obtained better results than some of them, but his own experience was distinctly favourable to the use of sulphonal. He had used it in cases of post-epileptic excitement with good effect. He had not found it of much benefit in melancholia. In one case dangerous collapse had occurred.

Dr. JOHNSTONE, in replying on the discussion, said that he was much flattered by what had been said regarding his paper. He had never met cases in which patients had become habituated to the use of sulphonal. It was his regular practice to diminish the dose. He had had no distinct evil resulting in any case from the use of sulphonal, but he was suspicious of it, and he was very careful in giving it. In the case of a person of good bodily health he might "pile on" the sulphonal, but the physical condition of the patient should be always carefully considered. He thought that the best way of giving sulphonal to a patient was in the form of a fine powder with a little water or tea. He had not found a white fur on the tongue in the majority of cases. He had not weighed his patients systematically before and after the use of sulphonal, and had only given sulphonal to those who actually required a hypnotic or sedative, not in an experimental way. The kind of sulphonal he used was manufactured in Berlin. The disagreeable after-effects of sulphonal were very grave, and it was the more intelligent patients who so complained. He had not given sulphonal an extended trial in cases of epilepsy. He believed that one death from sulphonal had occurred, and was recorded in "The British Medical Journal." It was not from a medicinal dose.

Dr. MACPHERSON then exhibited the plans of the Stirling District Asylum, including those of the new hospital for acute cases.

An interesting discussion on the principles and details involved was shortened by the limited time at the disposal of the meeting.

Dr. G. M. ROBERTSON thereafter read part of his paper on a visit to the Hypnotic Schools in France, which will be presented by Dr. Clouston to the Committee of Hypnotism appointed by the British Medical Association.

Discussion had to be postponed, but Dr. Robertson was warmly thanked for his interesting and valuable report.

Dr. Bruce showed a ruptured heart. (See "Clinical Notes and Cases.")

The members dined at the Edinburgh Hotel in accordance with usual custom.

IRISH MEETING.

An Irish Quarterly Meeting was held at the Richmond (Dublin District) Asylum, Dublin, on June 18, 1891. The following members were present:—D. Yellowlees, M.D., LL.D., etc. (President), in the chair, Drs. Law Wade, Finnigan, Molony, Patton, Nash, Nolan, Ashe, and Conolly Norman (Secretary); and the following guests: Dr. West, of Chicago, and Drs. Mills and Shackleton.

The minutes of the preceding meeting having been read, confirmed, and signed,

The PRESIDENT read a communication on "Recovery from Melancholia." After some preliminary remarks on the increase in the number of cases of melancholia which came under treatment of recent years, which, however it is to be accounted for, the speaker regarded as an indisputable clinical fact, he proceeded to describe in detail two cases to show that in melancholia one need hardly despair of the possibility of cure. The first occurred in the person of a governess, a woman of intelligence and culture, aged 32 years. She was possessed of the delusion that she was the devil, and kept continually whispering, "I'm the devil, I'm the devil, I'm the devil!" Otherwise she scarcely spoke, and took little notice of her surroundings. This condition of affairs lasted for ten years, and yet she made a good recovery. It is interesting to

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observe that her improvement seemed to originate in a trivial way. One evening she was with much difficulty persuaded to join in a game of whist. At first she kept muttering her old refrain, "I'm the devil," but she soon became interested in the game, announced correctly that clubs were trumps, took a trick, and threw herself into the work in hand, talking no more then of her diabolical fancies. From that evening she grew better. The second case was even more remarkable. A woman 44 years of age, suffering from her second attack of insanity, thought every person was conspiring to poison her. She recovered after an illness of fifteen years' duration, during eight years and eight months of which time she had to be fed with the stomach tube, in consequence of obstinate refusal of food depending upon the delusion above referred to. By a happy combination of management and accident she was induced to take food. One day with great difficulty the speaker got a spoonful of food into her mouth. There she retained it. By accident the chair she was seated on tilted over backwards. The patient gave a gasp and gulped down the mouthful of food. The spell being broken, there was no longer any difficulty about getting her to take nourishment, and she improved steadily from that time.

Dr. PATTON concurred with the President in thinking that though cases of an acute and desperate character were rarer now than formerly, there was, on the whole, a great increase in the amount of melancholia we see. In his experience patients even possessed of ineradicable delusion soon weary of the stomach tube.

Dr. FINNIGAN referred to two cases in his practice at the Mullingar Asylum. The first was a young school mistress, without hereditary taint or other easily assignable cause of illness. The case had passed into a chronic condition, and had not exhibited any sign of improvement. A somewhat anomalous symptom was observed—that the patient was jealous of the nurses, especially those who were good-looking or specially tidy in appearance. She also kept her face constantly covered, though she did not seem to have any delusion suggesting this. She exhibited an abnormal growth of hair on the chin, and a disfiguring nebula on one cornea. Dr. Finnigan, conceiving that these conditions might have indirect ætiological importance, removed the beard by epilation and the nebula by tattooing. The result was extremely satisfactory, and the patient made a good recovery. In the second case very obstinate refusal of food, occurring in a young female melancholiac, was overcome by simply directing that all nourishment was to be given in future per rectum, with the expected result that the patient, sooner than suffer what she conceived to be the indignity of the mode of feeding, took food voluntarily, and began rapidly to recover.

Dr. MOLONY, among other cases bearing on the subject, recounted that of an elderly lady who was insane for nine years. During all that time she suffered from delusions of a sexual character, which caused her much distress (that she was ravished by beasts, etc.), and she was apt to be blasphemous and obscene in language. For no assignable reason she suddenly improved after this great lapse of time, and rapidly became quite well.

Drs. ASHE and CONOLLY NORMAN also spoke.

Dr. NASH read a paper on a "Case of Rupture of the Heart occurring in a Melancholiac." (See Clinical Cases.)

Dr. LAW WADE had seen a case in which a woman died suddenly immediately an emetic had taken effect. Necropsy revealed cardiac rupture.

The PRESIDENT mentioned two cases. One had occurred in an old man who was a patient at Gartnavel, the other in a gentleman who had previously been in good health, a member of our own profession. In neither case could a diagnosis be made ante-mortem, but the second was remarkable as being attended by a distinct sensation. The sufferer when seated at dinner got what was described as a sort of fit. When he recovered he said someone had struck him on the back. He died the same evening.

Dr. PATTON also spoke.

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Dr. CONOLLY NORMAN read a "Note on Cocainism."

Dr. YELLOWLEES thought that the consumption of cocain must be very local, perhaps in part depending on the custom among medical men of prescribing it. He had not a case.

Dr. ASHE referred to the fact that coca leaves, if not cocain, were largely used in Bolivia and seemed to do no harm, though relief from weariness and a pleasant exaltation were produced. He was anxious to learn in what doses the drug had been used.

Dr. CONOLLY NORMAN, in replying, said that in China the average man consumed a little opium every day, and did not become a slave to it; in this country it was not so. However, even in South America cases did occur of chronic cocain poisoning. The nickname "coquero" was applied to the chronic cocainist, and he was recognized by his shrunken, pallid features, his tremulous extremities, his constant chattering, and his inability to work or tell the truth. As to dose, half a grain or less would produce slight intoxicating effects in the tyro. Those who used the drug habitually might consume 20 grains up to two or three drachms in the day. In bad cases it was difficult to be quite sure how much was used. Patients became confused, and were apt to be deliberately untruthful.

The SECRETARY then read a short note on a case of "Folie Communiquée." Two ladies lived close to each other in a Dublin suburb. One was an officer's widow, aged about 50, the other was a companion to a lady, and was unmarried, aged 29 years. They were acquainted, but not in any way intimate. The elder lady had lost her husband abroad some years ago. Latterly she had begun to entertain suspicions of foul play, as she said she never could get sufficiently definite accounts of the manner of his death. She became gradually convinced that Sir A. B., who had been at one time at the head of her husband's department, had poisoned him. Then she thought Sir A. B. was persecuting her by electricity, telephone, etc. To avoid this she came to the neighbourhood of Dublin, and was happy for a time. She now made the acquaintance of the younger lady. The latter was a person of good family history, and, except the disagreeable nature of her position, no cause of aberration suggests itself in her case. Very soon the widow found that Sir A. B. had settled in the next house to her (a delusion), and that he had resumed operating on her by electricity and talking to her, often very indecently, by telephone. About the same time, as well as can be made out, the younger woman began to suspect her employer of accusing her, first of dishonesty, then of unchastity. Then she thought that her employer was guilty of all sorts of monstrous crimes—murder, adultery, and worse—and had made these charges to shut the patient's mouth and screen herself. Then the Chief Secretary for Ireland was suborned by her employer; the matter was talked about (under false names) in the House of Commons, patient was watched continually by the police, and so forth. Some months ago this person was admitted to the District Asylum. The older lady remains at large. The singular part of their case is this, that they have adopted each other's delusions almost in full. Both are shrewd, sharp-tongued women, suspicious and alert even beyond the ordinary mode of paranoiacs of their class. The younger deeply resents confinement in an asylum, and makes caustic remarks on the delusions of those about her. Yet she indignantly denies the suggestion that her friend, the widow, entertains delusions. On the contrary, she *knows* that Sir A. B. lives beside her friend for the purpose of persecution. She has not heard him telephoning, but she believes it is done. (This patient has never exhibited hallucinations of hearing.) She has often seen Sir A. B. watching and walking after the widow. Both ladies are quite positive that Sir A. B. met them at a public promenade the day before the younger lady was sent to the asylum, and that he watched the widow in an insulting manner and made signals to her. From the way the story is told one makes little doubt that somebody did pass and stare at the women, attracted,

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no doubt, by their suspicious glances. The well-known public man whom they name was certainly not in Ireland at the time. The younger lady never accused him of having made advances to herself or of having persecuted her, nor does she mention him in connection with her own wrongs. Similarly with the other lady. The machinery of her friend's myths is firmly believed in *qud* her friend, but it is never transferred to her own case, which stands on a different footing. Each refers, in a general way, to the case of the other as showing that occult persecutions are possible. The case, as far as it goes, is truly one of communication. Some cases which have been so classed—insanity in twins for instance—may occasionally be rather due to a common cause than to communication. Not seldom, perhaps, imbeciles, or very weak-minded persons, may accept the delusions of relatively intelligent lunatics, but it is distinctly rare to find patients suffering from well-marked delusional insanity acquiring further delusions by direct communication.

The PRESIDENT recalled a case of one sister having communicated to another the delusion that the police were watching them and that the people in their lodgings were robbing them.

Drs. FINNIGAN and MOLONY spoke.

Dr. CONOLLY NORMAN said that as the Association had honoured his asylum by holding this meeting therein, he thought it right to show the members some samples of the work that was passing through his hands, and as alienists had been reproached of late for their supposed neglect of general medical work, he had selected exhibits, all collected in the asylum P.M. room within the last few months, of which but one was specially interesting to workers in nervous diseases. The following specimens were laid on the table and described:—*Gross:* (1) Stomach showing numerous penetrating adenomata (pendulous dendriform growths into the cavity of the organ). (2) The viscera of a lunatic who was in the habit of swallowing stones, etc. Five days before his death, being up to that time apparently in his ordinary health, he was seized with acute dyspnœa. Nothing could be found in his throat. The dyspnœa abated, but he developed right pneumonia. Post-mortem this was found to be apparently dependent upon the presence of a foreign body in the right bronchus in the shape of a piece of iron about 2½ inches long by ¼ wide, being half the "heel tip" of a shoe. A quantity of pebbles, pieces of pipe shank, etc., were found in the stomach, and an ordinary Brittania metal teaspoon lay in the colon just at the hepatic flexure. About an inch and a half of the handle of the teaspoon projected through a perforation of the gut into the peritoneal cavity, and was encysted in the sack of a limited peritonitis. Of the abdominal lesion there had been no indication during life. (3) The abdominal and thoracic viscera of a patient, who died of dysentery, exhibiting (*a*) characteristic lesions in large intestine, (*b*) multiple abscesses of liver, (*c*) one of which had perforated the diaphragm and opened into the right lung, (*d*) which contained a small depôt of bile-stained pus. (4) Brain of an epileptic lad showing marked microgyry of pre-frontal and occipital convolutions on left side, the motor area little less developed than on right side. During life no special symptom was noted save partial loss of power of right arm, but this was attributed to a bad burn in childhood followed by webbing about the elbow. Among the microscopic specimens were various forms of inflammation of kidney, surgical (from a case of stone), tubercular, gouty in different stages, "large white kidney," etc., adenoma ("dendroid polypus") of stomach; a case of primary cancer of the liver, cancer of liver secondary to cancer in other viscera, sections of which were also shown; cirrhoses of liver, alcoholic and biliary; a series of sections illustrating the various forms of ulceration of the intestines, carcinomatous, tubercular and typhoid, together with dysenteric lesions in several stages and in different portions of the large intestine; tubercular peritonitis which had simulated malignant tumour; ditto, ordinary types, various forms of uterine and ovarian "fibroids," inflammations of lung and pleura consecutive to influenza, etc., etc.

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