healing of the mentally ill into the closest approximation to the care and healing of the physically ill. He proposed the toast of the health of the Visiting Committee and staff, coupled with the name of the Medical Superintendent, Dr. Barton White.

Dr. BARTON WHITE, in response, said he had to read a paper within a few minutes, and would now simply thank Dr. Marr for all he had said, and members for the heartiness with which they had drunk the toast.

THE DINNER.

Members and a number of distinguished guests dined together on the evening of Wednesday, February 15, at the Royal Hotel, Bristol, Dr. Hamilton Marr presiding.

The guests were: F. E. Metcalfe, Esq., Alderman and Chairman of the Mental Hospital; Prof. Edward Fawcett, M.D., F.R.S.; Prof. A. J. Nixon, *C.M.G.*, M.D., F.R.C.P., Professor of Medicine, Bristol University, Dean of Medical School, Royal Infirmary; Carey Coombs, M.D., F.R.C.P.; Patrick Watson-Williams, M.D., Consulting Surgeon for Diseases of the Ear, Nose and Throat, Bristol Mental Hospital; Geoffrey Hadfield, M.D., F.R.C.P.

At the appropriate moment the usual loyal toasts were honoured. The PRESIDENT proposed the health and prosperity of the Bristol Mental Hospital, coupling it with the name of Mr. F. E. Metcalfe, who responded, and in return toasted the Association. Dr. C. HUBERT BOND replied for the Association. Prof. G. M. ROBERTSON proposed the health of the University of Bristol, coupling it with the names of the Dean of the Faculty of Medicine and Professor Nixon.

VISIT TO THE UNIVERSITY.

The members visited the imposing new buildings of the University in the morning of Thursday, February 16, and were shown round by Mr. E. G. Francis, M.A., the Registrar; an interesting account of many of the architectural features being given by Prof. Fawcett.

These buildings were commenced before the war and were opened by the King in June, 1925. There is a lofty Entrance Hall with a double flight of stairs, its roof consisting of fan-vaulting in stone, like the well-known examples of mediæval work in Gloucester Cathedral and elsewhere. The Great Hall of the University, which seats over one thousand people, is beautifully panelled and has a hammer-beam roof built of English oak.

Amongst other rooms visited were the Reception Room, the Council Chamber and the Library, and all of these were much admired for their beautiful proportions and for the excellence of the craftsmen's work in wood and stone.

DIVISIONAL CLINICAL MEETINGS.

City Mental Hospital, Mapperley Hill, Nottingham.

The first Clinical Meeting of the Nottingham Clinical Area Group, under the auspices of the Association in the Northern and Midland Division, was held at the above hospital on January 27, 1928, at 3 p.m.

Present: Ten members and one visitor.

Dr. G. L. BRUNTON, who presided, gave a demonstration upon chronic encephalitis in the Female Infirmary Ward.

The main features of the disease were briefly outlined, the difficulties of custodial care and the need for medical officers to explore every method of treatment were pointed out, and seven typical cases were demonstrated. A girl of 14 years showed an important permanent neurological sign in that she had an ophthalmoplegia interna in which the pupils were unequal and inactive to light and accommodation. The discs were of good colour.

Prestwich Mental Hospital, Manchester.

A Divisional Clinical Meeting (Inaugural Meeting, Lancashire Area) was held at the above hospital on February 1, 1928. Present: 16 members and 10 non-members. Dr. David Blair presided.

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(1) Mr. GEOFFREY JEFFERSON, M.S., F.R.C.S., Hon. Neurological Surgeon to the Manchester Royal Infirmary, read a paper on his "Operations for Cerebral Tumours."

(2) "A Case of Intracranial Tumour," by Dr. C. R. NUNAN. [A *post-mortem* on this case had just been held, and Dr. Nunan was thus able to demonstrate the tumour *in situ*.]

The following are the notes, clinical and *post-mortem*, of the case:

The patient was a man who died at the age of 58 years. Ever since admission to the hospital in 1912 he suffered from what appeared to be true epileptic convulsions. These convulsions averaged six a year until the fortnight preceding his death, when they increased in frequency. He had 150 convulsions during this fortnight. At the onset of a seizure his mouth was drawn to the right side and he would extend his right arm. Between fits the patient was acutely confused, stuporose, demented, disinterested and disorientated in time and place, and his replies to the simplest questions were irrelevant. His speech was of the aphasic type. The sight of both eyes was failing for several months, but there was no squint; his gaze was fixed, and there was paresis of his right leg. It is possible he had some perversion of his sense of taste, as he would chew paper and firmly assert he was chewing tobacco. Owing to his mental condition it was not possible to ascertain the condition of his sense of smell, nor to confirm one's suspicions that he suffered from headache—he was wont to hold his hand to his forehead as one might do when suffering from frontal headache.

In 1919 he was queried as a case of general paralysis, but was never confirmed as such.

At the *post-mortem* a tumour the size of a tangerine was found attached to the base of the skull, near the left optic foramen and under and quite independent of the left frontal lobe. This tumour was an endothelioma.

(3) Dr. E. F. REEVE, Lecturer on Mental Diseases, University of Liverpool, and Dr. G. A. WATSON, Pathologist to the Lancashire Mental Hospitals Board, introduced a discussion on "The Diagnosis of General Paralysis."

Dr. Watson said: Having been asked to give a brief account of the methods employed towards this end at the Rainhill Mental Hospital, my remarks will be confined to this object.

As there is a large amount of work to get through with only a small laboratory staff, we have been compelled after trial of many methods to limit ourselves to those which we have found to be the most reliable, and, as far as possible, to the simplest.

1. *The diagnosis of syphilis—somatic and neuro-*.—Reliance is now placed almost entirely on the Dreyer-Ward sigma reaction, which was tested for a time against the Wassermann of an independent and skilled observer. The chief advantages of the sigma reaction over the Wassermann are: (i) That it is simpler—only two reagents are employed instead of five, and the hæmolytic system is eliminated; (ii) the reaction is "standard," is more definitely quantitative, and comparative results can be obtained by independent workers. The Wassermann is only done (by an independent observer) as a confirmation test in exceptional cases.

2. *The diagnosis of the form of neuro-syphilis from examination of the cerebro-spinal fluid*.—(i) Foam: quantity and persistence. (ii) Globulin: the Ross-Jones test only. (iii) The Boltz test: found to be almost, but not quite, invariably a test for globulin only. (iv) The colloidal gold (Lange) reaction. Other tests, such as the benzoin, gum mastic and gamboge reactions have, after trial against the colloidal gold reaction, been discarded. We have no strong objection to the benzoin test, although it occasionally gave us some anomalous results. The colloidal gold reaction has, in our experience, been found to be the *most reliable* and undoubtedly the *most delicate* of all the reactions tried. In the gold test the chief difficulties lie in the preparation and control of colloid. It requires experience, and also, for some unexplained reason, a certain amount of what can best be described as "knack." The usual text-book descriptions of the method of preparation do not always and entirely avail. Reliance is not placed on any fresh preparation until it has been tried against fluids from clinically typical cases of general paralysis and from obviously negative cases. We satisfy ourselves that a new preparation is sufficiently but not unduly "protected." Such can be successfully used for many months.

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When *all* the above-mentioned tests are positive a reliable laboratory diagnosis of general paralysis can be given and other tests are unnecessary. The laboratory diagnosis, in every case, has been arrived at independently and the clinical staff is in entire agreement with it.

As is well known, the gold sol test may give a paretic curve at times in cases other than general paralysis—especially disseminated sclerosis and some cases of cerebral tumour, but the other tests, and of course clinical examination, assist in excluding these.

The *cell-count* has been abandoned, except in special cases, for example, suspected cerebral tumour or meningitis. As a routine procedure in the laboratory diagnosis of general paralysis it does not compensate for the time and labour involved in the examination of a large number of specimens.

Prolonged trial has led us to believe that it is better to rely upon a limited number of tests, each carried out with meticulous care, than to attempt a greater number of such tests, some of which might, on occasion, have to be hurriedly completed.

3. *Post-mortem*.—(i) The Spatz test: This up to the present time has been found to be reliable in the differential diagnosis of general paralysis from other types of cerebral disease usually met with in mental hospital practice.

(ii) The final test of course is macro- and particularly microscopical examination of the brain in every case in which an autopsy can be obtained. It is this final test which has satisfied us as to the reliability of the tests carried out during life. One of our objects all along has been to find a flaw in the latter tests—properly carried out—and in this we have, so far, failed.

Dr. Reeve said: It has been urged that an endeavour should be made to establish the diagnosis before the cortical cells had undergone degeneration. To succeed in prolonging life when the patient had already attained the stage of dementia is frankly not worth while.

Syphilitic changes in the cerebro-spinal fluid are already present before any physical signs of nervous disease have developed.

The blood, at least, should be examined in every new admission into mental hospitals, and a positive reaction should be followed by an investigation of the cerebro-spinal fluid. Of 305 consecutive admissions into Rainhill Mental Hospital in which both were examined, the blood in 23·6% and the cerebro-spinal fluid in 11·7% gave a positive reaction.

A case occurs here and there where the blood is negative, although the cerebro-spinal fluid is strongly positive. This negative reaction of the blood is in all probability due to active anti-syphilitic treatment in an early stage of syphilitic infection, but after the spirochætal invasion of the meninges. An examination of the Rainhill records shows that clinical errors in diagnosis were apt to be made in cases where general paralysis commences at an advanced age, also when it occurs in unusually young subjects. Especially difficult is the diagnosis of those acute, fulminating cases which die within a few months of admission. The difficulty of making a differential diagnosis between the meningo-vascular type of cerebral syphilis and general paralysis was notable. In six cases which during recent years, no differential clinical diagnosis could be made.

In a recent death from cerebral syphilis in a male patient at Rainhill, who exhibited all the mental characteristics commonly associated with the exalted type of general paralysis, the brain was shown and Dr. Watson demonstrated its characteristic features.

Dr. H. T. KIRKLAND expressed his appreciation of the papers by Dr. Reeve and Dr. Watson.

He contrasted the high incidence-rate of syphilis and neuro-syphilis among new admissions at Rainhill with that at Preston, and referred to the dependence on laboratory methods for the diagnosis of early cases of general paralysis of the insane presenting few of the classical signs and symptoms. He pointed out the need for pursuing and trying out new lines of empirical treatment, in the hope of finding some sure method of arresting the paretic course even in the more chronic forms.

Dr. F. H. STEWART outlined the routine adopted at Cheddleton Mental Hospital in cases suspected of general paresis, which differed from that at Rainhill in the use of colloid benzoin instead of colloid gold, and of the cell-count in every case.

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The colloid benzoin test had failed in one case only, that of a melancholic who, twelve months later, gave a positive colloid benzoin. At the second test, however, the clinical condition had changed to one of melancholic general paralysis. The benzoin test had the merit of simplicity. Referring to laboratory tests applied after treatment by malaria, Dr. Stewart said that the Wassermann of the cerebro-spinal fluid was sometimes less emphatically positive, but might show no change even in patients who were clinically cured. This seemed to agree with the observation that treatment by malaria was as effective alone as when combined with organic arsenic. The idea therefore arose whether general paresis might not be due to some second factor added to the syphilis.

(4) "A Case in which the Differential Diagnosis lay between Cerebral Tumour and General Paralysis," demonstrated by Dr. GEORGE S. WILSON, of Prestwich Mental Hospital.

Dr. Wilson said he had selected a case for demonstration on account of the discussions which had taken place that afternoon, one on cerebral tumour, and another on the serological tests in general paralysis.

The case was admitted as one of general paralysis, but owing to the negative results from *all* the serological tests, doubt arose as to the accuracy of the original diagnosis and the question of cerebral tumour. Briefly the history of the case was as follows:

From 1914 onwards the patient had shown signs of defective memory coupled with outbursts of temper, which became more frequent and severe. In 1916, roughly two years after the first mental symptoms, the patient was knocked down by a bull (he is a butcher), and was in bed for a few days, suffering from shock and bruises. He resumed his work. In 1918 he was knocked off a tramcar and again suffered from shock. His wife expressed the opinion that both accidents were due to his mental condition rather than that his mental condition was the result of these accidents. In 1920 his condition became such that he had to cease work. In 1923 he suffered from twitchings of the facial muscles, but this passed off. Since then until admission last September he had become weaker in body and mind, and had required assistance in all his movements.

He was a total abstainer, but had a specific history. His present age was 61. His reception order was as follows: "Great difficulty in comprehending the meaning of ordinary remarks or questions. Inability to say when he had food or what he had last; no idea of the significance of day or night or time or place. His wife stated that he had to be cared for as regards putting to bed, dressing, feeding, etc. He thinks that he is able to go long walks."

On admission he weighed 12 st. 10 lbs.; he was now 9 st. 1 lb. There was nothing to note particularly about his alimentary, respiratory and circulatory systems. His nervous system was as follows: Defective vision with pupils reacting very sluggishly to light. Rombergism very marked. Knee-jerks diminished. Babinski negative. Tongue tremor marked. No ankle clonus. Optic discs pale, but these could not be examined thoroughly owing to the restlessness of the patient. Periodic attacks of severe headache. Mentally he was simple and childish. Had an exaggerated sense of well-being and was disorientated for time and place. He could walk only with assistance, but maintained that he could walk several miles. His memory was very defective. At times his manner was overbearing, and he maintained that he was superior to everyone else. His habits became faulty. He had had several outbursts of screaming and violent temper. He would state that his present condition was due to bestiality. He had periods of restlessness, during which he would pick and play with his bed-clothes. He had stated that he contracted venereal disease in Edinburgh, but could not give any date. At times he seemed to be persecuted by someone, because he suddenly shouted out, "Don't do it; please don't do it."

His blood and cerebro-spinal fluid had been examined, with negative results, by the Wassermann, sigma, gold sol, Ross-Jones, Noguchi and Boltz tests.

His son, a married man about 30 years of age, who stated that he had never exposed himself to any infection, showed a positive Wassermann, but his wife's blood was negative.

The case clinically resembled general paralysis, but the blood and cerebro-spinal fluid did not give the usual positive reactions to the various tests for this condition. On the other hand there were two of the cardinal signs of cerebral tumour well marked, (i) optic neuritis, and (ii) severe headache, but no vomiting

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and no localizing signs. There had been progressive mental and physical deterioration, much more rapid during the past three months. On the assumption that the condition might be due to a gumma which need not give a positive Wassermann, gold sol, etc., and yet might give rise to optic neuritis and headache. Potassium iodide and liq. hydr. perchlor. were administered *t.d.s.*, but with little or no effect.

The case was extremely interesting yet difficult, but he believed that it was one of the few cases of general paralysis which do not give the usual serological reactions.*

(5) Dr. F. C. LOGAN and Dr. J. A. A. SANG, of Prestwich Mental Hospital, read a paper on "Volvulus" and demonstrated cases which had been operated upon for this condition (*vide* p. 259).

(6) "A Case of Actinomycosis treated by Iodine in Milk," demonstrated by Dr. GEOFFREY TALBOT, of Prestwich Mental Hospital.

Dr. Talbot said: This patient, admitted in 1923, developed a large fluctuating abscess in the right ilio-lumbar region about January 1926. This was aspirated, and found to contain the typical colonies of actinomyces.

The patient's history furnished the fact that she was formerly a cook to a Scottish country household. On one occasion she was skinning an ox-tongue and noticed that "it was very hard and had cancer." In all probability this was the origin of her infection by the mouth, but not until 1926 were any external signs of the disease apparent. The site of the primary growth has not been discovered, but the most likely is the cæcum or appendix, with secondary involvement of the liver.

The treatment consisted in administering ♏v doses of the weak tincture of iodine in milk thrice daily for several months, with short intervals of intermission.

The aspiration of the abscess was continued as long as necessary, and soon a very marked and continuous improvement was noticed. There has been no recurrence of the disease. The exhibition of the iodine in milk is apparently true colloidal therapy, and judging by the result in the present case is worthy of more extended trial in similar conditions.

A microscopical preparation from this case was shown.

Rubery Hill Mental Hospital, Birmingham.

A Divisional Clinical Meeting was held at the above hospital on Thursday, March 15, 1928, at 3 p.m.

Present: Drs. F. J. Stuart, Wm. Reid, E. D. Hayes, A. H. Firth, B. H. Shaw, H. Astley Cooper, K. K. Drury, K. Sykes, F. A. Pickworth, E. S. Selkirk, J. W. Stocks, J. M. MacKenzie and T. C. Graves. Dr. Graves in the chair.

Dr. MACKENZIE opened a discussion on "Non-Specific Protein Therapy by T.A.B. Vaccine in General Paralysis." Temperature charts from cases so treated were shown and compared with malarial charts. Three cases of general paralysis treated with T.A.B. and N.A.B. were demonstrated.

The advantages of T.A.B. pyrexia over malaria were described and the indications and contra-indications outlined.

A male case (non-syphilitic) was shown for diagnosis in which there was a history of neurasthenia, following service in the Great War, with periods of confusion, and a sense of unreality experienced, with statements made by the patient suggestive of epilepsy. A history of severe influenza in 1918 was obtained. Considerable improvement had followed drainage of infected accessory nasal sinuses.

The special treatment block of the new wards at Rubery Hill was inspected, where a demonstration was given of continuous colon irrigation by use of apparatus fitted to a specially constructed table.

City Mental Hospital, Humberstone, Leicester.

A Divisional Clinical Meeting was held at the above hospital on Tuesday, March 27, 1928, at 3 p.m.

There was an attendance of about 35—10 from mental hospitals and 25 of the general practitioners and consultants (including Mr. C. J. Bond) from Leicester.

* Subsequent to the date of this meeting the patient died (March 20, 1928), and *post mortem* the brain was typical of general paralysis.

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Dr. J. FRANCIS DIXON, who presided, welcomed the visitors on behalf of the Visiting Committee, the Royal Medico-Psychological Association, and his colleagues, and outlined the purpose of these clinical meetings, *i.e.*, to stimulate interest and establish contact among assistant medical officers of convenient groups of mental hospitals, and to keep mental hospital practice in touch with the main current of general medicine.

Dr. T. WISHART DAVIDSON gave a clinical demonstration of the results of the malaria treatment of general paralysis. The cases numbered 48, and were grouped as follows:

Deaths unassociated with malaria	12 = 25%.
Deaths from malaria	5 = 10·4%.
Unimproved	7 = 14·5%.
Slightly improved	5 = 10·4%.
Much improved	7 = 14·5%.
Discharged	12 = 25%.

An account of all the cases at present in the hospital and of 10 of the discharged patients was given, and the cases demonstrated.

At the close of the proceedings Dr. Davidson was heartily thanked and congratulated, and an interesting discussion took place.

Sunderland Mental Hospital, Ryhope.

The first Divisional Clinical Meeting of the Newcastle District was held at the above mental hospital on March 28, 1928.

Present: Drs. M. A. Archdale, F. Back, Thomas C. Barkas, Eric P. Boyle, Joseph Braithwaite, D. H. Cameron, G. R. East, Allan A. Macdonald, Finlay D. MacGilp, H. D. MacPhail and Geo. F. May. Dr. M. A. Archdale in the chair.

Dr. BACK gave an account of his experience of malarial and tryparsamide treatments, both singly and combined, in cases of paretic dementia. He dealt with 96 cases at Sunderland and Sheffield. With the malarial treatment he thought we might expect at least 30% more and longer remissions than in cases not treated. Most of the cases, even if not fit to be discharged, became stationary, and seizures were particularly rare. Generally he found marked improvement in the serological conditions. The result was better the more rigors the individual was allowed to have—at least 12 or 14 rigors unless the blood-films, temperature and general condition made an earlier stop necessary. He did not think it made much difference whether the malarial infection was induced by mosquito or blood-transference, though some thought there was a greater tendency in the latter cases for the malaria to be abortive or self-cured within a short time.

Comparing the two treatments in the Sunderland Mental Hospital, of the 14 malaria cases in 1925, only one had been discharged, while of the 13 tryparsamide cases treated during the past two years 2 had been discharged and were doing well. In addition a man who did not appear to be doing satisfactorily after malarial treatment had been given tryparsamide, and was at home doing well.

The other malarial cases at Sunderland had only been infected this year.

Dr. Back showed a number of patients and charts illustrating his points.

Dr. ARCHDALE said one reason why the Sunderland cases of 1925 had not shown as good results as usual was that they were nearly all advanced or of long duration. Until this year they had better results with tryparsamide, but a serious drawback to this drug was its great expense. Other disadvantages were the long duration of treatment required, and the time-absorbing nature of the technique in administering the drug. They had had no cases of nephritis, but one man died of pneumonia at the end of his malarial course.

Drs. MACPHAIL and MACDONALD described similar treatments and results at the Newcastle Mental Hospital. Dr. MacPhail said they had had to cut short the malarial course of two cases on account of nephritis, and one man had died of pneumonia while convalescing from malaria. Dr. Macdonald said in his experience the serological results were equally good in the malarial and in the tryparsamide cases.

Dr. BARKAS described 4 cases he had treated by induced malaria.

Dr. MAY asked whether any of the cases treated had been previously infected with malaria during the Great War.

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Dr. MACPHAIL said a man at Newcastle who had twice been inoculated without being infected was of this kind, and Dr. Archdale said none of the Sunderland cases had been previously infected.

A discussion then took place on the "Possible Interpretations of the Schedule of Forms of Mental Disorder issued by the Board of Control," the subject being introduced by Dr. ARCHDALE. The discussion was confined mainly to the various ways in which schizophrenic cases might be classified under the schedule.

Dr. Archdale emphasized the point that many of the cases commonly called secondary dementia were really schizophrenic in type, and sometimes made most unexpected recoveries under various circumstances, including a severe illness or transfer to another mental hospital.

He also pointed out that many patients showed a mixture of reaction modes. Not only were organic cases often complicated by purely functional reactions which cleared up under suitable treatment, but functional cases occurred which in the course of a short time showed different reaction modes. Sometimes a case appeared for a time to be one of psycho-neurosis and later schizophrenia.

Another patient obviously schizophrenic might show much periodicity, and yet another obviously manic-depressive might have the manic or depressive phases complicated by stereotypies, affectations, mannerisms, hallucinations, delusions, etc., suggesting schizophrenia.

Dr. MACPHAIL emphasized the point that functional mental ailments were not comparable with ordinary bodily diseases, but were exaggerated reaction modes and inefficient adaptations.

Drs. EAST, MAY, BACK and BRAITHWAITE took part in the discussion, and the general conclusion was that though the official classification was unsatisfactory for cases which could not be proved to be organic, the time was not yet ripe for attempting to improve it.

Cheshire County Mental Hospital, Upton, Chester.

A Divisional Clinical Meeting was held at the above hospital on March 29, 1928, at 3 p.m.

Present: Fourteen medical men, including visitors. Dr. G. H. Grills presided.

Dr. ISABELLA A. GILLESPIE, Assistant Medical Officer at the hospital, read a paper on "Treatment of Post-Encephalitis." After discussing the prevalence and ætiology of the disease, she proceeded to describe its treatment by removal of septic foci, special feeding, ultra-violet therapy, liver treatment, diathermy, autogenous vaccines and induced malaria, especially the latter, which took up a considerable part of the paper.

Eighteen cases in all had been treated. The obvious resemblance between syphilis and general paralysis on the one hand and acute and chronic encephalitis on the other, and the case for malarial treatment were commented on. Twelve cases had improved after a course of induced malaria, and in five of these the improvement had been maintained; the others regressed to a varying extent.

Fourteen cases of post-encephalitis and several of general paralysis, illustrative of the effect of induced malaria on these two diseases, were shown by the medical staff.

Dr. PAUL, of Chester, thought that drugs were sometimes of use when administered in the radical sense referred to in the paper, *e.g.*, if injected for encephalitis. He stated that he had had a typical Parkinsonian case into which he injected potassium permanganate intravenously, and that the patient improved enormously and was able to dance before leaving the hospital.

A discussion arose on the relative merits of drugs like potassium permanganate and urotropin when the virus was in the brain. Urotropin might be considered as the better drug. Ten-grain doses of urotropin thrice daily appeared in the cerebro-spinal fluid as formalin (1 in 25,000) and 1 in 40,000 formalin hindered putrefaction outside the body.

Dr. F. H. HEALY, Assistant Medical Officer at the hospital, read a paper on "Menstruation in Relation to Mental Disorders," based upon the examination of 243 cases of menstrual age. The latter part of the paper is devoted to epilepsy, especially in relation to menstruation. These papers gave rise to interesting discussions, as did the cases demonstrated in the wards [Both papers will appear in the July issue of the Journal.]

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