admissions were actually less by twenty-three in 1907 than in 1906. The committee think that they are justified, on the whole, in assuming that the rate of increase of insanity in their area is a decreasing one, and, as far as we can see, this is so. Therefore they are averse to building their eleventh asylum, for the present at all events. The Lunacy Commissioners have been pressing for this for some time past, but in addition to the fact mentioned above, the Committee have in view the possibility (now turned into a certainty by the issue of the Report of the Commission on the Feeble-minded) that unification of London lunacy administration would become probable. When this is carried out a considerable quantity of unused accommodation provided by the Metropolitan Asylums Board will be available. The Committee are further of opinion that a good deal has to be said about the certification and adjudication of pauper lunatics in relation to asylum accommodation. Until all these points are settled they propose to hold their hand.

The Report deals at some length with the really splendid offer of Dr. Maudsley in relation to a mental hospital. That offer has been already discussed in these pages.

In lamenting the large quantity of recurrent insanity, and the necessity, for legal reasons, of discharging those who are certain to come back again, the Committee hint at the urgent need for steps being taken "to reduce the alarming possibilities which now exist for the multiplication of degenerates by the unsound of both sexes."

The Statistical Tables of the London County Asylum.

We must confess that at first sight the amount of space taken up by these tables is startling. They occupy 160 out of the 360 pages contained in the report. The next impression is one of admiration for the zeal which has prompted the carrying out of this vast scheme of tabulation. The work is enormously increased by the fact that the figures of the contributing asylums, which in themselves are gigantic, are worked up together and summarised into one tangible whole. Where averages have been called for in individual asylum reports, they have been provided in the summary. We feel that the Asylums Committee and its officers have laid every one concerned under a deep obligation in undertaking the heavy work of setting out in practicable form the facts recorded by its medical staff. There can be no gainsaying the fact that the present mass of information is the most valuable contribution that has up to this time been made to the statistical side of psychiatric science. The work has, indeed, been done well, set out plainly and conveniently. One great result of the new scheme, as it affects London, is that in the most important matters, such as causation, forms of insanity, and causes of death, it has become possible, for the first time, to give summaries of all the asylums' returns.

Turning to the scheme itself, it is only when one takes in hand this huge but compact enumeration of medical facts, relating to one-fifth of the pauper lunacy of the country, that one recognises the immense stride taken by the Association in the adoption of a new scheme of

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record. At the very outset the value of the cardinal differentiation between direct and indirect admissions is emphasised by the happenings of this first year of new tabulation. Instead of an average of 10 *per cent.* of the admissions being transfers a full third is shown, mostly due to the opening of Long Grove. This alone would have vitiated any comparison with preceding years. In other directions new lights, that cannot fail to be instructive, are thrown on questions, while, for anyone who takes a real interest in asylum figures, there is now ample scope for inquiry and thought, which may be applied without a feeling of their being wasted. The following are some of the points which appear to be worthy of note:

In Table A 2 we can compare for eighteen years the difference in results between calculating total recoveries on *total* admissions, and the same on *direct* admissions. The mean of the former is 30·65 *per cent.*, with variations between 22·18 (lowest) and 42·09 (highest), while in the latter case the analogous rates are 37·84, 31·78 and 45·88. Obviously the inclusion in total admissions of a quantity of indirect cases (mostly chronic transfers) tends to debase the recovery-rate on total admissions, and the coincidence of low recovery-rate with many indirect admissions is to be expected. But for some reason or other, not at present very obvious, the higher rates in the second method of calculation also coincide with the lowest number of these indirects. Can it be that the disturbance caused by the addition of abnormal amounts of chronic insanity tends to interfere with the treatment of recoverable cases? The number of direct admissions does not in itself seem to have any effect on the recovery-rate calculated on them.

Of 3,552 direct admissions only six (three of each sex) were sent out as not insane on admission. Seeing how easily delirious conditions, arising from other causes than insanity, may be mistaken for the latter disease, those figures demonstrate the immense care taken in certification.

The greater detail of duration of insanity on admission, as provided by Table B 2, does not seem to have altered the results generally found under the old system. It seems somewhat strange that of about 2,400 first-attack direct cases (excluding congenitals) 900 should have been kept out of the asylum for more than three months. As might be expected, the "not-firsts" returned much more expeditiously on relapse.

The Table B 3, dealing with age and civil state in the total of patients, does not disclose anything fresh, the disturbance in the usual relations between single, married and widowed, being probably due to the fact that one-third of the total admissions were transfers. But in the next table, B 4, which deals with the same elements in detail, and in regard of direct cases only, there is some novelty. From the total of direct cases, congenitals and "unknown-whether-first-attack-or-not" cases are removed, and the remainder are divided into "first-attack" and "not-firsts." In regard to the latter the age on first attack is recorded. It should be pointed out that in this table (B 4) the age treated is that at the commencement of the attack, whereas in the preceding table age on admission is dealt with. The average age of the first-attack cases works out at about forty-two, one year less than the

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age on admission of all cases, whereas the age on the commencement of the first attack, in those cases in which there had been more than one attack, is approximately thirty-five. We offer, for what it is worth, the suggestion that this disparity tends to show that those cases, in which a recurrent element will probably reveal itself, first happen at an earlier period than in those cases in which relapse is less probable. The fact that there is, on the average, seven years' longer opportunity for recurrence in each of the earlier cases has but little effect on this argument, since there is, as we know, plenty of time for recurrence after forty-two.

Table B 5 gives information that has never been summarised before in London, in consequence of views on classification having been hitherto difficult to homologate. There seems still to be some considerable want of harmony as to the precise interpretation of some of the terms in the new scheme. No great harm, however, is likely to arise, as there seems to be no doubt about the more frequently found and important groups. The volitional group (No. 12) and moral insanity (13) seem to command but very slight attention anywhere. The group made up by confusional insanity, stupor and primary dementia, all phases intimately connected with the evaluation of the term "dementia præcox," seems as little likely to be harmoniously interpreted as is this latter subject of contention. It would be interesting to know the respective views of the recorders as to what constitutes primary dementia. In 3,558 direct admissions this form of dementia is returned 93 times. In the four older asylums, admitting 1,676 direct cases, it was assigned twice, the other 91 entries occurring elsewhere in the balance of 1,772 admissions. It will be desirable, if not entirely necessary, that before long some authoritative interpretation of the particular term should be given. The new delusional group (11) seems to be quite a success, being made use of in about one-tenth of the direct and in a full quarter of the indirect admissions. In regard to the latter, its institution must be a source of relief to those who have hitherto had to make a choice between chronic mania and dementia. As between systematised and non-systematised delusion the results follow expectation, the former predominating in the transfers, the latter in the direct. We note that Dr. Stansfield introduces for one case the term "convalescent," a sort of half-way house between declared insanity and "not insane." This seems to us to be a very excellent way of dealing with cases which not infrequently cause a medical superintendent some heart-burning. He does not, we may feel sure, wish to suggest any doubt about the diagnosis of his brother outside, yet justice to the patient drives him that way, unless it can be shown to be possible that the case has been examined under differing circumstances. The term, so far from suggesting doubt, by implication supports the previous diagnosis. The fortunate infrequency of acute delirium is shown by its occurrence in only 8 out of 3,558 direct admissions.

The Occupations Table (B 6) establishes a point touching one form of environment. With one exception the returns show that the age-incidence of insanity is absolutely undisturbed by occupation. Whether in individual trades, under which are entered sufficient numbers to warrant consideration, or in the summation of the table page by page, or in the

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summary of the pages over which the table extends, the same result is found, closely adhering to the figures shown in the age-on-admission table. The column for ages 35–44 is best filled. Next comes the column on the left, from 25–34, and then the column to the right, from 45–54. The first of these everywhere contains about one-fourth part of the first-attack admissions (excluding congenital cases) to which this return is wisely confined. The exception alluded to above is in regard to female domestic servants, in whom the chief incidence is brought forward ten years, that is to say, the maximum appears under 25–34, the contiguous columns bearing the same relation to it as shown above, *viz.*, highest to the left, the next highest on the right. As the number of this class is very considerable, forming more than one-sixth of all the female cases, the general average would have been affected to some extent had it not been put right by the large number of female "no occupation" cases under 35–44. So the two sexes, on totals, closely correspond to each other and to the general age average. It should be noted that the "no occupations" were 73 among the 1,224 males and 681 among the 1,283 females. This table is full of interesting points; that of the earlier incidence among domestic servants might repay attempts at elucidation.

Table B 7, dealing with ætiology, is doubtless the one from which most is hoped. In time it certainly must afford valuable help in social, as well as medical, questions. There is, however, scope for the influence of considerable variation in medical opinion on certain points, such as has been alluded to already. In this table the chief point of variation is the difference between *principal* and *contributory*. There was in the old days a similar want of harmony between the then-existing terms *predisposing* and *exciting*. Curiously, as far as we can see in comparison with the former tables of this Council, the same proportion of doubt exists now as then, although it must be stated that now doubt relates to individual cases, while then it was in relation to causes assigned. Then, as now, this state of doubt was not general apparently, but felt by a few only. It is to be hoped that eventually there will be some way of getting over the difficulty, which, though it can be discounted in the study of individual asylum returns, must affect the general value of the summary. As to non-assignment of any cause at all, through failure to discover assured factors, the ratio remains about the same, *viz.*, about 12 *per cent.* But, as this year the prolific "cause" of previous attacks is excised, it must be held that investigation has been either closer or more successful. It has to be noted that, in comparison of the present with former years, direct admissions only are now treated. About 5,800 factors have been scheduled in respect of the 2,462 cases in which definite opinion is expressed. As only one factor is allowable to each case under the head of "principal," it follows that about 3,300 contributories have been marked.

As to individual factors alcohol stands out pre-eminent as usual. It is followed by other factors as shown in the following synopsis.

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	Principal.			Contributory.			Total.			Commissioners' Tables.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.(1)
Alcohol	272	223	495	275	60	335	547	283	830	377	162	539
Mental stress prolonged	186	267	453	141	128	269	327	395	722	—	—	—
Heredity (insane)	101	53	154	235	315	550	336	368	704	350	468	818
Cardio-vascular degeneration	13	3	16	200	153	353	213	156	369	—	—	—
Syphilis (acquired)	81	5	86	202	35	237	283	40	323	90	17	109
Senility	56	98	154	79	73	152	135	171	306	132	161	293
Epilepsy	109	66	175	45	41	86	154	107	261	—	—	—

(1) Figures for all England reduced to basis of L. C. C., total admissions.

The effect of "previous attacks" is shown by the sub-joined contrast between the relative frequency of certain factors in "first attack" and "not-first-attack" cases among those in which a definite ætiology is assigned:

	First attack. (M. 871 F. 934 T. 1805)			Not first attack. (M. 236 F. 314 T. 550)		
Alcohol	377	200	577	142	73	215
Heredity (insane)	234	242	476	85	109	194
Mental stress prolonged	242	278	520	72	106	178
Cardio-vascular degeneration	139	130	269	52	21	73
Syphilis	229	34	263	37	3	40
Senility	99	140	239	24	23	47
Epilepsy	113	79	192	22	13	35
Puberty and adolescence	71	95	166	15	27	42
Climacteric	1	125	126	1	43	44

We are glad to see even one case of a male returned under the head of climacteric. We believe that this factor might be returned oftener with truth and advantage.

Table B 8, working out the correlation of factors—the apple of the Statistical Committee's eye—demands an amount of attention which we cannot pretend to be able to give it now. It is immense and most praiseworthy. The precise bearings are yet to be worked out and valued. But that there is in it a mine of important information cannot be doubted, and the results must be more striking as year after year is added to the period of observation. We may here, however, state that according to this table in 334 admissions of general paralytics (M. 267, F. 67) the following correlation of factors was found in males, females, and total. Insane heredity, 35, 12, 27; alcoholic heredity, 16, 5, 21; prolonged mental stress, 41, 7, 48; alcohol, 64, 8, 72; syphilis, 131, 8, 139; cardio-vascular degeneration, 18, 5, 23; sexual excess, 9, 1, 10. Other factors were correlated in smaller quantities.

In Table B 9 general paralysis is dealt with in another way, and we venture to think that the statements contained in this table are very striking. We summarise them thus:

	Direct admissions.			General paralytics.			Ratios.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Single	733	732	1465	67	9	76	9·14	1·22	5·19
Married	808	828	1636	182	44	226	22·52	5·31	13·84
Widowed	143	306	449	17	14	31	11·73	4·57	6·90
Unknown	6	2	8	1	—	1	16·86	—	12·50
	1690	1868	3558	267	67	334	15·80	4·01	9·10
Syphilis noted in				136	13	149			

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The markedly smaller ratio occurring in the single cases may be to some extent accounted for by the larger proportion of unmarried people admitted in the periods of age when syphilis could hardly be acquired. But as these cannot number more than 250 the operation of this explanation is very limited, and the fact must remain that the incidence of general paralysis on married folk is a long way heavier than on single people, and less so on the widowed. As to the age incidence of general paralysis, the highest period is 35–44, then 45–54, next 25–34 and 55–64. Of four cases occurring in the period 20–24 three were females. Congenital syphilis accounts for only three cases against 146 in whom it was contracted by the individual.

Table C 2 does not show any fresh value at present. The correlation, peculiar to the table, between age at commencement and the duration of the attack, will require the accumulation of many years' experience before results of any worth can be deduced. In the old scheme it was possible to compare ages of all admissions with ages of all recoveries. But, of course, in such a year as the past one, in which one-third of the admissions were transfers, more or less chronic, the results of such a comparison would be utterly useless for contrast with preceding or succeeding years. Under the new system a comparison can be made with the more stable element of direct admissions. But, as said, some years must elapse before any useful results can be obtained.

C 3 gives much the same information as was obtainable before, regarding the forms of insanity which yielded recoveries. It is now given in summary for the first time in London. The chief point of interest, however, in the table as it now appears, is that, with one exception (moral insanity), every form of insanity in the whole official schedule has had its recoveries. Thus we read of 17 cases of secondary dementia getting well, 3 general paralytics, 6 with grosser brain disease, 38 with epilepsy, and 5 senile dements all having the same good fortune. These facts give rise to much reflection. The happenings have not been confined to one or two of the contributory asylums. Each has had one or more cases which have got well under circumstances that, in the general acceptance of terms, would preclude such a result. It cannot be doubted that there is in reality no general acceptance of terms such as to insure harmony in record. There may, of course, be here and there errors of original diagnosis, but the number of the cases, and the undoubted competence of those who have to judge, render it certain that difference of opinion, and not error, is at the root of the matter. Some doubt must attach to the term "recovery." To know exactly what absolute recovery means presupposes a knowledge of what constitutes perfect sanity. This knowledge being denied us, or being, at least, incapable of exact expression, it follows that all the criteria of recovery that are applicable can be only relative—relative to the average of man's mental, intellectual or emotional condition; relative to the pre-existent state of the individual or even to his present capacity to conduct himself and to provide for his own circumstances. The Statistical Committee were very wise in refusing to attempt any definition of this and related terms. Then, there is another fruitful source of difference of opinion—the exact interpretation of some of our commonly used

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names for disease. Dementia is, of course, the one which is most open to discussion. As is well known, some of our best authorities denounce its application to any form of mental weakness that can by any chance recover—indeed, the basis of actual degradation of brain structures, which underlies this contention, forbids the idea of amelioration of any kind. As against this, we find these twenty-two cases mentioned before as recovering from senile or secondary dementia. We do not include here any case of primary dementia, though the same principle of terminology is involved. It may be right in theory to restrict the significance of the term to one of confirmed hopelessness, but if this is to be so, a duty lies in those who support this to devise a term that will cover the conditions from which these twenty-two people have emerged. If they did not suffer from dementia, under which other head could they be returnable? We think that as it is there is a considerable amount of consequential or intercurrent mental weakening of a temporary nature, that goes now without any label, unless it be exhaustion from this or that, simply because there is no other fit term for it but this dread dementia. There is much in this and similar questions that needs adjudication by our Association. Until this takes place we can but hold that each man is entitled to speak of facts as he finds them.

One would have thought that systematised delusional insanity would have proved more intractable than the non-systematised variety. But comparing the thirty of the one and the thirty-three of the other with the general prevalences of the two forms, as indicated by the number of admissions (Table B 5), we find that the proportion of recovery is much the same.

C 4 brings forward entirely new matter, and we venture to think that it will eventually prove to be one of the most valuable of all the tables. The elucidation of ætiology—the prime question in the study of mental disease—cannot but be greatly assisted by the comparison of the known results of various ætiological incidences. The contrast made in the present table, between the factors ascertained on admission among the admissions with the same found among those who recovered, must be made with the full understanding that the two sets of figures do not necessarily apply to the same persons, and that in any case the classes from which the facts are gathered are not the same in both instances. The facts found on admission come from direct cases; those referring to recoveries are drawn from all recoveries, whether originally admitted direct or on transfer. With these reservations must be joined another —that, for reasons already given, total incidence of factors is taken in preference to "principle" incidence. We find that the following relations exist in some of the more interesting particulars, the number of cases in which factors were found on admission being shown in brackets. Insane heredity 300 (704), alcoholic heredity 46 (226), neurotic heredity 31 (62), congenital mental defect 74 (234), puberty and adolescence 64 (211), climacteric 58 (176), senility 24 (306), puerperal state 35 (77), lactation 14 (43), mental stress—sudden 96 (180), mental stress—prolonged 341 (722), privation and starvation 54 (169), alcohol 349 (830), influenza 23 (72), syphilis—acquired 50 (323), epilepsy 30 (261), cardio-vascular degeneration 47 (369), cases in which no factor was assignable, notwithstanding full history and observation

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39 (101), the same with defective history 95 (330). It will be noted that the highest proportion of recoveries to admissions is found just in those cases in which the exact force of the factors, as applied to individuals, is least definable, *viz.*, in prolonged mental stress and heredity of insanity. The low proportion subsisting between the admissions and recoveries in regard of alcoholic heredity is notable, and serves to support the views of those—Drs. Clouston, Robert Jones, Menzies, Parker, and others—who for years past have demonstrated the danger to offspring arising from parental inebriety.

Table D 1, giving the causes of death, divided into principal and contributory, and showing the correlation of the various causes, is all new work; in fact, this is the first occasion on which the causes of death have been summarised at all. The new departure, in denominating the causes, probably makes it easier for the certifier to assign a particular cause, but it does not remove difficulties or differences of practice any more than is the case with the new terms used in the ætiological tables. For instance, the efficiency of "senility" as a cause is viewed in various lights. Of the 1503 deaths, just 10 *per cent.* are returned as principally due to old age. In the individual asylums, leaving out the newer ones, the same percentage varies from 1·3 *per cent.* to 25 *per cent.* In only one asylum has it more than a negligible influence as a contributory. The correlation of the causes will have to accumulate for many years before results of any real value can be looked for. The causes of death were verified by *post-mortem* examination in 87 *per cent.* of the deaths. A little over one-third of these were due to diseases of the brain and nervous system, general paralysis taking precedence of all causes with 313 in number. In nine cases it was considered to be only contributory. Phthisis comes next with 196 cases as principal and 32 as contributory.

Table D 2 is very much the same as old Table V, the principal causes only being taken for correlation with age. We notice, however, that the arrangement of the cases is by no means the same in this table as it was in the last. The order, and indeed the grouping, still differ in some of the asylums. It is true that in the summary the latter is adhered to in both tables, but inside the groups themselves there is some dissimilarity between the two tables. This, no doubt, arises from the difficulty of harmonising the various forms of the table submitted to summarisation, but it is inconvenient. Further, actual error creeps in; for instance, at the very head of the list in Table D 1 the tuberculous affections count up as 210; in D 2 they make 213. It would be a great boon if every item could always be found at exactly the same place in the list in each table.

Table D 3 will in time be one of those which may be of great service, should the question of probable duration of life be again raised in relation to the insane. It will be remembered that a few years ago Sir William Gowers showed much interest in it. With regard to a lethal disease, such as general paralysis, the returns are very useful. Of 308 cases 25 died within 3 months' duration; 27 from 3–6 months; 20 from 7–9 months; 22 from 10–12 months; 92 from 1–2 years; 57 from 2–3 years; 51 from 3–5 years; and 14 over 5 and less than 10 years. The mean duration, taking the mean of the respective periods for the

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purpose, was just over 24 months. The inner question of the average duration in each form of paresis has still to be worked out, but should repay investigation. The average duration in the females was somewhat higher than in the males. Of 51 who died with a duration of 3 and less than 5 years, 36 were males to 15 females. With 5 and less than 10 years the relative numbers were 8 and 6. The numbers for any one year relating to acute delirium would be too small and uncertain to supply foundation for computation. The figures, however, for the past year stand thus: 8 cases were admitted; 1 recovered, 3 died, and 4 remained December 31st. One of the deaths occurred within one month of seizure; the other two between one and three months' duration.

The immense influence over the death-rate exercised by general paralysis is shown thus:

	M.	F.	T.
Ratio of *all deaths* to average daily number on registers	9·65	7·59	8·47
The same after cases of general paralysis have been removed from residence, and deaths	6·66	6·96	6·84

The mortality rate as between the sexes is actually reversed.

The remaining tables, dealing with the residue at the end of the year, offer but little ground for present remark. They both will be of importance in the study of duration of life in the asylum when that comes to be considered. But it will require an accumulation of many years before valuable information can be extracted from them. We are not quite sure that the substitution in Table E 2 of the form of mental disorder at the time of report, for that on admission will, from an actuarial point of view, be a success. In neither, of course, can individuals be followed, but in some forms of disease the fate of classes could be dimly traced, with the concurrent assistance of Tables B 5, C 3, and D 3 under the former definition.

In leaving this part of the report we must renew the expression of a feeling of admiration for the method in which the Asylums Committee and its officers have taken up their share in this great work. We look forward to the time when the area covered will include the large portion of London lunacy now administered by the Metropolitan Asylums Board. The present may, we feel sure, be taken as an earnest of the future.

The happenings in the individual asylums of the county have not been such as to lead to much remark here. The opening of Long Grove naturally entailed much labour and responsibility on Dr. Bond, who is grateful for being able to record the removal of about 1,200 cases from other asylums, where they had been boarded out, without any accident. We note that many of these proved to be of the noisy, violent and turbulent class. At Claybury, Dr. Robert Jones reports an unprecedented number of accidents and fractures, apparently in relation to the state of the polished floors, which is receiving the attention of the Committee. Of course imperviousness to fluids of all kinds is a great desideratum, but the placing of slippery surfaces under general paralytics and other feeble folk does not seem in the asylum to be regarded as irrational as would be the case outside the asylum. At the Epileptic Colony it is found that the supply of inmates from the other asylums is

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rapidly lessening, only six out of a total of eighty-seven admissions arriving after special appeal. In consequence direct admission from the parishes is growing, with the result that adolescent cases become more numerous.

Dr. Mott, in his report as Director of the Pathological Laboratory, states that the condition of the asylums as regards dysentery and diarrhœa has improved. In 14·59 *per cent.* of autopsies active tuberculous mischief was found. We note with pleasure that Dr. Mott has been selected to give the Morrisonian Lectures in Edinburgh for this year. The researches of Dr. Candler, made in the relations between diphtheroid organisms and general paralysis, entirely refute, Dr. Mott thinks, the assumption that the presence of these organisms in the blood and tissues of those suffering from paresis can be regarded as anything more than an accidental secondary or terminal microbial infection.

London Metropolitan Asylums Board.—The Commission on the Feeble-minded having reported on the evils of duality in the management of the insane of London, and having recommended that this authority shall not continue its share of the work, we suppose that in the course of time the Board will disappear from the scene. When this time comes, it may solace itself with the reflection that, in spite of the unpromising nature of the invalids who have been committed to its care, it has done an enormous amount of good in its day. Especially in its care of imbecile and deficient children has its work been notable and beneficent. The duties of the new body, whatever it may be, will prove to be lighter on account of the foundations laid down by the Asylums Board. We must confess that, as we have often said before, on every account one body must be better able than two to undertake one subject, but we hope that the new authority will be representative, not only of the County Council, but of this Board as well.

In the general report mention is made of the increasing evil of removing senile cases from workhouse wards to the Board's Asylums. Over one-quarter of the admissions exceeded seventy years in age. On the other hand the age limit of imbecile children has been lowered from five to three. It will be interesting to see if any improvement in general conduct and habits will ensue from this earlier coming under skilled control. So many senile and sick folk having been admitted of late, it has become necessary to cut up the big wards in many cases into smaller ones, as the former were found to be quite unsuitable. As Dr. Needham points out, this arrangement may be more expensive at first sight, but the extra cost of maintenance may be compensated by better supervision that will be entailed. The Asylums Committee speak very warmly of the efforts made at Darenth for the training of imbeciles in remunerative trades. They regret that it was not possible for the whole Board to have inspected with them the arrangements and work done. As is right, warm praise is accorded to Dr. Rotherham for the great advances made in this direction. We note that eleven separate trades are pursued, that each but the tinsmith's shop makes a satisfactory profit after allowing fully for the craftmaster's salary. The total profit works out at about £1,080, but no allowance is made for rent or maintenance of the shops. Still, if nothing is made, there is a heavy credit for the good influence of organised and intelligent work, and for the gratuitous

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teaching, which must always be a benefit, and sometimes may secure a livelihood for the pupils. We are told that the Committee minute books are made in the new printer's shop, and that two of the inmates are capable of binding any book throughout, and one is making rapid progress with gilt lettering.

The Children's Committee report that out of an average of 20,000 poor-law children, with whom they have to deal annually, about 1,500 require special treatment. The special expenditure for these amounted to £61,000 in 1907. The Committee can report that, apart from medical requirements, the general education given meets with the approval of H.M. Inspectors. Their reports speak quite favourably.

Miss Turner, the Medical Officer attached to the various homes, except that at Witham, speaks of increasing self-control brought about by training. She utters sound sense in the following:

"I think it is a pity that more is not done in the direction of rural occupations. There is plenty of scope in the Colony for gardening and poultry farming, and these occupations would interest the girls, and also give them the physical exercise in the open air which is so beneficial for their health. They are capable of something much more practical than playing at attending to little gardens. Heavy work, like digging and rolling, is beneficial for them; in fact, the heavier the work, provided it is not sufficient to strain them, the better. The difficulty with the big, strong ones among our girls is to find work which will fatigue them sufficiently. A few fowls are kept, but there is room for a good many more, and if methodically worked up this department might be made a profitable industry."

One home for boys has been recently placed under the care of Dr. Rotherham, whose labour-developing talents seem to be bearing fruit. In February of this year he writes that the new tailors' shops were opened in September of last year, and that several of the boys show remarkable aptitude for the work. One can already make new trousers and waistcoats and is a good machinist, while the next three best can make vests. He says that over 36 *per cent.* of the boys were addicted to bad habits. To check this by night, which has been hitherto a difficulty, a night attendant had been instituted, with marked benefit in conduct and industry. It is hoped that the addition of another trade-attendant will enable continuous supervision being kept up at all hours of the day.

In the various reports of the Medical Superintendents, Dr. Beresford complains of the class of senile patients sent to him. He thinks that, as in many of the cases there is nothing incompatible with senility, they do not come under the term "imbecility," which is an unfair reflection on their families. The average age on death at Tooting was seventy-three for the males and seventy-four for the females. This is 15 *per cent.* higher than at Leavesden or Caterham. As Tooting Bec admits 550 out of the 800 new admissions into all the Board's asylums, the character of those admissions may be guessed from the age on death. The mortality exceeded one-third of the average residence. There was great immunity from phthisis, only 5 of the 258 deaths being due to that cause. Dr. Beresford thinks that this is attributable to scrupulous cleanliness and free ventilation.

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Dr. Elkins, at Leavesden, is able to report a falling death-rate from tubercle, this being a percentage of 2·03 on the average number resident, against 5·46 in 1900. It will be remembered that he undertook very energetic action in the direction of segregation of phthisical patients, and this has proved successful.

At Caterham Dr. Campbell likewise complains of the character of the patients sent to him, the majority coming from other of the Board's asylums. He says that they are quite unfitted for his large wards. He notes a gradual falling-off of the patients having a capacity for work, this raising the rate of maintenance on account of the necessity to hire more help.

The statistics are still kept up with great care, but they are as yet in the old form of the Association. We believe that the new system is likely to be adopted. One point noticeable is that, among the fresh admissions, instead of the married being at the head of the Civil State table at the three asylums confined to adults, the single come first, followed by the widowed. At Tooting the numbers are respectively: Single 205, married 126, widowed 218. This latter number tells a sad tale, and probably confirms the idea that many of the patients come for negative rather than active reasons. This is further fortified by senility being returned as the factor in 293 admissions as against alcohol in twelve only. Yet once again we may, we think, say that the same tale is told by the table of heredity prepared at Tooting. Only 5·8 *per cent.* were found on admission to have insane relatives. As this table is in detail it may be assumed that more than casual attention was paid to the inquiry.

In the Medical Supplement we note a contribution by Dr. Sherlock, of the Belmont Asylum, which by its ability and value causes psychological study to take a worthy place by the side of much erudite inquiry into other branches of medicine—notably the incidence of zymotic disease. Dr. Sherlock chose his subject—The Pathology of Epileptic Idiocy—for his thesis in the London M.D. examination. An interesting comparison, in regard to certain factors, is made between forty-five male epileptic idiots and the same number of non-epileptic idiots. He found, after careful inquiry into the family history of each case, that in the former (Class I) there was heredity of nervous or mental disease in 55 *per cent.*, in the latter (Class II) the percentage was the same. But in regard to direct insanity, the preponderance of heredity was in favour of the latter class by 44 to 31 *per cent.* As to epilepsy in Class I, heredity showed itself in 22 *per cent.*, in Class II only 4·5 *per cent.* In the matter of alcohol the heredity was not strong in either case, being, for Class I, 20 *per cent.*, and for the other 13 *per cent.* Syphilis also plays a smaller part than might be expected, *viz.*, 18 and 11 *per cent.* respectively. As is pointed out, the disease may have a stronger predisposing power for epilepsy than for mental disease.

Then follows a long series of studies in particular stigmata of two parallel groups of seventy-five each—one of epileptic idiots, the other of non-epileptic idiots. Dr. Sherlock could not find any valuable results in the comparison, either in the direction of elucidating the pathology, or from the diagnostic point of view. Head measurements and asymmetry have been inquired into without much result.

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Asymmetry seems to have been found more often in the latter class, though only of slight degree. Abnormalities of the ears supply negative results, but in defects connected with the eyes more error was found with the epileptics in the proportion of 28 to 10. Ptosis was found in seven cases of epilepsy, none being found with the others, strabismus and inequality of the pupils (right smaller than left) being also more frequent with epilepsy. With regard to palatal differentiation from the normal, Dr. Sherlock adds a fourth class to those framed by Dr. Clouston. This consists in a wide and flat palate. There is no very marked difference in any of these classes as between epileptics and non-epileptics among the idiots.

Evidences of paralysis are found in a proportion, as between epileptics and non-epileptics, of 2 to 1. Paralysis of all limbs, right and left hemiplegia, are found in twenty epileptics and in three only of the non-epileptics. But paraplegia was found in nine of each of those classes. As regards the former affections, Dr. Sherlock thinks from Dr. Bourneville's figures, that his own show an exaggerated tendency, but that they support the accepted idea of there being a relation between early brain lesions and the development of epilepsy. Altogether he concludes that these and other of the usual stigmata cannot be taken very seriously. But there is one that has in his opinion great weight. He alludes to the adenoma sebaceum, and its representation on the face as the "butterfly rash." Dr. Sherlock gives considerable information about the cases in which this disease is found. He has termed it "anoia," and details some twenty cases from the records of Darenth and Belmont. Great mortality seems to attach to this condition, twelve of the twenty having died at the time of writing. The clinical characteristics are given as "the presence of a persistent eruption involving especially the face, and epileptiform seizures." In some of the cases the eruption preceded the fits, and the last on the list had not had its fits at the time of the report. Hypertrophic sclerosis is the pathological verdict pronounced by Dr. Sherlock. Growths in the brain (chiefly intra-ventricular) and in the kidneys were the dominant features of the autopsies conducted on some of the patients whose history is given. As these cases were anatomised before attention was given to anoia as anoia, these findings are, as Dr. Sherlock points out, not vitiated by prejudice in favour of the views expressed by him. He suggests that the toxic theory is the hypothesis the least inconsistent with what is known of epilepsy. Some very excellent photographs are appended to the essay, these showing interesting points in asymmetry and poor convolutional development. We think that Dr. Sherlock has made out his claim to have established anoia as a distinct pathological entity.

Staffordshire.—The reports of the three asylums maintained by this county have been bound together, and as each has adopted the new tables a very substantial volume is the result. We will venture to repeat a hope, expressed in a similar case, that some day increasing interest in the better condition of things statistical may happily lead to the working up together of the more important points in the individual reports. Thus there would be returns that would represent the county

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as a whole. The death-rate is very high in all the asylums, being 17·3 for the whole county. Tubercle appears to be largely responsible for this. General paralysis, on the contrary, shows a much less influence than usual, being 10·7 *per cent.* of the deaths as against a percentage of 16·7 for all England, according to the Commissioners' tables. Looking to the nature of the environment a heavy toll might have been expected. The admissions arising from that disease are worth reproducing, with the number of instances in which among the direct admissions there are assigned certain factors.

	Stafford.			Burntwood.			Cheddleton.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Direct admissions	111	107	218	171	130	301	127	103	230
General paralytics	6	—	6	16	7	23	15	3	18
Alcoholics	36	15	51	49	14	63	59	14	73
Syphilis	6	—	6	9	0	9	21	4	25
Mental stress prolonged	9	28	37	32	31	63	23	16	39

The freedom of such a centre as Stafford from general paralysis is remarkable.

The occurrence of the two stock forms of insanity, and the fate of those who suffer from these, vary very much in the three asylums.

	Stafford.			Burntwood.			Cheddleton.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Direct admissions—									
Mania, acute and recurrent	56	37	93	91	54	145	38	44	82
Melancholia, acute and recurrent	13	22	25	9	11	20	27	21	48
Recoveries (total)—									
Mania, acute and recurrent	23	15	38	38	34	72	16	20	36
Melancholia	4	14	18	—	6	6	17	12	29

West Riding, Wakefield.—Dr. Bevan Lewis is again able to show the remarkable benefits derived from saline purgatives, used to forestall colitis. In the last two quarters of 1902 there were forty-eight cases. In 1903 there were fifty-seven, and now there was only one in 1907. Another most important result has followed, *propter hoc*, not merely *post hoc*. Convulsive and congestive seizures, instead of being ordinary events in the life of general paralytics, have now become uncommon to a degree. Dr. Lewis deduces from this the probability of these seizures being due to intestinal toxication. He points out that in true epilepsy not the least effect is caused by the saline purgation. This is a great chapter in pathology. The electric appliances maintain their usefulness in the treatment of certain cases, and the out-patient's department is becoming an increasingly useful institution, its services being by no means confined to purely mental affections.

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