(*c*) The incidence of alcohol and syphilis as causative factors is unusually great.

(*d*) Amentia is more frequent.

(*e*) The percentage of cases of general paralysis is much greater.

(*f*) The recovery-rate of direct admissions is unusually small.

(*g*) In the series of cases investigated, mental alienation apparently attributable to injury, wounds, shell shock, gas-poisoning has occurred amongst potential psychopaths.

(*h*) Out of 140 cases, in 136 cases the mental trouble has occurred in potential psychopaths, and the various factors of stress associated with home service, service at the base, front line service, would be regarded by the alienists as accidental existing factors.

It is impossible to arrive at any other opinion than that the service patients, as a class, would, as regards the majority, have been patients in mental hospitals sooner or later had there been no war. As regards the minority, they would probably have constituted the pre-war groups of waifs and strays, and formed the inhabitants of the casual wards of workhouses and the inmates of civil prisons.

In conclusion, an apology appears to be necessary for laying stress upon facts which are the common experience of the majority of the members present. The excuses offered are that:

(1) The public is disposed to regard the service patient as one who is curable and ought to be cured.

(2) The statement that the cases are incurable is likely to lead to accusations from the layman of pre-judgment, and unwillingness to resort to recently advocated methods of treatment when old ones are ineffective.

Clinical Notes and Cases.

Notes on a Case of Pellagra occurring in an Insane Patient. By F. E. RAINSFORD, M.D.Dubl., Resident Physician, Stewart Institution, Palmerston, co. Dublin.[1]

SOME of you may do me the honour to remember that in 1913 I read a short paper before you in which I described a fatal case of pellagra—the first ever noted in this country. In the year in which that case occurred cases had also been recorded in Napsbury Asylum by Dr. Blandy, in Bethnal House by Dr. Cole, and in the Holloway Sanatorium by Dr. Emma Johnstone. Since then I have not heard much on the subject, nor, as far as my memory serves, has any case been recorded.

(1) Read at the Autumn Meeting of the Irish Division, November 4th, 1920.

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The case I am now about to describe differs in some small particulars from my previous case, but I believe you will—after hearing its details—agree with me in thinking that I am justified in diagnosing it as one of pellagra.

Miss X—, a hospital nurse, æt. 38, was admitted on July 18th, 1920, into the Stewart Institution Mental Hospital. In her medical certificates she is described as "melancholic, morose, restless, and stated to be sleepless and to refuse food."

The history furnished with her states that she was trained in a London hospital, and that during the war she went on a visit to a married friend in East Africa. On her arrival, owing to shortage of nurses, she was asked to take up work, which she did, first at Mombasa and later at Nairobi. She worked very hard, got quite broken down, and, in addition, got frequent malarial attacks, which further complicated her condition.

On her arrival in England she was met by a cousin, who informed me that he could hardly recognise her, she looked so fearfully thin and debilitated. Taken to her home in Ireland she did not improve, got very depressed, restless and confused, refused food, and became more physically broken down. Amenorrhœa is noted for seven months previous to admission.

On admission she is noted to be very thin and worn, not inclined to speak, restless, etc. Took light food, and could, when pressed, answer questions about herself fairly rationally. A rash of an acneiform nature was noted, chiefly affecting chin and sides of face around nose. It was red, not crusty, and had somewhat the appearance of adenoma sebaceum. Later the rash affected the forehead, and I was struck by its crescentic outline and clearly-defined margin. It remained in this state for some weeks, but about the beginning of September it got more inflamed and developed crusts, and it was now general over the face, running from about half an inch from the roots of the hair on the forehead to the tip of the chin. The eyelids were never affected, nor did the rash spread beyond the malar prominences on either side, and the ears were never involved. The nose was particularly sore both inside and out, and pus formed on the bridge. Her mental state at this time was one of apathy, and she seldom spoke. She ate food fairly well, but without any interest in it. Generally she stood motionless on the floor most of the day. She slowly lost weight.

As ordinary treatment for the eruption had no good result, and as the patient was growing weaker and was now confined to bed, I asked Dr. Walter Smith to see her, which he did on September 19th. His opinion was that it was a severe dermatitis and that it would be difficult to heal, and that there was probably a toxic origin.

Under his treatment the eruption slowly healed, but there was no improvement in the physical strength, which was being slowly sapped by continuous diarrhœa. There was a very heavy and offensive smell off the patient, and we now noted commencing gangrene of the toes, and later the skin on the hands and wrists became discoloured and began to desquamate. The gangrene of the toes was of a dry character, and one toe got completely destroyed, while the great toe on either foot became black and had an unhealthy serous discharge. There was never any purpura, but shortly before death a small septic sore formed on the crest of the tibia.

The case was now one of slow and progressive marasmus, and though plenty of nourishment was taken no physical improvement was ever noted.

October 9th: Eruption on face is healing slowly. Some of her toes show signs of low circulation, with black, bruised appearance; diarrhœa still at times.

October 19th: Eruption healing; feet cold, toes black. Two or three loose, foul motions daily.

Towards the end of October she was seen by Dr. Moorhead, who could not quite concur in the diagnosis of pellagra, but thought that the condition was one due to deficiency of vitamines and suggested a more extended vegetable dietary. This was done, but no special improvement followed.

October 29th: Rash almost healed. Diarrhœa not so bad. Is taking nourishment well.

October 30th: A change for the worse occurred. Patient got very restless and

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talkative; said she was better; had to be watched in bed, as she made constant efforts to get up; was very weak, and, if she did get out of bed, fell.

She died on the morning of November 1st, the rash on the face having then almost disappeared.

Reviewing the case, I base my diagnosis of pellagra, not so much on the face condition (which was more like severe crusty eczema), as on the purple-like discoloration of the hands and wrists, on the general prostration and debility, and on the gangrenous condition of the feet.

In 1913 Dr. Cole described a case in which the hands were deeply stained to a purplish brown, affected area continuous and containing no healthy patches; and he especially notes that the ends of the fingers from the roots of the nails were entirely free. This is an accurate description of the condition of the hands in my case also.

In none of the cases which have been described can I find any occurrence of gangrene of the extremities.

There was never any rise of temperature, the urine was free from albumen, and the reflexes (knee) were present.

The question of causation is still obscure, and notwithstanding extensive investigation little fresh light has been shed on it. Dr. Tambon attributed it to a fly. Profs. Alessandrini and Scala considered that it was a disease strictly limited to districts where the water comes from a clay soil and flows on or stands upon clay, and that it is the effect of a chronic intoxication, of which the cause is silica in colloidal solution in waters of a determined constitution.

It is remarkable that nearly all the cases recorded in England, with, I think, one exception, occurred in females, and it is further to be noted that even if pellagra attacks a healthy individual, it generally, after some recurrences, produces mental unsoundness. All the cases recorded in England, I should add, occurred in insane patients.

It is worth while considering whether, after all, the cause of pellagra may not be some deficiency of vitamines in the dietary, and whether it may not be a disease allied to scurvy. I think this theory is well worth further investigation, and should any further case of this kind ever come under my notice I would be disposed to treat it by anti-scorbutic methods.

A Case of Mental Deficiency associated with Dyspituitarism. By C. Farran-Ridge, B.Sc., M.B., Ch.M.Sydney, House Physician, Bethlem Royal Hospital, and Cecil Worster-Drought, M.A., M.D.Cantab., Neurologist to the Out-patient Department, Bethlem Royal Hospital, etc.

Our chief reason for recording the following case is on account of its presenting the interesting association of mental and moral deficiency

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