SOUTH-WESTERN DIVISION.

THE SPRING, 1939, MEETING of the South-Western Division was held, by kind invitation of the Committee of Visitors and Dr. N. Moulson, at Cefn Coed Hospital, Swansea, on Saturday, April 29, 1939.

Members and guests were entertained to lunch.

Apologies for absence were received from Dr. R. W. Armstrong (the Chairman), Dr. J. F. Lyons, Dr. J. W. Leech and others.

It was resolved that Dr. N. R. Phillips should act as Chairman.

The Minutes of the previous meeting were read and approved and signed by the Acting Chairman.

The following members were present: Drs. D. Menzies, L. C. F. Chevens, D. H. H. Thomas, T. E. Burrows, T. J. Hennelly, I. John Davies, Sidney Davies, J. J. Mason, F. W. Eurich, N. R. Phillips, D. Prentice, J. W. Fisher, H. Astley Cooper, P. Lornie, N. Moulson and S. Edgar Martin (Hon. Divisional Secretary).

The undermentioned attended as visitors: Drs. G. A. Betts, W. T. Wales, J. P. Spillane, C. Gordon Brown, E. Brown, Vyvyan J. Davies, A. F. Sliddon, T. W. H. Wair and others.

The following were proposed, seconded and elected:

Hon. Divisional Secretary: Dr. S. Edgar Martin.

Representative Members of Council: Drs. R. W. Armstrong and R. Eager.

Divisional Chairman: Dr. R. W. Armstrong.

Dr. S. Edgar Martin was nominated to serve on the Nursing Advisory Committee.

The HON. DIVISIONAL SECRETARY read a request from the Secretary, Educational Committee, for the nomination of three members; one name from these will be selected by the Educational Committee to form, with four others, the panel of Examiners. (Retiring Examiner: Dr. N. Moulson.) It was decided to nominate—

Dr. T. J. Hennelly, Medical Superintendent, Cardiff City Mental Hospital.

Dr. Sidney Davies, Medical Superintendent, Joint Counties Mental Hospital, Carmarthen.

Dr. N. Moulson, Medical Superintendent, Cefn Coed, Swansea.

The following were elected as Ordinary Members:

Dr. GEORGE ARNOLD BETTS, M.R.C.S., L.R.C.P., Assistant Medical Officer, County and City Mental Hospital, Hereford.

Proposed by Drs. T. E. Burrows, D. M. Cox and S. Edgar Martin.

Dr. THOMAS MORTIMER LING, M.D.Oxf., M.R.C.P., Medical Officer, Bristol Police; 50, Pembroke Road, Clifton, Bristol.

Proposed by Drs. G. de M. Rudolf, J. J. B. Martin and S. H. Lucas.

The HON. DIVISIONAL SECRETARY read a letter from Dr. J. J. B. Martin of Fishponds, Bristol, resigning his post as Examination Secretary for the Bristol Area, and it was agreed that Dr. J. F. Lyons, of Hortham Colony, should be asked to take the Secretaryship.

The following papers were then read:

Dr. J. P. SPILLANE, M.B., B.Ch., Cefn Coed Hospital, on **"The Distribution of Barbitone in the Body Fluids".**

Dr. F. W. EURICH, M.D., C.M. (Emeritus Professor of Forensic Medicine, Leeds University), on **"Malingering and Compensation Neuroses",** on which there was a discussion in which Dr. HENNELLY, Dr. N. R. PHILLIPS and others took part.

Dr. D. MENZIES, M.D., B.Ch., Deputy Medical Superintendent, Plymouth Mental Hospital, on **"The Uses of Sodium Amytal in Psychiatry",** and Dr. N. MOULSON, M.D., D.P.M., Medical Superintendent, Cefn Coed Hospital, Swansea, on **"Hysteria and Schizophrenia".**

Prof. F. W. EURICH, M.D: **"Traumatic Neuroses and Malingering."**

The speaker took it for granted that the symptomatology of these neuroses was well known. After denying that monetary gain is the motion underlying these neuroses, he stressed the importance of the autoplastic image of his condition, as

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built up by the injured workman. Whereas in ordinary cases of sickness the ugliness of that image would be lessened and the mind of the patient cheered by doctor, wife and family, these influences are often absent after an accident at work. Incautious expressions on the part of the doctor are dwelt upon, and the attitude of wife and friends is often one of pessimism and depressing to the patient. Other factors help to this unfortunate effect. These are: (i) Great differences in the sums awarded by the Workmen's Compensation Act and the National Health Insurance Act; as a result the workman is apt to consider that there is something malign in his occupation. (ii) The attitude of the employer to the workman before and after the accident. (iii) Repeated examinations by doctors at the request of the two parties, often resulting in a mistaken tendency on the part of the injured to be consistent when enumerating their complaints at each examination. And (iv) there is the temptation to make these more credible by the addition of exaggerations or fictitious complaints. Hence it is not sufficient to recognize the tendency to malinger; it must be shown that every complaint and alleged inability to work is untrue. The occasion was not a fitting one to describe methods of detection, but a warning was uttered against the putting of leading questions and the use of methods of examination which may exercise—e.g., the use of the faradic battery—suggestion. Lastly, the speaker drew attention to the fact that malingering and simulation are not necessarily prompted by monetary gain, but may be prompted by a wish for sympathy. Cases illustrating these various points were briefly described.

Dr. MOULSON: **"Hysteria and Schizophrenia."**

The speaker gave some attention to the types of condition that were included under these two names, and mentioned the association of their symptoms in the same patients.

He discussed the difficulty in making a clear distinction between the two types of disorder when the cases are seen in their early stages, this more particularly since we have become accustomed to the fuller information made available by our social workers. He referred to the importance of psychogenic factors producing ilnesses, apparently schizophrenic, which quickly responded to appropriate psychotherapeutic measures.

Reference was made to the extensive work of Claude and the supposed distinctions suggested in the standard text-books were analysed.

During the subsequent discussion Dr. HENNELLY stressed the importance of the histories obtained through the agency of social workers, and Dr. ASTLEY COOPER suggested certain emotional distinctions between the two types of disorder.

Dr. DUNCAN MENZIES: **"The Uses of Sodium Amytal in Psychiatry."**

Sodium-iso-amyl-ethyl-barbituric acid (sodium amytal) has been on the market for about ten years. Full details of its pharmacological action and reports of animal experiments can be found in other publications (1). Sodium amytal may be described as one of the quick-acting hypnotics which does not tend to accumulate in the tissues, and thus complete control of the dosage is possible. Indeed it is claimed (2) that the drug is completely destroyed in the body and, even after large doses, amytal cannot be recovered from the urine.

Its effect upon metabolism appears to be slight. Depression of the circulation and respiration after oral administration of the drug is moderate, and may be safely disregarded in ordinary clinical work.

DOSAGE.

The average effective hypnotic dose by mouth is from 6–9 gr. Experience has shown that the most useful dose is 9 gr. by mouth, and in exceptional cases this may be increased to 12 gr. The drug is supplied in 3-gr. capsules, which may be swallowed if the contents are shaken out, and dissolved in about 1 oz. of water. This latter method is often the best in mental hospital practice.

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Sodium amytal should be given before food on what is commonly called "an empty stomach.", and its action is quick, the patient falling asleep in from 10–20 minutes. No two patients react in the same way to any hypnotic, and sometimes the action is delayed for half-an-hour. The result of 9 gr. is from 3–6 hours of deep sleep, and by night in quiet surroundings the patient will usually sleep from 7–8 hours. On awakening after a single dose there is very little drowsiness, and it is surprising how quickly the patient recovers from the effects of the drug. If a restless patient should awake during the night a smaller dose (from 3–6 gr.) will usually prolong sleep until morning.

Rectal administration is effective in doses of from 9–12 gr. The contents of the capsules may be given as an enema dissolved in two ounces of water or, after puncturing the ends of the capsules, these may be inserted as suppositories. This method is especially useful in dealing with suspicious or resistive patients.

For intravenous use special ampoules are supplied of $7\frac{1}{2}$ gr., and a 10% solution is freshly prepared immediately before injection. The high cost of the ampoules has prevented extensive trial, and in practice it has been found that oral or rectal administration has been quite sufficient. The technique of intravenous injection is similar to that employed in evipan anæsthesia, and the rate of injection should not exceed 1 c.c. of the solution per minute. The patient falls asleep after 3–6 gr. have been injected, and the whole procedure is over in about 5 minutes. Rapid injection may cause circulatory collapse. We have adopted the intravenous route in a few emergencies when a patient had to be removed from one building to another by night. But the ordinary hypodermic of morphine and hyoscine is much more convenient.

Sodium amytal may also be given by intramuscular injection, and there again the high cost of the preparation advised is against its general adoption. This paper deals mainly with the uses of sodium amytal when given by mouth. These will be described under three headings:

(1) Its employment as a general sedative and hypnotic for occasional use.
(2) Sodium amytal in continued narcosis.
(3) The use of sodium amytal in refusal of food as an alternative to artificial feeding.

As a General Sedative.

No one will deny that there is a demand in psychiatric work for a safe, reliable, general-purpose hypnotic which will act quickly and is easily administered. Paraldehyde has held pride of place for many years in spite of its burning taste and pungent odour. When treating the chronic turbulent patient it is beyond doubt the cheapest and safest hypnotic for occasional use. But the patient suffering from the milder forms of mental illness is revolted by its administration, and some other sedative must be used.

In the attempt to find a substitute for paraldehyde sodium amytal was introduced, and used for the past two years as the hypnotic of choice in the ordinary case of restlessness and insomnia occurring amongst the recent admissions.

Out of a total consumption of 21,000 capsules in that period approximately 1,200 capsules have been used in treating about 300 admissions. This represents four or five hundred doses of from 6–9 gr. Many required only one or two doses; others had nightly doses for a week or two. Sodium amytal is particularly useful in the common type of worried, nervous patient, who has not slept for several nights before admission, and who is both fearful and suspicious of the mental hospital to which he has voluntarily committed himself. Its immediate effect is to restore confidence. The next morning the patient is more friendly, and willing to co-operate in examination and treatment. In calming the outbreaks of noisy talkativeness which disturb the serenity of the ward an occasional dose of sodium amytal is at least as effective as a paraldehyde draught. We have treated all types, including manias, agitated melancholics, seniles, schizophrenics and general paretics. The more excitable, turbulent, maniacal or catatonic patient who

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must be controlled immediately had better be given morphine and hyoscine. However, the oral administration of small doses of sodium amytal (3–6 gr.) may be used to supplement or augment the injection of morphine. It is most risky to give larger doses to patients who have had morphine, which itself tends to depress respiration. As a general rule sodium amytal is best administered alone, and not in combination with other drugs, except in circumstances to be hereafter described.

Sodium Amytal Narcosis.

The second use of sodium amytal in psychiatry is in the maintenance of continued narcosis. The technique evolved is very simple. Sodium amytal is given by mouth in doses of from 9–12 gr. three times a day before the three principal meals of the day. In most cases this will be found insufficient to maintain narcosis, and in addition 20–30 gr. of potassium bromide should be administered at the same times. Thus the true description should be amytal-bromide narcosis. Induction of narcosis is rapid, beginning with 9-gr. doses, and increasing to 12 gr. when the patient shows signs of awakening in the intervals. Instructions are left with the night nurse to give a fourth dose of 9 gr. should the patient be awake during the night. In practice this extra dose is rarely required. By adopting this simple procedure 15–16 hours' sleep may be secured in the 24-hours period.

Following the technique of somnifaine narcosis (2) the patient should be aroused at regular intervals for feeding and toilet. In order to obviate pulmonary œdema an upright position should be adopted for feeding, and the patient assisted on to a commode instead of using bed-pans. By thus preventing prolonged unconsciousness in a recumbent position we have never had the slightest sign of pulmonary congestion. These are well-known precautions to be observed in any type of narcosis, and need not be further stressed. The complications are few. Diplopia, ataxia, dysarthria, disturbances of colour vision are of little practical importance, and may be disregarded. Vomiting is very rare in amytal-bromide narcosis. The temperature and pulse-rate usually remain normal. The only practical difficulty is that sodium amytal acts so quickly in some cases that the patient may be sound asleep before the nurse has finished feeding him.

An improvement in technique which we have recently introduced to deal with these cases is to administer the sodium amytal *per rectum* after feeding the patient instead of by mouth before food. In all cases the nurse should be warned against the dangers of hurrying the feeding of a drowsy patient. Diet should be semi-solid or mainly liquid. Most of our patients increased in weight by from 4 lb. to 14 lb. The duration of narcosis is approximately 21 days, and withdrawal of the drug should be gradual.

Results of Amytal-Bromide Narcosis.

Only 30 cases (9 men and 21 women) have been treated up to the present, as the method was merely introduced to provide an alternative to somnifaine, and to avoid the painful intra-muscular injections necessary in that treatment. The diagnoses were 3 manias, 15 melancholics of various types, 2 obsessionals, 4 schizophrenics, 2 delusional states, 2 puerperal states, 2 anxiety states. Out of this mixed bag 10 patients were discharged recovered, 11 are improved, and of these, 5 are likely to be discharged in the near future; 9 were not improved by the treatment, and of these 2 have since been discharged as clinical recoveries. It must be admitted that the prognosis in 25 out of the 30 cases was considered good, at least as far as recovery from the immediate illness was concerned. The melancholics did best with 4 recoveries, the manias next with 2, and one schizophrenic had a good remission. The total figures are too small to draw any conclusions. But the results compare favourably with those claimed for somnifaine narcosis.

The third use of sodium amytal is to obviate the necessity for tube-feeding. Thorner (3) describes a technique by which sodium amytal is administered to "decatatonize" or relax the over-inhibited catatonic patient, and thus facilitate

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psychological examination. The method has been introduced in this country under the title of "narco-analysis" (4). It is not proposed to discuss these complicated procedures in this place. But consideration of these methods led one to wonder whether, if the resistive patient can be made to talk, perhaps he may also be induced to eat under the influence of sodium amytal. Patients who refuse food may be divided into two groups: (1) those who absolutely will not swallow anything; (2) the larger and more difficult sort who evade the stomach-tube by taking only just enough nourishment to keep themselves alive. In dealing with the first group sodium amytal is administered *per rectum* in doses from 6–9 gr. about half-an-hour before food. When the patient is slightly drowsy and resistance is reduced the nurse will usually succeed in feeding by the cup. If this fails, or the patient quickly falls asleep, then the nurse must be instructed to offer the feeding-cup immediately he shows signs of awakening, and then almost without fail a pint or more of milk will be swallowed. Co-operation of the nursing staff must be secured, and some natural scepticism overcome to ensure success.

Slightly different tactics must be adopted with the second class. A smaller dose, 3–6 gr. of sodium amytal is given by mouth about 10 minutes before meals, and it will be found that sufficient mental relaxation is produced to make the most difficult patient take a full meal. Hand-feeding must be adopted, and here again the co-operation of the staff is most important. We have treated cases by this method for periods of over 3 months, and it is surprising to see patients who profess no desire for food develop a hearty appetite as the amytal begins to take effect. In the past two years since adopting this technique tube-feeding has only been required in two cases, and for a few days. Actually sodium amytal was afterwards successful in these cases also, and the stomach-tube might have been avoided, if only a little more patience had been exerted. The low toxicity and rapid elimination of sodium amytal make its administration perfectly safe even to emaciated patients. If tolerance of the drug develops it may be necessary to increase the dose in a few cases to 9 gr. The procedure is repeated three times a day before meals, and no ill-effects have followed months of treatment. On the contrary it is frequently remarked how much improved is the patient's appearance. As the habit of enjoying food is re-established the amytal may be stopped. Many cases relapse, and the treatment must be resumed. But it is usually found that as nourishment improves the symptoms of the psychosis are alleviated. When undergoing this sodium amytal persuasion the patient should be nursed in bed under close observation. The subcutaneous injection of 10 units of insulin once daily will often stimulate the appetite, and many of our cases have had this combined with amytal. It is perhaps over-optimistic to hope that the feeding-tube will ever be wholly banished from the mental hospital; but everyone knows that the operation of artificial feeding may not be so simple as the text-books would have us believe, and any method which would at least lessen the occasion for its employment is worthy of consideration and trial.

Summary.

The exhibition of sodium amytal is described—

(1) As a general sedative.
(2) For the conduct of prolonged narcosis.
(3) As an alternative to artificial feeding.

I am indebted to Dr. E. G. T. Poynder, Medical Superintendent of Plymouth Mental Hospital, for his kind interest and encouragement.

References.

(1) Zerfas, L. G.—*Brit. Med. Journ.*, 1930, ii, p. 897.
(2) Menzies, D.—*Lancet*, 1937, ccxxxiv, ii, p. 550.
(3) Thorner, M. W.—*Journ. Nerv. and Ment. Dis.*, 1935, 82, p. 299.
(4) Horsley, J. S.—*Journ. Ment. Sci.*, 1936, lxxxii, p. 416.

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On the motion of the Acting Chairman (Dr. N. R. PHILLIPS) a vote of thanks to the above-named for their papers was proposed, seconded and carried unanimously.

A hearty vote of thanks was proposed to the Committee of Visitors and Dr. N. Moulson for the kind hospitality extended to members and guests.

Dr. N. R. Phillips was thanked for acting as Chairman in the absence of Dr. R. W. Armstrong.

Members and guests were then entertained to tea.

During the day an opportunity was afforded members and visitors to inspect the Hospital and grounds.

IRISH DIVISION.

THE SPRING QUARTERLY MEETING of the Irish Division was held at Grangegorman Mental Hospital, Dublin, by the kind invitation of Dr. J. Dunne, Resident Medical Superintendent, on Thursday, April 20, 1939.

The following members were present:

Dr. T. A. Greene in the Chair (and subsequently Dr. R. Thompson), Drs. J. Dunne, J. Scroope, S. Blake, Dora Allman, Evelyn O'Brien, J. O'C. Donelan, J. Fitzgerald, Mary Fitzgerald, C. J. McCarthy, F. O'C. Walshe, J. Glass, Annie Dunleavy, B. Moran, D. Hegarty, R. Taylor, D. Brennan, D. J. Geraghty, J. Kearney, T. J. Foley, W. N. Eustace, H. J. Eustace, J. Delaney, H. St.G. Smith, R. Brennan, W. R. Wright, P. Doherty, P. J. Aird, B. Lyons, B. Honan, M. A. Collins, R. Leeper, T. A. Conlon, J. N. Moore, J. Boland, and P. Moran (Hon. Sec.).

Apologies for unavoidable absence were received from Drs. D. Lothian and C. Moloney.

Dr. T. A. GREENE proposed and Dr. THOMPSON seconded that the sympathy of the Division be extended to the widow and family of the late Dr. Boyd, Resident Medical Superintendent, Antrim Mental Hospital.

In speaking to the motion Dr. THOMPSON paid a striking tribute to the late Dr. Boyd; gave an appreciation of his excellent work in the Antrim Mental Hospital; and said that, personally, he felt keenly the loss of an excellent colleague and a kind friend.

The motion was passed in silence, all the members standing.

The Minutes of the previous meeting were read, approved and signed by the Chairman.

The SECRETARY read correspondence with the Grangegorman Mental Hospital Committee *re* the provision of facilities for general training for mental nurses.

The Grangegorman Committee had taken Counsel's opinion as to their powers in this matter, and Counsel advised that the Minister's interference in this matter was *ultra vires* and that his sanction to any such scheme was not necessary.

The SECRETARY then read a letter from the Irish Mental Hospital Matrons' Association asking the Division to arrange for post-graduate lectures for mental nurses and for courses in occupational therapy.

Consideration of this matter had been adjourned from the November meeting.

After discussion it was decided to ask the Matrons' Association to formulate a scheme to meet their views in this matter, and submit it for consideration at the next meeting of the Division.

The following were, after ballot, elected members of the Association:

JOHN NORMAN PARKER MOORE, M.D., B.A., M.B., B.Ch., B.A.O., Assistant Medical Officer, St. Patrick's Hospital, Dublin.

ANTHONY EUSTACE, M.B., B.Ch., L.M., Assistant Medical Officer, St. Edmondsbury, Lucan, Dublin.

The Meeting then proceeded to the election of officers of the Division for the year 1939–40, and the following were, after ballot, elected:

Hon. Secretary: Dr. P. Moran.

Representative Members of Council: Dr. T. A. Greene and Dr. R. Thompson.

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