Part III.—Psychological Retrospect.

FRENCH RETROSPECT.

By Dr. MACEVOY.

New Contribution to the Study of False Porencephaly and True Porencephaly.—Bourneville and Schwartz, in *Progrès Médical* (No. 37, and No. 39, 1898), relate two cases of the former condition and one of the latter; as usual, full detailed notes are given of symptoms during life and post-mortem appearances. With further knowledge, the authors maintain their former view—thus differing from Heschl,—that arrest of development is the sole cause of true porencephaly, and that no pathological process is capable of bringing about an identical lesion to that found in true porencephaly.

The salient points which characterise true porencephaly are—

1. The cavity is more or less regularly funnel-shaped, with its base external and the apex directed towards the ventricle; the surface is smooth, and its only covering is the outer layer of the pia mater.

2. The convolutions present a characteristic and striking disposition, upon which much stress is laid. They all radiate towards the bottom of the excavation, which is a true point of convergence, whence they seem to take root.

3. The orifice of communication is always regular, often perfectly round—constituting the porus. This characteristic porus is always situated at the most dependent point of the porencephalic funnel.

4. Around the excavation one almost constantly meets with other anomalies, due to the same arrest of development. For instance, in the case described, the frontal and ascending parietal convolutions were obviously not destroyed, but either they were not developed or deviated from their normal path.

5. The lesions found in cases of what we term false porencephaly may be congenital, from disease of the fœtus, but they may also occur after birth, even long after; but true porencephaly is *always* a congenital disease of intra-uterine life, and *never* occurs after birth.

As regards the pathological process which brings about the loss of cerebral substance, so far we are only on hypothetical ground. Bourneville and Schwartz believe in the vascular theory, basing their view especially on the fact that the seat of the lesion nearly always involves the region of the middle cerebral artery.

Intangible Epilepsy.—Dr. Gelineau (*Revue de Psychiatrie*, 1898, No. 12) suggests the appellation intangible for those cases of epilepsy which resist all forms of treatment. He recognises two varieties. In the first variety, under treatment the attacks are fewer and less severe, but at the same time there occur marked alterations in the psychical condition of the patient. Instead of being calm, good-natured, easily managed, he becomes morose, violent, and extremely irritable. In

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some cases, with the complete disappearance of the fits there may supervene a state of dangerous violence. In others, again, dementia may succeed the suppression of the fits. Notes of cases are given.

The second variety of intangible epilepsy comprises those cases which practically do not react to any kind of treatment. Whatever drug is tried, it is obvious in these cases that not only is it not well tolerated, but the condition is aggravated. Notes of an interesting case of this kind are given.

Dr. Gelineau believes that intangible epilepsy is rare; in a long practice he has only observed eight or ten cases. The cause seems obscure. It is important, however, to recognise this kind of epilepsy, for while it is sad to have to fold one's arms in presence of a case tormented with frequently recurring fits, we must never forget that one of our great duties is "primum, non nocere!"

Degeneration and General Paralysis.—Professor Joffroy (*Revue de Psychiatrie*, 1898, No. 10) relates the case of a man, a degenerate under M. Magnan's care for some time, who developed general paralysis, and was ultimately admitted under his (Prof. Joffroy's) care, as an illustration of the view which he holds,—that a morbid heredity more or less marked, degeneration more or less obvious, is a frequent if not indispensable factor in the ætiology of general paralysis of the insane.

The patient, a foundling, born in 1851, of somewhat feminine build and of decidedly feminine habits in youth, became strongly addicted to sodomy after the age of fifteen, and led a life of debauch in Paris. In 1893 his memory began to fail, and he was arrested for occupying some one else's bed (? mistaking the story of the house). Sent to the asylum, M. Magnan noticed delusions, loss of memory, unequal pupils, and slight affection of speech.

In May, 1895, he came under Prof. Joffroy's care. His condition did not vary much until 1897, during which interval he had been working as tailor in the asylum. He now became more and more demented, with fleeting delusions. In November, 1897, he took to his bed, had general tremors, and was of dirty habits. In January, 1898, his speech became incomprehensible, and he died after getting weaker and weaker, physically and intellectually, in March, 1898. At the autopsy, characteristic lesions of general paralysis were found in the brain.

In considering the relation of general paralysis to degeneration, says Joffroy, the well-recognised rarity of the incidence of general paralysis among chronic lunatics is not an argument of weight against his view, for only a minority of degenerates are found in asylums.

In this case syphilis and alcohol could apparently be well excluded as ætiological factors. Venereal excesses? Joffroy dismisses this factor, because the patient was not a masturbator, and had a repugnance for the female sex, and because "all his genital life consisted in unnatural acts, in which he was almost constantly the passive agent." He therefore falls back on mental degeneration as the cause—if not the sole cause, at least the preponderant one—of the onset of general paralysis.

If the stigmata of degeneration, and especially psychical stigmata, are not commonly noted in the history of cases of general paralysis, it

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is perhaps because they are carefully concealed by the patient when he is well; for, says Joffroy, there is one point in connection with the history of general paralysis to which it is well to draw attention. It is not rare to see the disease manifesting itself at the onset by morbid acts recalling those of degenerates,—offences against public decency, for example. As a rule, they are looked upon as purely and simply manifestations of general paralysis. But might we not go further back, and suppose that there already existed in the individual a psychical stigma, carefully concealed so long as he enjoyed his reason, but laid bare when general paralysis caused enfeeblement of his intellectual faculties? We believe it is worth while drawing the attention of alienists and medico-legal experts to this point. Inquiry would probably often give negative results, on account of the considerable difficulties which the question presents; but one might, perhaps, obtain some extremely interesting positive ones.

As regards the histological examination of the spinal cord in the case referred to above, Joffroy lays stress upon the fact that very marked lesions of the nerve-cells were found associated with practically normal nerve-fibres and very slight proliferation of the neuroglia; at certain levels the sections exhibited complete disappearance of a number of cells. This is in accordance with the view that in general paralysis, degeneration of the neuron is primary.

Tabetic Lesions in General Paralysis.—Dr. Etienne Rabaud (in *Revue de Psychiatrie*, 1899, No. 2) brings forward a useful contribution to our knowledge of the relation of tabes to general paralysis. For many years the question has been on the "tapis," whether in cases of general paralysis, which present symptoms of locomotor ataxy, we are to look upon the disease as simply a variety of general paralysis with lesions spreading to the posterior columns, &c.; or whether we are in presence of an association of the two diseases, general paralysis and locomotor ataxy.

From the clinical standpoint, certain characteristics in the symptoms may lead one to suspect general paralysis in a patient suffering from spinal disease. Variability is an important peculiarity. Lightning pains may suddenly appear, persist for a few weeks or months, and then disappear; the reflexes become exaggerated, then are found later on diminished or lost. A remission of longer or shorter duration occurs, &c. &c. But, after all, the spinal symptoms of general paralysis are not well defined, and the sole presence of the tabetic syndroma may lead to errors.

Does morbid anatomy help us? Microscopically does a paralytic sclerosis differ from ataxic sclerosis? Rabaud answers yes.

It is of the utmost importance to examine the cord methodically and carefully in its whole length, for while the localisation of the sclerosis in general paralysis is very similar to that of locomotor ataxy it is not identical. According to him there are four important differences in general paralysis:

(*a*) The localisation of the tabetiform lesions varies from one level to another of the cord. It occupies along a certain track the site of exogenous fibres, then without definite transition is confined to a band occupied by endogenous fibres.

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(*b*) The examination of one section shows that there is no precise fasciculation; the lesions are diffuse.

(*c*) The posterior roots and the zone of Lissauer are healthy, or almost normal in general paralysis—even in association with marked lesions of the exogenous zones, as may be seen in some sections. This is very unlike simple tabes.

(*d*) The cells of the grey matter, those of the anterior horns, like those of the columns of Clarke, are affected. The affection varies in various segments of the cord.

These taken together clearly differentiate the two diseases. As regards the nature and origin of the morbid process, after carefully considering the distribution of the lesions, &c., Rabaud rejects various theories—vascular, meningitic, &c.,—and believes that the primitive lesion is intra-medullar, and affects the neurons of the grey matter. He concludes, with Joffroy, that "general paralysis does not, like locomotor ataxy, affect an anatomical system having a well-individualised physiological function, but attacks various anatomical systems possessing multiple physiological functions." Moreover, he adds, the various sclerotic lesions which are found in general paralysis can be explained by the affection of the neurons of the cornua.

In conclusion, while the author does not deny the possible co-existence of tabes dorsalis and general paralysis, he believes it is rare, and one must always be on one's guard in presence of a spinal case developing symptoms of general paralysis. The exact diagnosis is always difficult to establish, and often can only be settled by the help of pathological anatomy.

The Treatment of Morphinomania by Sudden Suppression, by A. Lutaud and B. Deering (*Revue de Psychiatrie*, 1899, No. 2).—While each year adds extensively to our knowledge of morphinomania, the question of treatment is still one that gives rise to marked difference of opinion. One class of physicians, including especially the Germans, advocate the sudden withdrawal of the drug as a first step; the opposite school, among whom are the majority of French writers, holds that this method may be the cause of grave accidents. Drs. Lutaud and Deering believe that the latter view is ill-founded.

With regard to cases of morphinomania, some distinction must be made, however; morphinomania, say our authors, is only curable when present in individuals not suffering from some necessarily fatal affection; it is only susceptible of rapid cure by sudden suppression during the period which precedes the cachectic state.

That sudden suppression of the drug is not fatal to life has been proved over and over again by the experience of prisons, in which morphinomaniacs are not unfrequently incarcerated for theft, &c. With regard to rapid suppression (that is gradual diminution, culminating in absolute suppression within four to eight days), not only is it possible, but Lutaud and Deering believe that it is the only rational method of treatment in moderate cases, and in patients who are not suffering from some serious organic disease. They except cases of asthma, phthisis, locomotor ataxy, or with well-marked cardiac and pulmonary lesions.

In order to carry it out, compulsory or voluntary sequestration is

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necessary; eight days of it do much more good to the patient than a year of patience and attentive care.

More than thirty observations have been collected by the authors, in which sudden suppression has led to a cure without any serious symptoms; while, on the other hand, "we still await authentic facts showing that this suppression can cause the dangers which one sees enumerated in some of our classical text-books."

The Non-equivalence of the two Cerebral Hemispheres.—It is well known that several peculiarities differentiate the right half from the left half of the brain—development, configuration, weight, physiological functions, &c.; . . . but an important point is the degree of secondary degeneration in the cord, consecutive to destructive lesions of the two sides; it is this question which MM. Klippel especially examines in the *Revue de Psychiatrie*, 1898, No. 2.

The following are some of his conclusions:

(*a*) Degeneration of the crossed pyramidal tract is more marked in lesions of the Rolandic convolutions of the grey central nuclei and capsular fibres when the focus of disease is in the left hemisphere.

(*b*) Participation of the direct pyramidal tract is more frequent with lesions of the left hemisphere.

The author also refers in this article to other pathological facts which bear upon the question of the non-equivalence of the two hemispheres, such as the incidence of emotional hemiplegia, reaction of the pharyngeal reflex with right and left hemiplegia, functional hemiplegia, hemianæsthesia, &c.

RETROSPECT OF CRIMINAL ANTHROPOLOGY.

By HAVELOCK ELLIS.

The Relation of Criminal Anthropology to Psychiatry.—In the excellent *Centralblatt für Anthropologie* (edited by Dr. Buschan), to which the attention of readers of the JOURNAL has been called in previous years, a brief but pregnant paper has lately appeared on the above subject by Prof. Zuccarelli ('Die Beziehungen zwischen Kriminal-Anthropologie, gerichtliche Medizin, und Psychiatrie,' 1898). Criminal anthropology has, of course, in common with psychiatry, the author remarks, the domain of psychic disturbances and the methods of clinical observation. But does criminal anthropology mean no more than that? Assuredly not. The specific and fundamental element of criminal anthropology is the direct, extended, and detailed study of anthropological morphology, both individual and racial, external and internal. It takes its methods and material from general anthropology; it makes use of comparative anatomy and physiology to ascertain the ontogenetic and phylogenetic position of anatomical forms and states of development; it takes advantage of general pathology and pathological anatomy. It suffices to recall the extent to which morphological questions have been recently studied, and the interest such

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