Thus I think that he meant, *e.g.*, to write "*steamer*," where he wrote "street," My reasons for believing this are founded on certain circumstances connected with the mode employed to bring him from his home to the Asylum. Again, in closing his epistle, he wrote "nothe," where he evidently meant to write "mother," and finally subscribed himself "your *welcome mother*," where he meant to put your "*affectionate son*." This is strong additional proof of the existence of a distinct aphasic feature in the case.

According to some authors *aphasia* would appear to be due to some lesion of the efferent fibres passing between the convolutions and the great co-ordinating centres in the basal ganglia, while others hold that the phenomena are the result of morbid change in the convolutions themselves. In A. Y.'s case it would seem as if the physiologically lower speech centres (internal speech is meant), being rendered free from the control of the higher (inhibitory) centres, the nervous arrangements used in speech had taken on an automatic and ataxic action; hence a free flow of utterances both in reply to and apart from questions, but without there being any power to choose or guide them in any way.

The pathology of the case is, of course, extremely obscure. The patient possibly suffered from a meningitis of rheumatic origin, and, if so, this condition may have determined the phenomena observed. It may be worth while to note here, in relation to this idea, that in the "Journal of Mental Science," Vol. xiii., p. 528, a case is mentioned—that of a hospital patient, whose loquacity for a few days before death was extraordinary, and who was found after death to have the two anterior lobes of his brain affected with scirrhus cancer, illustrating the possible effect of a local irritation of the convolutions on the speech-function.

Case of Endothelial Tumour of the Dura Mater: General Paralysis.
By T. W. McDowall, M.D. (With Plate.)

J. G. T., æt. 48, admitted 14 Dec., 1880, married, inspector of naval machinery, well educated.

Medical certificate:—"Although I have known him for long, he does not now know who I am. When spoken to he does not understand what is said. When asked questions, he simply repeats his own name. He raves indifferently on various subjects. He says his wife has defrauded him of all his money and is conspiring against him.

"His wife states that he has been violent and dangerous. He

https://doi.org/10.1192/bjp.30.129.87 Published online by Cambridge University Press

wanders about all night and has been apprehended by the police. He has threatened her life, add attacked his father with a poker."

History.—He has usually enjoyed good health, but some years ago he received a severe blow on the head by the falling of an iron door, which fractured his skull and caused the loss of his right eye. He was originally an engine-fitter and has always had good wages. For the last twelve months he has been ailing, and during that time he has had two or three "strokes," the last having occurred about a week ago, when he lost the power of speech entirely. He has become weak and tottering on his legs, has developed delusions of suspicion, and has been occasionally violent. He has been intemperate, but not of late. Since his mind became affected he has been depressed at times. He is cleanly in his habits. Communicated by his wife.

Family History.—Nothing definite can be found out at present.

15th Dec.—Since admission he has been quiet and well-behaved. He has taken his food and slept well.

Physical Condition.—Body well nourished. The right eye is destroyed; signs of an old fracture of right tibia low down. He is weak and tottering on his legs. The patellar-tendon-reflex is markedly increased; no ankle-clonus; plantar reflex much increased. Lips and facial muscles tremulous. Pronunciation halting and blurred. Eye grey; pupil rather small.

Respir. Syst. Normal.
Circul. „ Normal.
Digest. „ Tongue pale and slightly furred: tremulous.

Mental State.—He is most attentive when spoken to, and answers some questions, but it is a long time before he can form his ideas and express them. He has no notion where he is, or why he was brought here. His memory is almost obliterated. Facial expression demented, but pleased and contented. He does not appear to have any grand delusions, but he evidently does not appreciate his infirm mental and bodily condition. No hallucinations or illusions. He admits intemperance but denies syphilis. He can remember a few past events, *e.g.*, the accident by which his head was hurt, but he is quite at fault as to recent occurrences.

Diagnosis.—Dementia with general paralysis.

16 Dec.—He slept well. Has taken food well. Is cleanly, quiet and sociable.

17 Dec.—Sleeps well; quiet; sociable; cheerful and self-satisfied.

23 Dec.—To-day he is noticed to be pale and very stupid. He falls about, and when assisted on to his legs, is found to be very tottering. The left leg and side seem to be semi-paralysed. Pupil contracted. Ordered to remain indoors.

24 Dec.—Very restless all night. Is quite demented; takes food fairly; feeble on legs. No distinctly localised paralysis. Pulse 80-100.

7 Jan.—Quiet, demented, feeble. Kept in bed in Infirmary. Generally restless at nights; is generally found searching all round

https://doi.org/10.1192/bjp.30.129.87 Published online by Cambridge University Press

his single room or under the mattresses ; says he has lost his way and cannot find his station, owing to having overslept himself or having got into the wrong train. Takes food well.

19 Jan.—In much the same state ; sometimes awkward and troublesome. Requires chloral at night and brom. of potass. by day.

29 Jan.—Less restless by night and day. Still confined to bed ; feeble on legs. Appetite excellent.

28 Feb.—No change.

16 March.—Gradually becoming more demented, more feeble, and losing flesh though he eats well. Often restless at night, "losing his way" and "searching for things."

13 Ap.—Becoming rapidly worse. He had a slight attack of paralysis about a week ago. He could not speak intelligibly, and could scarcely swallow : great tremor of facial muscles. The right arm was almost quite powerless ; mental powers much enfeebled. Now he has somewhat recovered. He talks fairly distinctly, feeds himself, but is kept in bed.

21 Ap.—To-day he had a prolonged convulsive attack, the left side of face being chiefly affected. The left eye turned to the right side. The left arm was paralysed and helpless ; the right rigid and occasionally convulsed ; the right leg slightly. He is semi-conscious. Passes water in bed.

22 Ap.—Still in same state : can take a little milk when carefully given. Bowels well moved.

23 Ap.—He has now recovered consciousness and convulsions have ceased.

28 Ap.—In his usual state : very feeble and tottering ; cannot stand without support. He now requires to be fed.

7 May.—Feeble and demented. Takes food well and is now able to feed himself.

8 May.—To-day he had two severe epileptiform attacks. The convulsions were general and followed by stertor, complete insensibility, then by prolonged semi-consciousness. Has taken a little milk with difficulty.

14 May.—Since last note, patient has had fits more or less every day. Has been taking chloral in ʒß doses twice daily, and the seizures have markedly diminished in frequency and severity. The left arm is chiefly convulsed now, though sometimes the convulsions are general or affect the whole left side. He has not spoken for some days ; has difficulty in swallowing.

19 May.—Fits slight. Patient very dirty in habits ; smears everything with filth. Very feeble.

24 May.—He has in a measure recovered consciousness, and can answer when spoken to ; looks about him ; swallows plenty of food without difficulty. He is decidedly stronger and can walk if assisted. Occasionally he has a very transient convulsive attack. Very dirty. Chloral discontinued.

3 June.—Has had no fits since last note : is quiet, cheerful, de-

mented; when asked how he is, he always says "first rate." Is in bed, feeble and helpless. Not quite so dirty in his habits. Takes food well, and sleeps a good deal: does not lose flesh.

27 July.—Has so much recovered strength as to be able to be out of bed daily and to feed himself; has lost flesh considerably during last month; is cheerful and self-satisfied.

26 Sept.—Gradually he is becoming more feeble and demented, and has been confined to bed for the last week. During that time he has had several epileptic seizures, but they can at once be stopped by the administration of chloral. The fits are general, but most marked on right (?) side.

18 Oct.—During the last two days the fits have been more frequent, and chloral seems to have lost its former influence over them. He had nearly 40 fits yesterday; to-day they occur about every 10 minutes, and each lasts about 1 minute. The right side of the body jerks as if a succession of electric discharges were being passed through it. The facial muscles on the same side are affected in a similar manner. Each fit is preceded by a piercing cry.

19th Oct.—During the last 12 hours his general condition has changed much for the worse. He cannot take any nourishment, and the fits succeed each other rapidly.

21st Oct.—Yesterday the fits were not so numerous or severe, but he was in a too exhausted state to recover. Died this morning at 8.30.

Post-mortem examination, 27 hours after death.

Rigor mortis well marked in legs, slightly in arms. No bed sores, bruises, or other marks of injury. Hypostatic congestion well marked. Body well nourished.

Skull-cap of average thickness and density; firmly adherent to dura mater in frontal region.

The brain was removed with difficulty, because the tips of the frontal lobes and, talking roughly, their orbital surfaces were either adherent to the dura mater or continuous with it. The area mentioned contains a hard tumour, which projects deeply on each side of the crista galli. So far as can be made out the bones of the skull are not involved, though reddened in a peculiar way (they are of normal hardness), but the dura mater anterior to the sella turcica cannot be separated or distinguished from the tumour.

Under surface of brain.—A tumour extends from optic commissure to tip of frontal lobes. It seems only to displace the convolutions, and involves mainly the first frontal on each side. Its posterior extremity touches, but does not involve the optic commissure and nerves. The right optic nerve and left tract are markedly atrophied. The internal half of tip of left tempero-sphenoidal lobe is represented by a bag of serum as large as a walnut. There is no atheroma of vessels at base.

Superior surface.—Vessels full of dark blood. The convolutions are flattened. The membranes are clear and transparent except to a slight

extent in the parietal region. The membranes are adherent in many spots to the subjacent convolutions.

On section antero-posteriorly (see illustration) the tumour is found to occupy nearly the whole of each frontal lobe. The tumour is so hard that it creaks under the knife, like an ordinary scirrhus. Near the under surface it contains a few small bony spiculæ. The tumour is not surrounded by softened brain-tissue, and it can in most places be separated from the neighbouring textures. A large portion of superior surface of left frontal lobe is soft to touch, but not changed in external appearance.

Whole brain, freed from fluid, weighs 49 oz.

Microscopic examination of the tumour (in fresh state) showed it to be very rich in vessels. It is evidently cancerous in nature, and the cells are arranged in nests, as is so frequently seen in epithelial growths. When the nests have opened out the cells are as a rule very long and narrow, very much like connective tissue of fibres and corpuscles. Juice scraped from surface of tumour contains cells of a variety of shape ; all evidently cancerous.

Floor of 4th ventricle rough and thickened. Cord removed. Both layers of arachnoid opaque, thickened, and, as a rule, adherent, especially in dorsal region.

No further examination of body permitted.

Remarks.—The drawings which accompany this record sufficiently show the position and structure of the growth. No. 1 shows the internal aspect of the left hemisphere and the surface of the tumour after section antero-posteriorly. It is a typical example of its kind, and lithograph No. 2 showing its minute structure does so exceedingly well. As to its mode of growth, it may be as well to quote from Ziegler's "General Pathological Anatomy" (translated by Macalister). He says: "The way in which the alveolar structure is developed can often be clearly made out, especially in tumours of the central nervous system. The normal intervascular tissue is transformed into masses of sarcoma-cells, while septa are formed between the cell-masses by the fibrous tissues lying along the course of the vessels. In other cases it looks as if a plexus of pre-existing or new-formed vessels took on as it were an investment of cells, and this grew thicker and thicker till at length the intervascular spaces were entirely filled up. Accordingly we find this form of growth described as a plexiform angio-sarcoma. It has also been described, and not infrequently, as endothelioma. On this view the cell-nests arise by proliferation from endothelial cells. This certainly happens when masses of cells are formed from the endothelial covering of the subarachnoid

meshwork and pia mater; the masses afterwards group themselves into 'nests.'" In a note Ziegler states that the vessels of the brain, lymphatic glands, serous membranes, and testis possess what is called a perithelium, that is the adventitia is invested with endothelial cells. Proliferation begins in the cells of this perithelium, and the vessel is thus invested with a stratified covering.

OCCASIONAL NOTES OF THE QUARTER.

The Isle of Man Asylum and Dr. Outterson Wood.

It will aid the understanding of the circumstances under which recent changes have taken place in the Isle of Man Asylum, if we briefly explain the character of the management and government of that institution.

The government is vested in the Tynwald Court. This consists of two branches, (*a*) The House of Keys (or the representative branch) The Government of the Island, and (*b*) The Council, the latter being composed of eight members appointed by the Home Government.

The House of Keys and the Council meet as separate bodies, each in their legislative capacities; and combined, they act in their executive capacities for the purpose of discussing important public questions, passing bills, and the appointment of Committees, such as the Highway Board, the Harbour Board, and the Lunatic Asylum Committee. The latter is appointed annually, a fact not without significance in recent troubles.

The present asylum was built and opened in 1868. From that time till 1881 Sir William Drinkwater had been a member of that Committee, and acted as Chairman. The number of the patients had steadily increased, and more accommodation was imperatively called for. To meet this Sir Wm. Drinkwater, and Committee, laid before the Tynwald Court a plan to provide increased accommodation for the female patients. This was objected to by the House of Keys. The resignation of Sir William Drinkwater and his colleagues followed, a Committee of the House of Keys having been formed to consider the necessity (if any) of providing increased accommodation in the asylum. In the meantime another Asylum Committee had been appointed by the Tynwald Court, under the chairmanship of the