutaneous hyperæsthesia, and of pain-punctæ in the tract of nerves, while the usual ætiological factors, too, were lacking. Some of the symptoms pointed to a doubtful tabetic diagnosis, but the absence of an ætiological factor, the age of the patient, the relatively acute progress of the case, the variations in the affection on the one hand, while standing and walking, and the ataxy on the other hand while reclining (in other words the abasic-astasic symptoms of motor disturbance), and other signs (bilateral ovaralgia, concentric limitation of the visual field, and the fact that the patient had in earlier life suffered from similar symptoms), pointed directly to hysteria. The ultimate issue of the case—the rapid disappearance of all symptoms except the ovaralgia, intercostal pain, and the knee-jerk signs—confirmed the diagnosis. In the second case, where hysteria was combined with actual tabes, the patient, a man aged 47, had, fifteen years before, acquired syphilis, and evinced undoubted signs of locomotor ataxy. After he had been treated by the Charcot-Mochutkowski method (prolonged suspension)—a proceeding which appeared to make a great mental impression on him—he expressed a feeling of progressive decline in health, and after

https://doi.org/10.1192/bjp.41.175.728 Published online by Cambridge University Press

about seven days there ensued involuntary unconscious uncontrollable movements in the lower extremities, sometimes limited to a desired movement and becoming after a while a tonic contracture. Motor irritation symptoms in tabes usually take the form of involuntary, sometimes wholly unconscious, mostly athetosiform movements of the hands, or as more rapid passing muscular contractions, both on intentional movement or quite spontaneously. Many explanations have been sought for these movements in tabes—they have been looked upon as reflex phenomena induced by lightning pains, or as the early sign of a degeneration of the lateral columns of the cord, or as evidence of neuritis, or as the expression of a "static ataxy," *i.e.*, as the result of an inco-ordinate working of the muscular tonus with consequent loss of balance. In all cases where tabes displays motor symptoms one must keep in view the possibility of some conjoint motile affection, *e.g.*, chorea, myoclonus, maladie des tics, or hysteria. In the case under consideration, as a careful review of the symptoms during its progress and a strict inquiry into the history indicated (the advent of various phobiæ, imperative ideas and imperative movements, the previous presence of all these symptoms, their disappearance and subsequent return after a mental shock, viz., the suspension treatment, on which after an incubative stage—Charcot's "meditation-stage"—there supervened these nervous phenomena), the diagnosis of a rare form of hysteria was made to be coexistent with the tabetic affection.

The Centre of Phonation in the Brain.

This is a question which has engaged the attention of experimentalists during the past twelve years. The only positive result arrived at so far has been that in certain animals a circumscribed area at the base of the præfrontal gyrus may be found, which by electric stimulation will cause a closure of the glottis by complete symmetrical adduction of both vocal cords. This effect is obtainable irrespective of the focus stimulated, whether right or left, and regardless of previous extirpation of the opposite corresponding focus. This, then, is a condition wholly different from that which pertains in the cortical centres for facial and other movements, and, as proved by Semon and Horsley, when both centres are extirpated, or even when both cerebral hemispheres are removed, there never ensues any vocal cord paralysis. In animals thus treated the glottis aperture is not at all changed in shape, and the laryngeal functions appear to be fully maintained. The so-called phonation centre cannot thus rank with other motor cortical centres. One investigator, Masini, is said to have discovered a cortex centre which on irritation caused adduction of the opposite vocal cord only—but his result has not been verified by prior observers (Krause, Horsley, Semon, and others) or by later experimenters who have worked to obtain his results (Onodi, Klemperer). The absence of clinical evidence of vocal cord paralysis due to cortical lesion corresponds, too, with the failure artificially to induce unilateral focal action. Klemperer has recently (Archiv. f. Laryng., B. ii., H. 3)

https://doi.org/10.1192/bjp.41.175.728 Published online by Cambridge University Press