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PART 1.—ORIGINAL ARTICLES.

The Morisonian Lectures on Insanity for 1873. By the late DAVID SKAE, M.D., F.R.C.S.E., Physician-Superintendent of the Royal Edinburgh Asylum, &c., &c. Edited by T. S. CLOUSTON, M.D., F.R.S.E.

(Continued from Vol. XX., *p.* 211.*)*

LECTURE V.*

Syphilitic Insanity.—This is the first of the varieties of insanity in Dr. Skae's classification that is due to the action of a poison introduced from without. As might be expected, its symptoms are much more definite than those of the more constitutional and hereditary varieties of mental alienation. Something, too, is known of its pathology, and yet it is only about twenty years since the fact was recognised that the syphilitic poison could produce mental derangement at all. It has been described by English, French, and German authors on insanity and syphilis, but Dr. Wille, the latest German writer on the subject, has given us by far the most complete account of the disease in all its forms so far as it is at present known. An excellent abstract of his paper appeared in the "Journal of Mental Science" for January last, by Dr. Addison.† It is one of the forms of insanity that must be studied in connection with the other syphilitic affections of the nervous system, if we wish to understand it. To describe its symptoms without reference to the syphilitic form of epilepsy, of paralysis, and neuralgia, would be a mistake in every respect. Dr. Reade, of Belfast, and Dr. Todd, of London, were the first in this country to direct special attention to the occurrence of mania as a direct result of syphilis.

* To prevent mistakes, it may be mentioned that this lecture was written entirely by Dr. Clouston.—T. S. C.

† Jo. Ment. Sci., Jan., 1873.

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They both showed that it was one of a train of symptoms that had the specific infection for its starting point; that those symptoms proved clearly that the nervous system, both spinal cord and brain, as well as their membranes, were involved in such cases, and that whatever cured the syphilis cured the neuroses. Dr. Duncan published three very interesting cases of syphilitic insanity in 1863.* Dr. Hugh Grainger Stewart published three cases in 1870.† Dr. Wille has collated the symptoms of 77 cases of syphilis, in which there were mental symptoms of one kind or other. Many of Lancereaux's cases, given in his work on syphilis, have mental impairment or disturbance as a part of their history.

Those cases vary much in their history and symptoms, but they have certain points in common that enable us to form a picture of a typical case of syphilitic insanity.

Such a patient has had constitutional syphilis, and has suffered more severely than usual from the headaches, aggravated at night, that characterise the disease. Those headaches are increased by pressure, are deeply seated, and may be felt either in the frontal or occipital regions. He usually has pains in the neck, and a general hyperæsthetic condition of the nerves. Sleeplessness then occurs, sometimes from the severe pains, sometimes as an independent symptom. At this stage there are often motor and sensory disturbances, such as slight paralysis of the face, eye, or extremities, spasmodic disturbances, epileptiform attacks, giddiness, local anæsthesia, disturbances of co-ordination, and loss of sight or hearing. The first purely mental symptom that makes its appearance—and it is almost invariable in all the cases of syphilitic insanity—is depression of mind, and hypochondriacal fears. The patient has a morbid fear as to the effects of the syphilitic infection; he thinks he is going to die, and there is a loss of energy and originating power of mind. Lancereaux calls this a syphilitic neurosis of the intelligence. This depression of mind may continue for some time, and then pass away, having been the only mental symptom present, especially if the syphilisis cured; in other cases it remains, and other psychical affections appear. The patient begins to lose his memory, and his mind gets impaired generally, the mental condition gradually getting worse, and passing into a deep dementia, without the occurrence of any other symptom. This was the course of the disease in 34 of Dr. Wille's 77

* Brit. Med. Jo. † Dublin Qu. Jo. of Med. Sci., 1863.

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cases. In other six this steady downward course of the patient was broken by attacks of maniacal, melancholic, or delirious violence. The rapidly progressive mental weakening is very often associated with progressive motor paralysis of the extremities. Some such cases in their physical and mental symptoms simulate general paralysis very closely, but the previous occurrence of the constitutional symptoms of syphilis, the absence of delusions of grandeur, the usual youth of the patient, and, above all, to the practised eye, the absence of the true general paralytic want of co-ordination of the muscles, sufficiently distinguish the two diseases. After the dementia has existed for some time the case may be regarded as hopeless, and the prospects of the patient's living long are fortunately small.

Such is a typical form of the malady, but who that knows the protean symptoms of constitutional syphilis would expect all the cases of syphilitic insanity to be alike? Before they reach the goal of confirmed dementia, whither they all strongly tend, and where nine out of ten that have not been cured in the early stage terminate very quickly, the minority, as they run their course, exhibit a wondrous variety of symptoms.

In certain cases, as pointed out by Griesinger, where there is pre-existing disease of the brain, where there have been previous attacks of insanity, or where there is a strong hereditary predisposition to nervous diseases, an attack of syphilitic insanity may break out within two weeks after infection, being contemporaneous with the first secondary symptoms, or it may even precede them. In such cases the preliminary hypochondriacal mental symptoms scarely appear at all, but the patient at once passes into a state of acute delirium or maniacal fury. Such cases are not so uniform as the others, sometimes the mania alternating with melancholia, sometimes disappearing for a time, the patient appearing to be quite well, or lastly, assuming the type of ordinary idiopathic insanity. Dr. Hugh Grainger Stewart's cases were of this kind, and he points out that they all had the following points in common—1. The character of their delusions (that they are the victims of conspiracy, persecution, and spiritual influence). One of them imagined that he underwent a kind of nightly torture called by him the "Cylinder finish;" another said that most ingenious machines were introduced into her brain to torture her; the third that people shot vitriol, ammonia, and "black poison" at him all night, to avoid which he

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wedged his bedroom door, covered the key-holes with blankets, stuffed his ears and nostrils with cotton wool, and his mouth with a pocket handkerchief, all these defensive measures against his imaginary bombardment taking him an hour to carry out before he went to bed. I have under my own care just now a woman who had led a dissipated life, and had syphilis, who imagines that she is put into a "stove" by night, is tortured, her head beaten, and her person ravished until she is nearly dead.

2. The second symptom they all had in common was that they were suicidal and dangerous to others. 3. The next was that they all had hallucinations of the senses, and were all much worse at night. 4. The last symptom was that they all suffered much from cephalalgia of the syphilitic kind.

Such cases are very hopeless from the beginning. We may call them cases of syphilitic insanity engrafted on an original insane neurosis in the patient.

The next striking variety of Syphilitic insanity is where it follows distinct syphilitic epilepsy or apoplectiform attacks, and in this way partakes of the character of the ordinary epileptic insanity. Two of Dr. Duncan's cases were of this character.*

The last variety I shall refer to is that where there are delusions of grandeur at first, and progressive paralysis afterwards; cases in fact where the symptoms are almost identical with general paralysis. Several German writers, Meyer, Westphal, Oedmansson, and Griesinger, have specially studied this kind of case: and, while they do not altogether agree as to their conclusions, the weight of evidence is in favour of the view that those are cases of general paralysis, who, having previously had syphilis, have the character of their symptoms influenced by it to some extent, a casual relation only existing between the two diseases. That many

* Since the above was written very characteristic cases of this variety of Syphilitic insanity have been published, by Mr. H. Hayes Newington and Dr. Batty Tuke., in the Jan. No. of the "Journal of Mental Science," pp. 555 and 560, and in the No. of the same Journal for July, 1874, p. 262 Dr. Batty Tuke gives an admirable description of the morbid appearances found after death in one of his cases, illustrated by lithographs. His paper is a most valuable and original one. Mr. Newington suggests that where the symptoms result from a gummatous tumour the insanity should be called "Syphilomatous."

In the same Journal, p. 564, Dr. Cadell relates a case of mental excitement occurring contemporaneously with the secondary symptoms of syphilis.

In the April No. for 1874, Dr. Wilks relates cases of this disease, and in the Jan. No. for 1875, Dr. Hughlings Jackson gives cases of nervous symptoms in congenital syphilis.

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more general paralytics are not so affected seems the only surprising thing, for their disease in many cases has undoubtedly been caused by excessive venery.

The most careful attempts have been made by the German physicians to elucidate the pathology of syphilitic mental disease, and to connect the mental disturbances present with the pathological changes found in the brain after death. Very much has been done to make us certain in regard to some points, but the whole matter has not yet been settled. Pathologically four forms of syphilitic disturbance of the brain have been made out:—1. Nodes formed on the internal surface of the skull pressing on and setting up irritation of the brain substance. 2. Gummatous tumours of the brain and its meninges, most commonly the latter. These two forms seem to be very constantly associated with the epileptiform kind of syphilitic insanity. 3. Meningitis affecting the cortical substance of the brain secondarily, the general result being a sort of gluing of the membranes to the convolutions to each other and to the skull. This is usually associated with the typical syphilitic insanity with its initiatory cephalalgia and hypochondriasis, its gradual loss of mental power, its disturbances of motion and sensation in the cerebral nerves, and its terminal dementia and paralysis. The fourth pathological species of syphilitic insanity said to exist is a purely hypothetical one. It is described as the irritative form, from cerebral anæmia, and the irritant effect of the virus on the central nervous system. In other words, cases where nothing at all can be found after death are so classed. Such are the cases of acute syphilitic insanity following the infection very soon, and associated with the insane neurosis. The important thing which may be regarded as quite certain is, that a form of insanity may occur as the result of the syphilitic virus, which shows no post mortem appearances in the brain after the death of the patient. In some few cases, while no trace of the disease is found in the brain, yet gummatous deposits, or caries of the bones, or nodes, are found in other parts.*

* A fifth pathological state as definite as the first three, and one which will probably be found to be associated with them all when looked for microscopically, is the thickening of the coats of the small cerebral vessels by the depositions of concentric rings of plasma, thus producing a gradual diminution of the calibre of the vessels, a diminished blood supply, and subsequent softening of the brain substance and apoplexies, described by Dr. Tuke in this Journal for Oct., 1874, p. 352. This condition had been indicated by German syphilographers, but not described and figured as fully as Dr. Tuke has done.

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In a conversation I had with the late Dr. Skae, about syphilitic insanity, with reference to this course of lectures, he told me that the form of syphilis connected with condylomatous tumours, which he was the first to show was innoculable when he was one of the surgeons to the Lock Hospital, he believed to be specially prone to be connected with insanity. These condylomatous tumours are found chiefly on the mucus membranes, causing the huskiness of voice so universal in prostitutes, but the virus also seems to show a special affinity for the central nervous system, thus causing a form of syphilitic insanity.

Westphal states that there is a marked pathologico-anatomical distinction between syphilitic paralysis and general paralysis. Not to speak of the caries of the bones of the skull, so often found in syphilis, or the specific gummatous tumours and gluey inflammation of the membranes, he says that the products of the morbid changes in the arachnoid are cellular in the syphilitic cases, and fibrous in the general paralytic, and that the adherence of the pia mater *alone* to the cortical substance, which is almost always found in the latter disease, is never found in the former.

The prognosis in syphilitic insanity is generally unfavourable, though in cases where the poison seems merely to have acted as the match to set in a blaze an already smouldering fire of latent insanity, it is more favourable. But when convulsions, paralysis of single nerves, and local anæsthesia have appeared the prospect of recovery for the patient is very bad, and when progressive paralysis and advancing dementia have set in, the case is almost hopeless. There is this to be always kept in mind, however, that the most desperate cases have recovered, or got partially better. In all cases relapses are to be anticipated for some time.

Before leaving the subject of syphilitic insanity, I shall refer to a counterfeit or pseudo variety of it, which Dr. Skae specially alluded to in the conversation I have mentioned, and which I find also described by Dr. Wille. Cases of this kind are often as common as the real disease. The following is one of them.

A gentleman admitted into Morningside Asylum said he had had syphilis, that he must die, was depressed, and apparently hypochondriacal, refused to take food, and said he would infect anyone with whom he came in contact. There was no evidence of syphilis to be found on any part of his body. He had enlarged tonsils, but this did not

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appear to be specific. He continued a long time most miserable, assuring the medical attendant that he was suffering from "the disease;" that he had it in all his bones, that it was killing him fast. So far as could be made out from his relatives, he had never had any venereal disease, more than perhaps gonorrhœa.

In such cases, the whole idea about syphilis is a mere delusion, and is usually only one part of the delusional insanity under which the patient labours.

Delirium Tremens.—I shall not take up your time in describing this well-known neurosis. It may, perhaps, be thought a misnomer to call it a form of insanity, but it is so clearly allied to Dr. Skae's other groups that I think he was quite right to include it. It would be a mistake to confine the varieties of insanity in any classification to those patients who have only mental symptoms, or require to be sent to lunatic asylums. This would be specialism carried into medical nosology. Rather every student of insanity should specially devote attention to those varieties of nervous affection that combine bodily symptoms with the mental. Looked at from a psychical point of view, Delirium Tremens may be said to be a malady caused by alcohol in virtue of its special chemical affinity for the nervous tissue, in which there are great mental excitement, terror, and confusion, sleeplessness, hallucinations of vision, having in addition motor symptoms partially involuntary, partial paralysis of certain nerves and ganglia, notably those regulating the heart's action. There is one mental symptom of much importance, that frequently occurs at the commencement of delirium tremens, the non-observance of which is apt to prove fatal to the patient, and that is the suicidal impulse. This is part of the fear, and the "thousand miseries" to which the patient is a prey, but is so apt to exist before the other symptoms of the disease have been fully developed that it is not thought of or guarded against as it should be. Of the two thousand suicides that occur in this country in a year, a very large proportion indeed must be due to this cause. This fact is much lost sight of by systematic writers on the disease. Delirium tremens is one of the fields on which those who devote themselves to the treatment of mental diseases and the ordinary physician meet, and a correct idea of it is not obtained except when looked at from both points of view.

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There is a variety of true insanity that is very apt to follow an attack of delirium tremens, the one running into the other, that is not alluded to by systematic writers on the subject. When the motor and acute mental symptoms have passed off, the patient is found to labour under confusion of mind with suspicions, and often with hallucinations of hearing. This I consider a most critical stage in the disease whenever it occurs. It is most apt to be seen in cases who have a hereditary tendency to insanity, or in those who have had very many previous attacks of this disease. It is always a very anxious stage of the disease for the medical attendant, and is not without danger to the patient, suicide being frequently committed. The prognosis is in most cases good if proper treatment is adopted, and the points of the greatest importance in such cases is to get the patient out of bed whenever the suspicions appear, to stop any sedative or hypnotic medicines he may be getting, to have him walk much in the open air, or to send him for a change of scene under the charge of a trustworthy attendant or companion, and on no account think of sending him to an asylum. The mistake most apt to be committed by the family practitioner is to persist in keeping such cases in bed, while the specialist is apt to err in pronouncing such symptoms as true insanity requiring asylum treatment. The symptoms most apt to persist, and if so to affect the favourable prognosis, are the hallucinations of hearing.

The Insanity of Alcoholism.—This is, as you are all aware, a slow and chronic form of Delirium Tremens. As Trousseau says, "The mental phenomena are the same—they develope themselves more slowly, but their change of type is only apparent. Slacken the tumultuous pace of the fancies which jostle and caper in the maniac's brain, and although you do not thereby effect any essential modification, you will completely alter the aspect of his delirium. For the disgust, the repugnance at food which characterize febrile anorexia, substitute passive indifference, absence of appetite—the gastric state of chronic alcoholism. In place of disturbance of vision, or the changing hallucinations of delirium tremens, there are confused perceptions, *muscæ volitantes*, cloudiness, fogginess, and transient flashes of false light." An attack of chronic alcoholism is ushered in by the same sleeplessness and motor restlessness as one of delirium tremens, and Dr. Anstie thinks this "motor disturbance is independent of the

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peculiar mental restlessness." The disease is, as a general rule, easily distinguished, and is a very definite pathological entity both in its symptoms, causes, and course. It is a very curable disease at first, but as most commonly happens, when cured, the cause is soon at work again, and a relapse is the result. After a patient has had many attacks, there are certain mental, moral, motor, and sensory changes that take place, all running hand in hand, and abundantly proving the complete solidarity of the psychical and somatic functions of the nervous system. The intellectual power becomes weakened, they begin to exhibit many of the moral perversions and weaknesses, such as cowardice and untruthfulness, which I shall presently describe as characteristic of the dipsomaniac; the motor deficiency is shown by the muscular unsteadiness and trembling which become permanent, though aggravated during the acute outbursts, and there is a sensory paralysis of the limbs. All these things show degeneration of the nerve structure, from chronic poisoning, and excessive stimulation. Last of all a state of dementia is reached, the goal of all insanities, and that of alcoholism is in no way distinguishable psychologically from the profound dementia of other forms of mental disease. The motor and sensory complications alone mark its original form.*

Dipsomania.—This is a form of insanity that may conveniently be treated of at this point, though not nearly allied pathologically to alcoholism. Dr. Skae held very decided views as to the existence and well-marked character of this disease, and his opinions were the result of very much practical experience in the treatment of such cases. While he had no doubt that many persons labour under a true neurotic disease, the chief symptom of which is an intense craving for alcoholic drinks which they cannot control, a disease which presents all the characters of other brain diseases in being frequently periodic, in its damaging and weakening effect on all the functions of the brain when of long duration, in its being very commonly a hereditary affection, some of

* In the "Edin. Med. Journ.," for Dec., 1874, Mr. Hayes Newington, in one of "The Royal Edin. Asylum Papers," describes a kind of alcoholic mania of short duration, occurring as the result of alcoholic poisoning in a brain hereditarily predisposed to insanity, and very easily overset in its functions by a small quantity of the poison that would not be enough to cause delirium tremens. The brain gives way, in fact, from inherent weakness, before the latter disease has time to come on. The brain weakness is shown by the small amount of self-control, and the early tendencies to vice always shown by such cases. To this kind of brain disturbance he would limit the term "*Mania à Potu*."

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the ancestors and relations of the patients having the same disease, or suffering from other nervous affections, and lastly in its being frequently the result of physical causes that are also common causes of brain diseases, such as blows on the head—while he held this opinion strongly, yet he was by no means extreme or irrational in holding that all habitual drunkards are dipsomaniacs, or that it is always easy to distinguish between the two things. Last year Dr. Skae expressed his views in a very full and definite way before Mr. Dalrymple's Committee of the House of Commons, on his Habitual Drunkards' Bill. I think I cannot do better than give you an abstract of this evidence, the notes of which I drew up for him at his dictation the night before he went to London to be examined. He said, "I think there is a great variety among drunkards. First of all there is the regular drunkard who keeps sober during the day and gets drunk at night; attending to his business regularly. Such men may carry on for many years without injury to themselves or others. I have known one case where a gentleman was carried to bed drunk every night for 50 years, and yet he made a large fortune, and was in the market every morning attending to his business. I do not think that these are cases requiring any interference. The next class I would call the tipplers, who take small glasses of whisky or spirits of some sort, or ale or beer at intervals during the whole day." "Another class are what we call dipsomaniacs, or I would rather call it moral insanity, of which the drinking is one of the principal features. Those persons lose all control over themselves, and drink to any extent possible; in fact, they will drink anything they can get hold of, and if they cannot get spirits they will drink hair wash, or anything of a stimulating kind. Some of these cases are periodic, and come on at long intervals of time, perhaps two or three years; others come on at short intervals of time, perhaps every month or three months; those persons keep well for a few months, and then take ill again, when they lose all self-control. These cases are mostly hereditary, though very often caused by disease, by blows on the head, sometimes by hæmorrhage and the loss of a large quantity of blood, sometimes by disease of the brain. All these cases I mention to show that this is really a disease, and not mere cases of drunkenness. I think that these persons ought certainly to be restrained for a considerable length of time, in the hope of curing them of this craving. Then there is another form of

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insanity brought on by drinking, namely delirium tremens: that is a form of delirium rather than insanity." "Then, besides these, there are forms of insanity (with a craving for drinking) characterised by delusions, for example, hallucinations of hearing and seeing. These, I think, are truly insane, and have distinct delusions; they are very often suspicious of their friends, and are dangerous to be at large. I think that these are the principal forms which I have noted." "I have known a lady (who laboured under true dipsomania) drink shoe black and turpentine. There are other symptoms of insanity besides the mere drinking. Such persons are entirely given to lying. You cannot believe a word they say when under the influence of the drink-craving, and they very often entertain a dislike to their friends which makes them dangerous. I have a gentleman under my care just now, who has been well for three years, but when he is ill he hates his wife and he hates his own life."

Such is the variety of insanity denominated dipsomania in the table. In regard to its frequency as compared with other forms of insanity, I find that in the first thousand cases admitted into the Carlisle Asylum, there were 50 of this disease, or about 5 per cent. Its curability is, I fear, very slight; or, at all events, it is most apt to relapse.

Before I leave those varieties of insanity that result from poisons introduced into the blood (the syphilitic forms, delirium tremens, and insanity of alcoholism), I may mention two other very curious and interesting forms, not mentioned in the table, that result in the same way. Happily neither the one nor the other is met with in this country. Griesinger describes the cases of young men in a malarious district who suffered from attacks of insanity coming on in the one case every other day, and in the other every fourth day, both being cured by quinine. This was clearly a *Malarious Insanity;* in the one case being tertian and in the other quartan. The symptoms were acute delirious excitement, with delusions, coming on suddenly and accompanied by quick strong pulse and heat of head."

Pellagrous Insanity.—In certain parts of France, and much more in certain parts of Italy, a disease known as Pellagra is common. It is caused by the use of diseased Indian corn as an article of diet. The mental phenomena, which are part of the complete evolution of this disease, "are very interesting in themselves, and still more important as contributing

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another instance to the comparison of insanity with other diseases which is such a promising branch of study."* Prof. Lombroso has fully described the "Pellagrous Insanity" that is part of this disease in certain cases. He says it is characterised by "greater moral impressionability. A slight insult, the threatening of some trivial danger, completely carries them away, although they, perhaps, appeared before to be of sound mind. For example, a woman believes herself to be lost because she has missed mass; another person is in despair and goes mad because he has lent a pistol to a friend who will not return it. A woman hears her companions laughing at her dress, and becomes insane from grief; another, merely because her husband, a fisherman, is a few minutes late, breaks out into violent mania." "A real or apparent stupidity, an obstinate mutism"—called by Lambroso "a psychical catalepsy"—is common. A most curious symptom of pellagrous insanity, and one said to be the most characteristic of all, is what is called by the Italian physicians "Hydromania." "In one set of cases water is sought or desired on account of its coldness, in another set from its shining surface, the latter set being equally fond of the sight of fire, and will burn furniture to see the blaze. A third set of such patients have a profound dislike for the sight or touch of water on account of the vertigo it instantly produces in them. The symptoms are intermittent, being most common in the colder months. After death distinct pathological lesions are found in the brain. The most wonderful thing of all about pellagra and its insanity is that it is only curable by arsenic, and no other remedy, and that its recurrence is preventible by first steeping the diseased grain in lime, and then subjecting it to heat.

Post-Febrile Insanity.—The next form of insanity I shall refer to is that called by Dr. Skae post-febrile insanity. The exhaustion of the vital powers that is caused by zymotic diseases sometimes takes special effect on the higher functions of the brain, and we have an attack of insanity resulting. The nervous affections that often follow fevers in children are well known. These, no doubt, are precisely analagous to the post-febrile insanity of the adult. That insanity which sometimes followed fevers was known from the earliest times, and was evidently much more common two hundred years ago than now, but it was then ascribed not to the exhausting effects of the

* Dr. Gasquet, "Journ. Ment. Sci.," January, 1872.

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fever, but to its not having been treated with "sufficient dilution" and purges to carry off the entire *materies morbi*, thus leaving a dangerous element in the system that was liable to fly to the head, and cause insanity. Arnold thought that insanity was much less common in his time than in Sydenham's after fevers and agues, because they purged more than the older physicians, and used the Peruvian bark more freely. Post-febrile insanity is not specially confined to one kind of fever. I have gone over the records of over a thousand cases of insanity that were sent to the Carlisle Asylum, and I find that among those there have been ten cases of such post-febrile insanity, four of which followed scarlet fever, two small-pox, one typhus, one typhoid, one intermittent, and in the tenth case I could not ascertain the exact form. Those are small numbers to determine the statistics of a disease, but I am not aware of any fuller statistics on the subject. I think those numbers represent in a general way the comparative frequency of its occurrence after the different fevers. Scarlatina is unquestionably the most frequent cause, and small-pox the next. It is said to follow typhus more frequently than typhoid, and as intermittent fever is now unknown in this country, this is a very rare cause of the disease. Whether this represents the comparative exhausting powers of the poisons of those fevers on the brain, or whether scarlatina is at the head from its greater frequency, or from its more common occurrence in youth when the brain has not attained its maturity, I am unable to say with certainty. The form of insanity that results after scarlatina is almost always characterised by symptoms of dementia which is incurable. We might expect this from the well known occurrence of idiocy and epilepsy in children after this disease of sequelæ and complications. More frequently than after any other fever we hear the remark, "Such a person has never been the same since he had scarlet fever." On the whole I think there is fair ground for the assumption that the poison of this disease is more apt to leave permanent brain disease than any of the others. When mental symptoms follow the disappearance of scarlatina they do so at once; the patient not having an attack of acute excitement so commonly as that he is left after the disease in a state of partial dementia. The weakness of mind is not complete, but more of a partial imbecility, a blunting of all the mental faculties and affections, with attacks of sub-acute excitement and irritability. In

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two of my four cases there was deafness along with the imbecility, showing that the effects of the disease had not been confined to the brain convolutions, but had also affected the centres of special sensation.

The form of insanity that follows small-pox is of the same character as that of scarlatina, but is even more incurable. That of typhus and typhoid is more clearly the result of brain exhaustion from those diseases when they have continued for a long time. The patient seems to come out of the fever, showing no particular symptom of weakness of mind or insanity until some weeks afterwards, when he takes an attack of acute excitement, or "gets into a low way," and a long continued intractable depression results. Tuke and Bucknill and Maudsley say that the insanity that follows typhus is of a more incurable kind than that resulting from typhoid. Sydenham describes the form of insanity that used to follow ague, and in his time this seems not to have been uncommon. He calls it a peculiar form of mania, and says that the long continuance of the fever, and its being of a quartan type, seem to produce the mental symptoms more than any other circumstances. If treated by the exhibition of strong evacuants it degenerates into hopeless fatuity. My single case of the disease was that of a sailor who had regular attacks of ague, drank hard, lived on salt provisions during his voyage home, and on his arrival had an acute maniacal attack. He was thin, pale, and slightly scorbutic. I treated him with abundant diet, malt liquors, fresh air, quinine and iron, and a few draughts of chloral at bedtime, and he was quite well again in two months, having gained 20lbs. in weight in that time. In this case, of course, there were the other causes of brain exhaustion as well as the ague.

Of my ten cases only the last mentioned patient, and one of the scarlet fever cases, had acute symptoms of any sort, and they were the only ones who recovered. All the others were incurable, six of them being hopelessly demented, and the two others hopelessly melancholic. There was hereditary predisposition to insanity in only three of the ten cases.

Post-febrile insanity may be said, therefore, to be generally characterised by sub-acute symptoms, to result clearly from the brain being poisoned by zymotic poison and exhausted by fever, not to require a hereditary tendency for its development, and to be a most incurable form of insanity from the beginning.

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While on the subject of fever and insanity, a very singular fact deserves notice. The delirium that so often accompanies all sorts of fevers and inflammations is wonderfully like the maniacal symptoms of many kinds of insanity, and unquestionably the general state of the brain cells must be much the same in the two conditions, yet I never knew an attack of inflammatory or feverish delirium to run on without an intermission into an attack of maniacal excitement, however predisposed the patient might be to insanity. How little do the mere general symptoms of a disease of the nervous system indicate to us its essential nature and true pathology!

Insanity of Oxaluria and Phosphuria.—All writers on the urine have noticed the hypochondriasis, depression of mind, want of energy and originating power, and the irritability that often go along with the presence of much oxalate of lime or phosphates in the urine. Dr. Prout thought that the mental state was probably the cause of those abnormal products in the urine, and he especially mentions "a nervous state of the system, and particularly mental anxiety or fear," as causes that "will frequently produce in many people an excess of the salt in the urine."* Golding Bird says that "persons affected with 'oxaluria' are generally remarkably depressed in spirits, hypochondriacal, extremely nervous, painfully susceptible to external impressions, and in many cases labour under the impression that they are about to fall victims to consumption." He says, in reference to phosphuria, that there are cases with this condition characterised by high nervous irritability, following injury to the spine. The late Dr. Begbie directed special attention to oxaluria as a cause of a nervous disorder which was characterised by a very highly neurotic condition of the patient. He says such patients are commonly in the prime of life, belong usually to the upper classes, and have indulged freely in the good things, especially the *sweets* of the table. He says their sufferings often threaten their mental condition. "They are usually peevish, sensitive, and irritable, or dull and desponding, and melancholic." "They are not unfrequently hurried to the brink of mental derangement." His theory of the causation of these miseries is that they "flow from the oxalic diathesis from a poison generated during the process of digestion and assimilation, carried into the blood by the

* Prout, p. 176, 2nd ed. G. Bird, p. 250 and 307.

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ordinary channels, but limited in its pernicious consequences by the busy agency of the urinary organs in separating it from the circulation, and discharging it from the system." Several of the cases he gives were certainly almost insane, but I fancy few such require asylum treatment. He shows that the nervous symptoms are apparently a result of the oxaluria, and disappear under the treatment that cures it. There is, on the other hand, no doubt of the fact that oxalates may be found in very great abundance in the urine of persons in good health. Lehmann, Bence Jones, and Garrod, and many others, direct special attention to this fact. The former, along with many other physicians, think that its appearance is not at all essentially connected with any special disease or train of symptoms. Speaking generally, the chemical physicians who have written on the urine take this view, while the clinical physicians take the opposite.

Dr. Skae held the opinion that there were certain cases of insanity with melancholic symptoms, directly dependent on the oxaluric and phosphuric conditions. They were usually men rather over the prime of life, who had exhausted their brain power by over work. They were frequently suicidal. The prognosis was very favourable in these cases.

Undoubtedly one of the strong arguments in favour of the view that such a variety of insanity exists, and one of the most certain means of saying that any particular case should be classed under it, is the fact that the treatment for oxaluria under which it disappears seems to cure the insanity also.

It may of course be said that we know so little of the real conditions associated with oxaluria that it is scarcely justifiable to assign it as a cause of any form of insanity. The conditions under which the oxaluria appears may be merely the symptom of some other disease of which the morbid psychosis is also a part, or it may be the *result* of the disordered brain condition instead of being its *cause*. I think probably Dr. Skae would have said, in answer to this, "Well, supposing this is so, yet if there is a characteristic and special form of mental disease in any way associated with oxaluria, and the knowledge of this fact will help us to understand its course, its prognosis, and its treatment better than we should have been able to do without this knowledge, then that is all I mean by calling it an insanity of oxaluria or phosphuria. It is the chief value of my system of classification that it is

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bound by no principle, etiological or other, except that of enabling us to know something more about our cases than the old system, and classifying them in more natural groups."*

Insanity of Bright's Disease.—Though not mentioned on Dr. Skae's list, there is a variety of mental derangement, half delirium and half mania, which results from uræmic poisoning. I have met with two cases of this disease, and Dr. Grainger Stewart says he has also seen a case of this kind. It usually occurs in chronic cases of Bright's disease, with contracted kidneys, where there has been enlargement of the heart, and a tendency to dropsy for some time, and where the central nervous system has been long subjected to the influence of imperfectly purified blood. The symptoms present are mania of a delirious kind, with extreme restlessness, delusions as to the persons round the patient, an absolute want or fear of jumping through windows, or other actions that would kill or injure the patient. The symptoms are characterised by remissions, during which the patient is quiet, and rather composed in mind, but rational, and very prostrate in body. One of my cases was a man of 50, with a family history of insanity, who had once been much depressed in mind (but was not in an asylum) after a fever. He seems to have had heart disease for many years, and to have had Bright's disease for at least two or three years previous to his admission into the asylum. He had dropsy of his legs for some weeks before the mental symptoms began. He was at first morose and irritable to a morbid degree, and steadily got worse in mind, his symptoms changing to exaltation and excitement, fancying he could do wonders, had absurd schemes of making money, and threatened to murder everyone near him. On admission he was in a state of mental exaltation and excitement, gesticulating, saying he has been married, and had no children (which were delusions), and his memory quite gone. His speech was thick and indistinct, his tongue coated, his pupils dilated, and slowly sensitive to light, the reflex action

* The following case has been kindly sent me by my friend Dr. Grainger Stewart:—"Wm. M., æt. 39, a light-house keeper, applied for advice at the Royal Infirmary, July 21st, 1871, complaining of lowness of spirits and want of appetite. His friends explained that his depression had been such as to compel him to give up his employment, that he had been jealous of his wife, and required constantly to be looked after. His urine contained oxalates. Ordered to be looked after, and to take 20 drops of nit. hyd. acid, dilute, three times a day. 31st, greatly better; no oxalates. Aug. 20th, quite well."

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of the cord dulled, and temperature below normal; legs œdematous; his lungs were dull at bases, his heart hypertrophied, had a loud murmur with first and second sound; urine contained much albumen, and a few tube casts, sp. gr. 1020. This man alternated between this state of mind and that of a drowsy, stupid, but fairly rational condition, till two days before his death, when he got semi-comatose, with fits of delirium. He only lived five weeks after admission, or about two months from the appearance of his mental symptoms. This is a typical case of the disease. No doubt the mental cells of his brain were the weak point of his central nervous system from his hereditary predisposition to insanity, and the uræmic poison took effect there instead of causing convulsions.*

The Morbid Psychology of Criminals. By DAVID NICOLSON, M.B., Medical Officer, Her Majesty's Convict Prison, Portsmouth.

(*Continued from page* 551, *vol.* xx.)

II. STATES OF MENTAL DEPRESSION.

Melancholy, including Hypochondriasis, Home-sickness, and Self-innocence as to Crime.

We have seen that Simple mental weakness, the first form of weakmindedness, is neither more nor less than a want of mind, in some degree. In it the higher emotions are blunt, perception is dull, and all the processes are backward or sluggish.

In the States of depression which make up the second form of weakmindedness, the general condition of mind may be described as one of *inertia*, in the presence of a prominent activity in one direction. In well marked cases of morbid mental depression (not limiting ourselves just now to mere weakmindedness), the perceptive, intellectual, and reasoning faculties which are the normal belongings of the individual are made latent through torpidity of volition. The will is without energy; it is incapable of exertion; it cannot act; it is paralysed. This want of volitional power appears to be induced by an intense activity of self-consciousness, which

* Since the above was written, Dr. Wilks has directed attention to "Mania as a symptom of Bright's Disease." Jo. Ment. Sci., July, 1874, p. 243.

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