to be confined. Still, however, he is easily appeased, apt to mistake his bed, and lose his way in the ward.

December 28th. There is no very appreciable progress since last report, except that he is learning the names of officials and patients better. He is apt to have fits of depression, and prefers to keep out of sight at the doctor's visit, because the doctor tests his memory, which makes him nervous. Was at Christmas tree last night, and received a comical present from the tree. This morning he has a dim recollection of getting something, but he cannot tell what it was. He is often witty, and banters the attendants and patients a good deal.

The course of the case from this date onward was one of steady improvement, the memory became more retentive, but he often forgot instructions received. As regards all details connected with his trade his memory was almost from the first quite good, but for a long time it was evidently incapable of retaining and reviving at will new impressions. In the beginning of February he made himself useful in the sick ward, and on the 24th was discharged recovered. The points of interest in this case are these:—*First:* Mental excitement before admission, such as might be expected after a fit of drinking. *Second:* Delusions of identity of long duration, showing themselves after the alcoholic effects might reasonably be expected to have disappeared. *Third:* A decided weakness of memory, an inability to register and recall at will new impressions (this was exaggerated by nervousness). This peculiar affection of memory is, I understand, not unknown. It may, in fact, be common in cases of mental disorder from lead-poisoning, and may be less frequent in asylums than in ordinary hospitals, seeing that *per se* it cannot technically be considered a symptom of insanity. *Lastly:* Certain disorders of the motor system, such as hand tremor, and an unsteadiness of gait, a difficulty in turning sharply round and an irregularity in shape of the pupils. With the exception of the last, these had disappeared as he got stronger.

Subsequent Note.—This man reported himself two months after discharge. His memory had improved very little. He was able to resume work, but required a memory-aid occasionally in the shape of an overseer; and when he got instructions was at first confused, until fairly started with the job in hand. Blue line is still present, but less marked than on admission. Complains of weight over vertex, and of bad taste in mouth. Is now a journeyman, and not able for a foreman's work as previously.

Unilateral Sweating: Note on Further Cases of. By Wm. Julius Mickle, M.D.

In the "Journal of Mental Science" for July, 1877, p. 196, I placed on record some examples of unilaterally increased sweating, or hyperidrosis, particularly three cases occurring in general paralysis. In one of these cases of

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general paralysis, the unilateral excessive sweating affecting one side of the face and head was not associated with any local convulsion or paralysis, but the eyeball of the same side was sightless, and completely withered and shrunken, as the result of disease following an injury incurred long before he came under care. In the second case, convulsion and paralysis affected the same side of the body as that on which the accompanying unilateral facial sweating occurred; and in the third case the first appearance of the sweating followed the onset of hypochondriacal symptoms, and was contemporaneous with slight transitory unilateral facial paralysis of the same side, although the tendency to this sweating remained for a time after the local paresis had cleared up. In the first and third of these cases the right was the side of the face affected, and the left in the second. Full details of all these cases were given in the paper.

In that part of the above-mentioned paper which treats of the pathology of the symptom, p. 206, *loc. cit.*, I discussed the question whether the sweating was due to some disorder or lesion of the vaso-motor system, or to a morbid excitation of nerves which may be supposed to more directly control secretion, and I suggested that there might be sweat-secretory nerves, which exercise an immediate control over the perspiratory function analogous to that which certain secretory nerves were at that date believed to exercise over some other secretions, as, for example, the salivary. Since that time views similar to those thus theoretically suggested in my paper have resulted from the experiments of Luchsinger, Nawrocki, Adamkiewicz, and Vulpian.

The fourth case mentioned in the same paper, p. 201, *loc. cit.*, was that of an agitated melancholiac, who became phthisical, and in whom, after death, the greater part of the left supra-marginal gyrus was found to have been destroyed and absorbed; while a branched calculus filled the pelvis of the right kidney, which organ was much wasted. The phthisical changes were more advanced in the left lung. The hyperidrosis was of the left side of the face, and was rather less marked than in the preceding patients.

To the above I now add brief notes of two other cases observed since the publication of my paper in 1877. One of these examples occurred in a general paralytic whose symptoms were somewhat obscure and ambiguous; the other was seen in chronic melancholia.

Case I.—J. H. M., Royal Engineers, admitted July 12th, 1879,

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aged 34. Recognized mental disease had existed for six months previous to admission, but the affection had come on insidiously; overstrain and anxiety about military office work, and about his change of religious profession were the causes assigned for the mental disease. At first there was gradual failure of memory and increasing feebleness of intellect. He was silent but mischievous, restless, and destructive. It was necessary to feed him; the habits became filthy; he passed urine and fæces in bed. Bedsores made their appearance, and only healed to recur. This was before admission here.

On admission he was emaciated, feeble, helpless, of wet and dirty habits, melancholic, and rarely spoke.

Vomiting became rather troublesome. The mental condition for a time approximated to melancholia attonita.

Later on there was diarrhœa. The tongue also was tremulous, the speech shaky; the pupils were slightly irregular, sluggish, and often unequal, the left being usually the larger.

At last, besides local spasms there were epileptiform seizures, especially affecting the right side and followed by right hemiplegia. These recurred frequently, and in the intervals sweating confined to the right side of the face was often noted. Thus, to take one note only, on January 12th, 1880, he had four epileptiform convulsions, mainly of the right side. Chloral enema. The right lower face and right upper limb were somewhat paretic, and the right side of the face bedewed with perspiration. At times the profuse sweating was limited to the right side of the visage, with a very little on the left side of the nose; at others there was more general and more equalized sweating. The left pupil was the larger: blebs formed on the right hand. 60ozs., and, again, 20ozs. of pleuritic fluid were removed from the left side by the aspirator. Death $6\frac{1}{2}$ months after admission.

As to the necropsy, only the following points need be mentioned here. The olfactory bulbs and tracts were somewhat wasted. There was some atrophy of brain convolutions with œdema of meninges and opacity in fronto-parietal regions. Adhesion and decortication slight, affecting the first and second frontal gyri on both sides, and the left ascending frontal very slightly, also slight cerebellar adhesions. White medullary substance rather pale, and slightly firmer in frontal region than elsewhere. ʒv. serosity in the large lateral ventricles. Faint granulation of ependyma of lateral ventricles. Left hemisphere $\frac{1}{2}$oz. less than right. No very special naked-eye changes in pons Varolii or medulla oblongata. Fluids from cranial cavity $4\frac{1}{2}$ozs.

Case II.—J. C., soldier, æt. 40. Chronic melancholia, with various delusions, formerly suicidal. Thin and pale, he at one time had slight morbid signs at the lung-apices. One morning in November, 1881, he complained of severe abdominal pain, looked ill, was quickly

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purged, and became faint, and as if threatened with syncope. I found him pale, with dilated pupils, and the right side of the face beaded with large drops of perspiration, which if removed readily re-accumulated, whereas the left side of the face was only of a greasy-looking, clammy, slight moistness, with no beads.

As to his customary state, the following may be mentioned:—

Hair of head and face partly and prematurely grey, slight yellowish pigmentation of forehead, skin everywhere rough and slightly scaly, central line of features slightly convex towards right side. Tongue flabby, indented, protruded slightly towards the left side; many of the teeth, especially the back ones, carious, broken-down, or missing, and this in both jaws, especially on the right side. Pupils equal, act fairly to light and in accommodation; patch of slight left corneal opacity (following disease about 20 years ago, he said); a scar on right temple, of which he recollected no history. No present indications of syphilis, and he denied having had any venereal disease except gonorrhœa. Heart fairly healthy.

Note.—After the above was written this patient made a suicidal attempt; had delusions as to torture, persecution, and intestinal inaction; hæmoptysis, phthisis, iritis, and keratitis. Then came on indications of pulmonary gangrene. On several occasions was observed unilateral sweating of the right temple and upper part of cheek, there being none above the level of the *ala nasi*, and none on the left side. The hair, also, was damp on the right side of the head, and the right side of the nape was moister and more clammy than the left. On these occasions there was no sweat on the lower neck or on the chest. At times general sweats occurred.

Necropsy (briefly expressed).—Brain flabby. Cerebral cortex slightly atrophied, pale, but mottled. Greenish discoloration and early decomposition of anterior half of basal aspect of cerebrum. Small foul abscess in left second frontal gyrus, and surrounding greenish discoloration. Right fifth cranial nerve somewhat softened, and easily separating from its insertion. In left lung, caseous nodules; patches of decomposition, lower lobe. Right lung adherent; gangrenous patches in upper part, hepatized portions below. Spleen 12½ozs., dark, firm, capsule thickened; containing a small portion broken down into fœtid, ashen grey, semi-fluid material. Liver 51½ozs.; deep-green hue, partially decomposed, and spongy from disappearance of parts of parenchyma.

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