patient had more fits when the fæcal acidity showed a low reaction, sometimes the reverse condition obtained.

The increased carbohydrate diet produced no appreciable alteration in the reaction of the fæces or urine. Similarly there was no general increase or diminution in the number of fits which occurred when the patients were on this diet, as compared to the number occurring when patients were taking an ordinary diet.

The general mental state of patients when taking extra carbohydrate remained much about the same as previously. There occurred nothing in the nature of epileptic equivalents or replacements.

If acidosis be regarded as an ætiological factor in epilepsy, the ingestion of extra carbohydrate did not appear to aggravate the condition.

The degree of fæcal acidity was not systematically compared with that of the non-epileptic subject. In two normal cases, however, the examination of fæces showed varied reactions in the same proportion as the above, so it would be inferred that the results would be comparable. Further, the reactions obtained in the first series of analyses showed a similar variation in reaction to those shown by the true epileptics.

Clinical Notes and Cases.

Notes on Treatment by Hypnotic and Hypnoidal Methods of Extern Cases.(1) By JOHN J. FITZGERALD, M.D., Assistant Physician, Cork Mental Hospital.

THE question of early treatment of incipient mental illness—a problem which is being solved to some extent in England—has not, so far as I am aware, been dealt with yet in the Free State. The establishment of out-patient clinics in mental hospitals would be a desirable way to institute such treatment here.

It has been stated that very few patients would come for treatment to the out-patient clinic of a mental hospital as they would be branded as being insane by their attendance at such a place. I admit there is something in this objection, and no doubt the better arrangement would be to have a doctor from the mental hospital attending on certain days at a general hospital, where he would

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have the assistance of specialists in various branches of medicine and surgery.

I shall now describe to you an unofficial extern department which I have conducted for the past twelve years. In the year 1913 I moved from my quarters in the asylum to Mile House, Blarney Road, on the asylum estate, which had been occupied as a private residence for nearly forty years before its purchase by the asylum authorities. I may explain here that the mental hospital grounds at Cork lie between two public roads. The entrance to the asylum is from the Lee Road, the entrance to Mile House is from the Blarney Road; so that the objection that some patients would have to attend at a mental hospital for treatment does not arise. About this time I read the Report of the Status of British Psychiatry Committee issued by the Medico-Psychological Association, which advocated the treatment of early or incipient cases of mental derangement at out-patient departments of general or mental hospitals. It occurred to me that I might possibly do some good for cases of incipient insanity by commencing an unofficial extern department of the Cork Mental Hospital at Mile House. With this idea I spoke to some leading physicians and surgeons at a local meeting of the British Medical Association, and told them that if they had amongst their hospital patients any who were threatened with mental breakdown, I should be glad to treat those patients free of charge at Mile House.

Since that time, now twelve years ago, I have been treating about 16 such patients a year, and am able to say that the results have been most encouraging. The only failures were certifiable cases. Of course the work has been in private, but an official extern would have dealt with a much greater number of cases. I hope that out-patient departments will soon be created at all our mental hospitals; we shall then be doing something towards the prevention of insanity. Out-patient departments need not commence on a pretentious scale, and may in consequence be immediately established. One physician and one social worker for each out-patient clinic will be enough at the beginning; the latter could be recruited from our nursing staffs. The social worker would help the medical officer in taking notes of cases and in visiting patients' homes to give advice and assistance, and to investigate the conditions of a patient's home life and surroundings.

Co-operation between medical officers of mental hospitals, schools, dispensaries and teachers would gradually follow. Early symptoms of abnormality in children could be early detected and dealt with immediately, and many prevented from becoming patients of our Free State mental hospitals in ten or twenty years' time.

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Most of the patients who come to Mile House, although unable to pay a fee, are able to buy medicines and extra dietary. As regards the very poor who are unable to buy either food or medicines, a gratuitous supply of medicines, etc., will be necessary; this matter could be adjusted after a while. Some expenditure in preventative treatment would be better than having to erect auxiliary mental hospitals.

Patients applying for treatment at Mile House are thoroughly examined physically, urine tested, and the presence of possible focal lesions of tonsils, teeth or naso-pharynx looked for. If any such lesions are found the patients are sent to the general hospital for appropriate treatment. The general physical examination of the patient being finished they are invited to recline on a couch in a room with the blinds drawn, instructed to assume a position of comfort with relaxation of their muscles, then told to close their eyes, breathe regularly and compose themselves as if going to sleep A softly ticking clock or watch near them adds to the general air of rest and monotony; patients are not asked to fix their attention on the ticking of the watch or clock. After they have lain quietly for some ten minutes on the couch in silence, they are asked if any troublesome or worrying thoughts arise in their minds to tell the doctor about them, and that the mere telling and discussion of these distressing thoughts will give mental ease.

At the first interview patients are usually constrained and not very communicative, but on subsequent interviews they talk freely about their sorrows and worries, and always express themselves, when leaving, as feeling relieved and happier in their minds.

Patients have told me again and again that they found it much eaiser to recollect incidents of their past lives, and to explain their mental troubles, when lying on a couch in a state of quietude and rest in a darkened room, than when they were sitting bolt upright opposite doctors in an out-patient department of a general hospital or in doctors' consulting-rooms.

I have adopted this particular method of examining and treating the mental states from Boris Sidis. He calls it the hypnoidal system. It is of use in all cases, but particularly in cases of psycho-neuroses. I frequently avail myself of light hypnosis when treating some patients. The lightest degree of hypnosis is all that is necessary for suggestive treatment, and if a patient is not improving after three sittings I discontinue it, and rely altogether on the hypnoidal system just described.

Nearly all patients are given small doses of sodium bromide at commencement of treatment, and each patient is fully instructed as regards dietary, exercise, rest, regulation of bowels, etc. Tonics,

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cod-liver oil, hypophosphites, maltine and other drugs are prescribed if necessary.

As a rule I do not treat by suggestion at the first interview, but always give an optimistic prognosis to patient and friends. One difficulty cropped up soon after the extern was commenced. I had, when treating females, to have a female relative or friend of the patient's in the room with me. I need not say that no woman or girl patient would talk freely to a doctor under these circumstances. However, this hitch was overcome easily, as my wife, Dr. Lucia FitzGerald, who is an assistant medical officer here, has taken over all female patients, and obtained equally good results with her cases.

I trust that the title of this paper, and the fact that I have described at some length the particular form of psychotherapy that we have found useful, will not obscure my real motive, which is to make a plea for the immediate establishment of out-patient clinics attached to the mental hospitals in the Free State.

The following are some notes on four cases of patients treated at Mile House:

CASE 1.—*Acute melancholia.*—Male, æt. 48, widower, no children. Family history: Several near relatives insane. Patient was powerfully built, a cooper; had been a heavyweight boxer in his early years. He had a few months before begun to sleep badly, and ordinarily a cheerful man, fond of singing at his work, he was noticed by his fellow-workmen to have become silent and morose. Was the sole support of a large family of boys and girls, children of a deceased brother. He had been under treatment as an out-patient for about six weeks at a local general hospital, and was supposed to be suffering from "nerves." He was not improving, and his relatives were about to get him admitted into the asylum. When he was brought to see me he was free from delusions, but complained of want of sleep, loss of appetite; said he felt miserable and unhappy, and had a vague apprehension of some impending trouble. I treated him by hypnoidal methods. At his fifth visit, while in a hypnoidal state, he told me that he had many years before suffered keen mental distress and remorse over an incident in his life which, however, he had long ceased to worry or think about. He had one day, when leaving his home for work, been asked by his wife to bring a doctor to see her, as she felt very ill. He laughed her fears away, as she looked the picture of health, although she was an exceptionally stout woman. In a few hours he was summoned home as his wife had died suddenly. I assured him that he was in no way to blame in the matter; that he could not have foreseen it, and that the record of his whole life showed him to be a decent and kindhearted man. He went away comforted, but still depressed. On the morning following, a brother who slept in the same bedroom was amazed to find that the patient was quite himself again. He visited me a few days afterwards, expressed himself as delighted with his recovery and immediately returned to work, and has remained perfectly well for the last ten years. He had been attending here about two and a half weeks when this happy result came about. I gave him bromides in small doses twice daily, a stomachic tonic, and allowed him two bottles of stout a day. I told him to rise late, go to bed early, keep his bowels freely open. A brother, as I have mentioned, slept in the same bedroom, and he was never left alone day or night while depressed.

CASE 2.—*Acute melancholia.*—Boy, æt. 10½. Patient's brothers and sisters were healthy and normal. His father, described as a ne'er-do-well, had deserted the mother when the patient was a baby. Patient was of normal intelligence and conduct, fond of play and healthy. Four weeks previously he had become acutely depressed, used to start up at night from his sleep and scream loudly, and his

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mother had great difficulty in soothing him. At the first interview said he could not say what was making him so miserable unless "it is that my soul is lost." Said he could neither play nor study. He had been attending a local dispensary and had already been put on extra dietary. At his first visit it was very difficult to get him to relax his muscles, but on being told to pretend that he was playing at being dead he succeeded in doing so at last. Hypnosis was induced by means of fixed gazing and simple passes; he was easily hypnotized, and suggestions were made with one hand on his forehead that his fears would vanish and that he would become quite happy and well. He was feeling happier when aroused and returned in two days' time, when he was again hypnotized. On this occasion he passed into a natural sleep for about half an hour; when roused he sat up and said with delight and surprise on his face, "Oh, every bit of it is gone, doctor." His mother was present on both occasions when he was hypnotized by my wife. His mother was told to keep him from school for a year, and not to allow him to study. He has remained well and healthy for the last two years.

CASE 3.—*Acute climacteric melancholia.*—Married woman, æt. 50. A brother and several cousins were insane; a son is a patient in Cork Mental Hospital, suffering from dementia præcox; three other children healthy. She suffered from insomnia for months and was very hypochondriacal, and lately very depressed. Had anorexia, was extremely constipated, and had irregular and scanty menstruation for some months. Her youngest child was over 14 years old. She was full of vague forebodings: said she was suffering from a disease of the stomach that would kill her. She reiterated again and again, "My case is hopeless; you can do nothing for me." She also said that she heard terrifying noises by night in her home. Laxatives were prescribed; she was told to take light, easily digested food, and ordered a mixture containing small doses of bromide of sodium. She was put into a state of light hypnosis before leaving, and the usual suggestions were made. She remained in bed for a week at home. She had never expressed a desire to commit suicide, but nevertheless her husband was instructed not to leave her by herself at any time. At the end of a week her husband brought her to the extern again; he said that she was very depressed on the previous night, and he wanted to see about getting her into the mental hospital. She was hypnotized easily on this occasion, passing readily into a cataleptic state, and at suggestions imagined she was back at home and described what she saw there. Suggestions of a hopeful and optimistic nature were made, and when awakened she said she felt much better. She came again in a week's time; she seemed very cheerful and rational, but said she had a momentary feeling of apprehension at times. Hypnosis was again induced, and repeated suggestions of renewed health and happiness given. She has remained perfectly well for the last five years, doing her housework and coming through a good deal of domestic trouble without any tendency to a mental breakdown.

CASE 4.—*Psychasthenia.*—Unmarried woman, æt. 28. Family history bad: much insanity and various neuroses amongst progenitors and near relatives. Used to assist her mother to run a small shop. At the age of 16 she had had what was described as "a nervous breakdown." At that time her mother said patient was very frightened and depressed, feared to be left alone, slept badly, lost weight, and had outbursts of violent temper on the slightest provocation. She also was much troubled with religious scruples. Under treatment by a city doctor her acute symptoms subsided, and she was pronounced to be as well as ever she could hope to be. For twelve years afterwards she had never been able to go for a walk alone, although she sometimes assisted in the shop and generally ate and slept well. A few weeks before she was sent to me she had had an exacerbation of all her old symptoms, and her old religious scruples were redoubled and intensified. If left alone in her room she would become terrified, and would faint if she went into a railway carriage, even if accompanied by several relatives. The physician attending her had fully made up his mind that she should be sent to the asylum, but having heard of our extern department sent her on to it. She came, accompanied by her mother and sister. She looked worn and anæmic; no evidence of any delusions or hallucinations was present. She was very emotional: said she had a constant dread that she would kill her sister; was obsessed with a multitude of other fears, *e.g.*, of screaming in church, of assaulting strangers in trams, of breaking windows of trams or of shops in the town. Her mother told me patient had to be assisted to dress and undress. Patient herself explained this by saying

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that during the process of dressing and undressing herself she had to stop to pray against blasphemous and obscene thoughts that used to come into her mind. She had been operated on by a nose specialist some time before, because someone told her that her symptoms were due to obstructed nasal respiration. Hypnoidal treatment was employed the whole time in this case. She steadily improved, although she had several relapses during the course of treatment. She attended three times a week for six months, and twice a week for two months, and then once a week for another few months; then once or twice a month for a few months longer. She has enjoyed perfect health mentally and physically for the past few years. She nursed her mother during a long fatal illness, and has had other family troubles, which she has been able to go through without any mental derangement.

The Circulation of the Hands in Primary Dementia. By P. B. MUMFORD, M.D., M.R.C.P., Visiting Pathologist, Parkside Mental Hospital; Assistant to the Dermatologist, Manchester Royal Infirmary; Assistant, Manchester and Salford Skin Hospital.

AN examination of a series of cases of primary dementia will reveal, amongst the other and more generally recognized characteristics, a deviation from normal in the colour of the hands. As a general rule, even in warm weather, the hands are blue-red in colour, colder than the average, and show an excessive moisture of the palms and contiguous surfaces of the fingers. These are commonly observed physical changes, but the mechanism of their production is but little understood.

Several interesting facts regarding certain physiological properties of their superficial blood-vessels are to be noted, as follows:

In the first place, it will be found that immersion of such hands in water at a temperature of about 42° C. results in the production of an intense arterial-tinted erythema over the areas so exposed. Secondly, mechanical pressure stimulation by stroking of these areas will be followed by a similar deep red and irregular blotching over the skin so stimulated.

The only possible explanation of these results lies in the fact that heat and moderate pressure stroking are both known to result in arteriolar and capillary vaso-dilatation. (Reddening of skin follows the application of these stimuli to any healthy skin.) The excessive erythema thus produced in primary dementia is a direct consequence of the existence of capillary paralysis (either partial or complete), and is analogous in every respect with the erythema which is produced by similar stimulation of the healthy hands after their prolonged exposure to cold. In each case some capillary paralysis of a temporary or permanent nature exists.

It should be remembered that the hand of a primary dement is cold, not because of low external temperature, but because of excessive local heat-loss secondary to enlargement of the capillary

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