there is localized congestion that is so marked as to resemble an ecchymosis. There is now a vessel along each malleus; optic papillæ are pinkish. Pulse 84 and fuller. 10.30. p.m. Right drum head is very much injected along handle of malleus and upper margin. Left less so, but yet injected. Both papillæ very pink, left more so than right. Face flushed, eyes suffused, ocular conjunctiva decidedly congested. Slight head-ache; tinnitus in both ears. 11. Redness of auricle diminishing, especially the circumscribed spot on lobe of left one; face still flushed, tinnitus continues; no headache; feels exhilarated. Drum heads still injected along malleus; not more so, however, rather less; optic papillæ have a decidedly pinkish hue; no more lateral vessels seen, however; right is especially pink; tinnitus still continues; vision normal.

To determine the question with even greater certainty the doctor says—

I trephined a medium-sized dog, and screwed a cephalo-hæmometer into the opening in the skull made by the trephine, so that the fluid in the glass tube stood at zero. I then introduced into the cellular tissue two grains of sulphate of quinine, dissolved in water acidulated with sulphuric acid. This was done at half-past 3 o'clock p.m. At 3.35 the fluid had risen one degree on the scale. (= $\frac{1}{10}$ inch.) It continued to rise gradually but steadily, till at 4.10. it had passed over ten degrees (= 1 inch of the tube). At 4.30., one hour after injection of the quinine, the fluid was at + 15°. It continued at this point till 5.10., when it began to fall, and at 8.15. was at zero. It remained stationary for over an hour, at no time falling to the minus division of the scale. The stage of excitement scarcely lasted 15 minutes. It was succeeded by a state of sedation, during which the salivation was excessive, and the animal appeared very much as if under the influence of a full dose of alcohol. As the normal condition of the dog was regained, the fluid fell in the tube, and reached zero almost simultaneously with the disappearance of the symptoms of intoxication. I repeated the experiment on different dogs with variable doses of quinine, from two grains to fifteen, in all four times, and invariably with the result of a steady rise of the fluid in the tube as the effect of the drug increased, and its fall to the zero as the influence wore off. At no time did the fluid reach a lower point than that at which it stood before the administration of the quinine.

PART IV.—NOTES AND NEWS.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

A Quarterly Meeting was held on the 27th ult., in the Rooms of the Royal Medical and Chirurgical Society; Dr. ROGERS, the President, was in the chair.

POST-MORTEM EXAMINATIONS IN NEWGATE.

The Secretary, Dr. W. RHYS WILLIAMS mentioned that he had applied to one of the Surgeons of Newgate for permission to examine the brain and spinal cord of a man hanged for murder, in whose case the plea of insanity had been set up. The answer was, that the Surgeon himself was willing to allow it, but there was an order from the Secretary of State that no post-mortem examination of criminals who were hanged should be made.

Dr. MAUDSLEY thought it possible that this regulation might apply to outsiders only, and that Mr. Gibson, the Surgeon of Newgate, might make an examination if he thought fit. In the case to which Dr. Williams referred, it was not likely that the brain or spinal cord would have shown anything. He (Dr. Maudsley) had a long conversation with the man, and could find no sign of insanity about him, and no evidence whatever of insanity in the account which he gave of the circumstances

https://doi.org/10.1192/bjp.21.93.148 Published online by Cambridge University Press

under which the crime was committed. In fact, he and the woman, who was his victim, had been going from publichouse to publichouse all the morning, drinking, on the day of the murder. He therefore declined to appear and give evidence at the trial.

Dr. WILLIAMS had heard the evidence given at the trial, and had formed the same opinion.

Dr. BLANDFORD observed that—If such a rule now existed at Newgate, it had not always been so; he remembered having made a post-mortem examination there fifteen years ago, just after the man was hanged. It was the Sheriffs who had to grant permission.

The SECRETARY undertook to inquire of Mr. Gibson concerning the rule, before inviting the Association to express an opinion about it.

EXCESSIVE OPIUM TAKING.

Dr. RAYNER had a case of this kind to relate; that of a man who had been in the habit of taking four ounces of laudanum daily, and had become suicidal, threatening to strangle himself. He had been taking nearly his full quantity up to the time of his being placed under Dr. Rayner's care. It was stopped at once; the man at first slept only three or four hours each night, but in the course of a fortnight or three weeks slept quite naturally; by the end of five weeks he had gained 23lbs in weight, and was convalescent, expressing his determination not to return to the practice. This man was fifty-eight years of age, but his father, who was still living, and was nearly ninety, had been an opium-eater to a large amount nearly thirty years It was interesting to observe that the man suffered very little from suddenly leaving off his opium.

Mr. G. THOMPSON described a case in which chloral had been used with success for a patient suffering from general paralysis, who had been accustomed to take three drachms of Batley in the morning, and the same quantity at night. He now took only two drachms in the morning, and ten grains of choral at night, and was very much better, with regular and comfortable rest.

Dr. IRVINE related the case of a medical student he knew, who used to take an ounce of tincture of opium in the morning, and three ounces in the evening. He once took eighteen ounces in one day; and Dr. Irvine once came upon him in the act, and saw him then swallow, in the druggist's shop, six ounces of laudanum and two ounces of chloroform. This young man became perfectly delirious when he got no opium. Dr. Irvine narrated some particulars of his sad history.

PHYSIOLOGY OF GENERAL PARALYSIS OF THE INSANE AND EPILEPSY.

Mr. G. THOMPSON read a paper upon this subject.

(See Part I.—Original Articles.)

A discussion ensued, which was commenced by Dr. Savage with some remarks on the worthless indications of certain pulse-tracings, where the lever, merely resting on the artery, just showed its rise and fall. It was needful to have a graduated pressure, as in Mahomed's instrument. He had to thank Dr. Rayner for pulse-tracings of eight chronic cases, and sixteen or eighteen more acute cases, such as were common in Bethlem. In the past year he had also taken periodical pulse tracings of twenty-five fresh cases in Bethlem, but had not been able to get anyone that was characteristic of general paralysis. There was, certainly, general paralysis of different kinds; that of the insane, and of the not insane, purely senile in some cases, but running a rapid course in others, within six months. What was found by examination after death, in such cases, was the *debris* of various components of the ruined nervous system, like the mixed ruins of a house burnt down. He could scarcely accept Dr. Thompson's view, that serous effusion caused the wasting in senile dementia. Indeed, the idea of serous apoplexy was now given up.

Dr. RAYNER referred to an observation which Mr Thompson had made about the condition of the optic disc in general paralysis. He had, with the assistance of a very competent person, examined forty or more cases of this; and the result was that, instead of there being any anæmia, there was more vascularity, or quite as much as is usual, except in some of the old cases.

Dr. BLANDFORD thought it something new to hear that the condition of general

https://doi.org/10.1192/bjp.21.93.148 Published online by Cambridge University Press

paralysis was one of cerebral anæmia. He had rather considered it to be, in its earlier stages at any rate, a condition of hyperæmia, accompanied by excitement for a period. This was borne out, too, by all the post-mortem appearances. All those twistings of the arteries, and aneurisms, which were discovered, seemed to show a hyperæmic condition, one of great vascularity, Mr. Thompson had spoken of the curative effect of Calabar bean. But from the West Riding reports, as he (Dr. Blandford) read them, it appeared that Calabar bean was used to correct the state of hyperæmia, and to reduce the action of the heart. Its effect had been to produce fainting in one case, while the patient was out for a walk.

Dr. MAUDSLEY regretted to hear the observations of Dr. Hughlings Jackson spoken of in the manner Mr. Thompson had referred to them. There could not be a more accurate observer, or one more sincere and enthusiastic in the cause of science, than Dr. Jackson; and his observations were far from being influenced by any theory. It was the more inconsistent to make those reflections, while lauding Dr. Ferrier for his experiments, which were first made in consequence of the pathological observations previously made by Dr. Jackson, as to the seat of the morbid lesions in epilepsy. He (Dr. Maudsley) did not understand that the term "discharging lesions" was meant to imply any particular theory, but it was used simply as descriptive of the phenomena. It was so far good as there was an actual discharge of some sort. Mr. Thompson seemed to consider that the lesion in epilepsy was the result of a harden ing of the neuroglia, and that the fit was occasioned by a disturbance of the circulation from the unyielding nature of those tissues. Yet, in the same breath, he argued that this hardening was not the cause of the disease, but its effect. How then were the first fits caused? Although he (Dr. Maudsley) had not made any particular observations as to this point, his impression was, that only in the far advanced cases of epilepsy, or epileptic dementia, where the epilepsy had continued a long time, was this hardening of the neuroglia to be found.

Dr. BOYD reminded the members of the Association that he had read a paper on this subject four years ago. The principal lesions which he had discovered in post-mortem examinations of the cases referred to were those of the spinal cord. But all the tissues of the body were no doubt more susceptible of injury than in the ordinary condition. This was probably the cause of that brittleness of the bones, which appeared in some of the cases of fractured ribs that had brought scandal on asylums.

After a little further conversation, Mr. THOMPSON replied, noticing first the strictures of Dr. Savage upon his use of the sphygmograph. He had used it for the last eight years, with all improvements or modifications yet known. In every case, he had taken care to estimate the exact pressure, and had applied a higher or lower pressure when there was no satisfactory result. He had never got an actual tracing of the pulse of a patient in general paralysis under the effect of administration of Calabar bean. But he could, with the same pressure, get a different pulse-tracing from the patient at different hours of the day; and there would be a great difference shown for half an-hour after taking such a stimulant as one glass of beer. In general paralysis, as Dr. Savage had said, the symptoms were those of premature aging; but this was due to mal-nutrition from the obstruction of the vessels. The observations concerning the optic discs, which had been called in question, were those of Dr. Clifford Allbutt, who had most carefully and patiently investigated the subject. He wished Dr. Rayner could see how those observations were conducted at the West Riding Asylum. With reference to one of the remarks of Dr. Blandford, he did not admit that in every case where there was excitement, there was always hyperæmia. As for the effects of Calabar bean, he did not remember any case at the West Riding Asylum, while under his charge, of a patient fainting from it. He thanked Dr. Maudsley for noticing the paper he had read, and agreed with him in the justice of his tribute to Dr. Jackson. Still, he could not understand the use of the term "discharging lesion" as it had been used. Dr. Ferrier, for his part, was careful that there should be no lesion in the cases which he reported upon. When they saw the condition of the neuroglia at the end of an epileptic fit, it might fairly be supposed that the same condition existed at the beginning, and that this was, itself, the cause of that fit and of previous fits. He preferred looking to these indications, instead of to what might be seen after death. He would only add, with regard to Calabar bean, that he did not give it during excitement, but when the excitement was over, and he was sure that it did good. Before it was used, within the first seventeen months of his being there, not one patient of a certain class who was there when he came was left alive; but since Calabar bean was given, some had lived three or four years. It had, therefore, at least the merit of prolonging life.

https://doi.org/10.1192/bjp.21.93.148 Published online by Cambridge University Press

SUDDEN RECOVERY FROM MELANCHOLIA.

Dr. W. RHYS WILLIAMS had to describe two remarkable cases of sudden recovery after a long attack of melancholia. The first was that of E. G., female, 49 years of age, admitted into Bethlem Hospital, in February, 1870. She had had an attack of one month's duration 22 years ago, and had been confined in two lunatic asylums. She had attempted to destroy herself by throwing herself out of window. She was very much emaciated, sallow, and extremely weak. As she refused to take any food it was doubtful whether she could be kept alive, but she was fed by force with a stomach pump during four months. In July her condition was slightly improved. In September it was decidedly improved, and she had gained flesh. She continued about the same in November. During the whole year, 1871, she seemed much the same; and up to September, 1872, there was no real improvement But in January, 1873, without any warning, there was a sudden change. She then appeared perfectly well in mental condition; her bodily health, too, from that time steadily improved. She was kept till June, and was then discharged as a case of recovery. This was remarkable after her strong exhibition before of suicidal despondency, when she used to put her head on the floor and try to break her neck. The second case he would mention was that of a single woman, who had been a schoolmistress, admitted in November, 1873. The cause of her derangement was mental anxiety. In January, and during the next four months, there was no improvement; and in May they were still feeding her with the spoon or stomach pump; but, on the 5th of November, she suddenly became quite well and cheerful, speaking easily and naturally. She had continued well, and was now discharged as cured. These two cases offered some features of interest. There was, in each case, a very sudden recovery, and the mental delusion lasted only for a term. In these cases it was manifest the injury could not have been of a destructive character, but functional or dynamic. Another case had been described of a patient who, during four years, had been forcibly dressed, fed, and cared for, but suddenly woke up cured. Again, there was a case of five years' standing, which took such a turn, resulting in a greatly improved mental condition. In these cases, however, Sir William Gull thought there was a large element of hypochondria, and the patients were not really insane. But hypochondriacs did not commit suicide; and there had been frequent attempts at suicide by those patients he had in Bethlem. He did not put much faith in any special medical treatment of such cases by the administration of drugs. Electricity, indeed, had been tried with much benefit. But it had often been suggested that the true method was to bring strong mental emotions to bear on the patients, and though it was not easy to do this, the chief hope must be in moral treatment. He would merely add, with regard to feeding the patients who refused food, that various means were in use, but he preferred the œsophagal tube, or sometimes the stomach pump. It was wise not to make this feeding too agreeable an operation. By letting it be felt to be irksome, the resistance of the patient might perhaps be overcome.

The CHAIRMAN was reminded, by one remark of Dr. Williams, that at a meeting of the Clinical Society there was a discussion whether a disease was melancholia or hypochondria. His own notion was, that the term hypochondria ought to be eliminated entirely from their nosology. Patients were insane or were not insane, but nobody who had hypochondria should, therefore, be described as insane. A case of speaking all at once, after a long silence, had occurred in a Russian sailor, or rather a Finn, who was under his own care. During two years and a half this man never spoke, and was supposed to be a Welshman; it was said that he had been in that condition during five years before. But he suddenly broke out in speech of a strongly abusive tone, and talked all day long for several days.

Dr. MAUDSLEY recollected the discussion of the case referred to at the Clinical Society. There was no more reason for calling it hypochondria than any other case of ordinary melancholia; the man had delusions, and thought sometimes that the birds were staring at him; sometimes that he was in hell, and that the people around him were devils. As for cases of sudden recovery, it would be important to learn the experience of physicians on the question whether such recoveries were permanent. He should, at one time, have felt inclined to say that sudden recoveries were not more to be trusted than sudden conversions; but his opinion was now somewhat modified. He related two instances which were quite in point.

Several cases bearing upon this question were mentioned by Dr. SAVAGE, Dr. EAGER, and one or two other members. One was that of a lady who became insane

https://doi.org/10.1192/bjp.21.93.148 Published online by Cambridge University Press

in the seventh month of pregnancy, and who, within a few minutes of her delivery, recovered for the time, but fell into deep melancholia in less than five hours afterwards; she was several months in Bethlem. There was, on the other hand, a woman with melancholia at St. Luke's, who recovered on being told of the death of her child, and who is now well at home. Another patient was accidentally scalded by the hot water tap in a bath, and was quite cured from that moment of her mental disorder.

The members of the Association had an opportunity of inspecting, through microscopes on the table, several different sections of spinal cords in the conditions of health and of general paralysis.

Dr. SAVAGE produced these for exhibition.

Correspondence.

To the Editors of the Journal of Mental Science.

SIRS,—In reading the report of the Quarterly Meeting of the Association held in Edinburgh in November, printed in the January number of the Journal, I find, in the discussion of Dr. Ireland's paper on Mahomet, an opinion ascribed to me which I certainly did not mean to express, viz.: that the prophet's "supposed revelations were not due to Epilepsy." It appears to me that the idea of the divine mission of Mahomet originated in an Epileptic trance, or some closely allied condition; and that *many* of his subsequent revelations had a like origin.

I am, &c.,

JAMES C. HOWDEN.

Montrose Royal Lunatic Asylum, March, 1875.

To the Editors of the Journal of Mental Science.

GENTLEMEN,—As an article on the Physiology of General Paralysis and Epilepsy by Mr. George Thompson, of the Bristol City Asylum, which appeared in the January number of the Journal of Mental Science, and a continuation of that article which was read at a recent meeting of the Medico-Psychological Association in London, have, I understand, created very false impressions as to my views, I should be glad to have an opportunity of stating that on the subjects discussed in that paper and on that occasion I differ, and have always differed, from my friend, Mr. Thompson, *toto cœlo*.

Mr. Thompson has fallen into a grievous error in representing me as having confidence in the Calabar Bean as a *cure* for General Paralysis. Were I capable of such optimism, my opinion would be of little moment. While claiming for the Calabar Bean a valuable power of modifying and arresting the progress of that most persistent malady, I have never suggested that it should be regarded as a cure. Mr. Thompson will doubtless be surprised to hear that the two cases of general paralysis to which he refers, which appeared in the "British Medical Journal," and in which recovery seemed to take place under treatment by the Calabar Bean, were published in the form which they there assumed without my knowledge or sanction, and indeed much to my regret. I shall take an early opportunity of setting forth explicitly my notions about the pathology of general paralysis (which is, I presume, what is meant by its *physiology*,) and my experience in the use of the Calabar Bean, and in the meantime I must ask your permission to protect myself from misconstruction by a general disavowal of any agreement with Mr. Thompson, on any point that arises in his contribution to your pages.

I am, Gentlemen,

Your obedient Servant,

J. CRICHTON BROWNE.

West Riding Asylum, Wakefield, March 17th, 1875.

https://doi.org/10.1192/bjp.21.93.148 Published online by Cambridge University Press