drachm, was given with proper aperients in the fluid food. She had beautiful teeth, and I therefore fed her three times a day with the nasal tube. She recovered in three weeks, and left the asylum four weeks after admission perfectly well.

7a. Prognosis is bad if the treatment by drugs and by feeding is delayed.

A gentleman aged 43, was admitted, suffering from advanced general paralysis. He was in a state of great filth, and his own relations confessed it would have been better if he had been treated properly three months sooner. His life could not have been saved, but it might at least have been prolonged for some years. His circulation was feeble, and his vitality at a low ebb. There was only partial refusal of food, which was overcome by ordinary spoon feeding. Gangrene of the legs set in, and he died ten days after admission from blood poisoning.

This illustration will conclude the series of propositions I have attempted to lay down concerning prognosis in cases of refusal of food.

From what has been advanced it will be readily seen that *the therapeutic value of food administered against the patient's inclination depends far more upon the condition of the patient himself than upon the mode of administration or the kind of food administered.*

The Prognosis in Insanity. By D. G. Thomson, M.D.

II.

(Continued from Vol. xxviii., p. 210.)

Mental Exaltation, Mania.—The question of the Prognosis in Mental Exaltation—Mania—in its various forms, is a far more debatable and uncertain matter than in melancholia. The symptoms in melancholia being of a negative character due to a lowering or suspension of brain activity, we do not look for all those diversities, endless varieties and aspects which we may find in mania, be it simple, acute, or chronic. Generally there is an increased vitality, a state of hyperæsthesia, an increase in the activity of the brain, generally of the whole brain, and we must believe that these states will not so easily end in complete resolution as the condition of merely depressed action, or rather no action, which obtains in melancholia—I mean in melancholia generally, and not those states of acute melancholia which are supposed to be closely allied to the state which in other brains and under other subjective circumstances

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would give rise to mania from a pathological point of view. If this increased activity does not rapidly terminate in resolution, one of two things must occur—either exhaustion or atrophy, resulting in death or dementia, will supervene, or abnormal tissue will invade or replace healthy nerve paths or areas, and chronic aberration of mind ensue.

Thus, then, we are at once brought to the influence of duration on the prognosis, for, with rare exceptions, recoveries after long periods of mania do not occur, as is not unfrequently the case in melancholia. As prognosis in mania depends greatly also on the amount or degree of exaltation, it is advisable to consider the marked varieties of mania separately.

Firstly, as regards simple mania, it may be stated as an axiom that with the exception of acute maniacal delirium, the *Délire aigu* of the French, a good prognosis may be given in proportion to the degree of acuteness of the attack. Bucknill and Tuke state that boisterous, noisy mania, particularly occurring in the adolescent, is generally perfectly recovered from, but in mania without delirium or excitement, with, as a general rule, delusions in which the symptoms point rather to perversion of the mental powers than to mere excess of normal activity (although the latter may be also perverted more or less) the prognosis is very grave. More particularly is this the case when the person who, to the casual observer, may not appear insane at all, who may be able to attend in a measure to his affairs, and conduct himself pretty much like his sane fellow-creatures in the social economy, yet on examination is found to be the subject of fixed and permanent delusions which may be few in number, showing that the new nerve paths, on which these abnormal thoughts and conclusions travel, have become well trodden. Then we have evidence that an ineradicable habit has been formed and an unfavourable prognosis may be given accordingly. Such a patient may appear in fair bodily health, sleep and eat well, and show no cause for the alienation. Recovery in such cases is rare; the tendency being for them to remain chronic, not exactly *in statu quo*, for gradually the aberration increases in extent, involving by degrees other mental faculties.

They may, however, live long lives, and show no tendency to lapse into dementia, as often happens after acute mania. Instances are on record in which such cases have been restored by severe mental shock, such as fright, operations, acute intercurrent diseases, and other violent stimulation of the mind, showing that the intellect is rather "unhinged" than physi-

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cally diseased. Yet I cannot say, although I have seen all of these events occur in this form of mania, that I have seen benefit arise therefrom.

Secondly, acute maniacal delirium. This differs chiefly from acute mania by the presence of a higher degree of fever, shown by high pulse, temperature, great tissue-waste and consequent exhaustion.

The fatal exhaustion is ushered in by a sudden cessation of the excitement, and a gradually increasing stupor. This stupor in the last six deaths from exhaustion after acute mania which have been under my notice, has been well marked; to the inexperienced it might be looked upon as a good sign, for instead of the ravings and gesticulations, the patient exhibits a placid calm, as if sound asleep; the pulse, however, is feeble and rapid, and the respiration shallow and frequent, but the patient can still be roused, and the conjunctivæ are sensitive; gradually, however, the stupor deepens into coma, the face is bathed in cold sweats, the pulse becomes imperceptible, and the breathing stertorous, and in from 24-48 hours from the subsidence of the maniacal symptoms, death takes place. In such cases the tongue all along is in the condition known as typhoid, the breath is foul, and there is general decomposition and putridity in the sordes collected on the teeth and gums; in three cases of which I have notes, death seemed to be accelerated by rapid inflammation of the parotid gland, with the formation of septic abscesses in the gland structure. Whether the generally foul state of the secretions in the mouth actually spreads up the gland duct, and so gives rise to inflammation of a septic character or not I cannot say, but I think it highly probable.

Dr. Conolly records seven cases in the "Lancet" many years ago, all of which proved fatal. On the other hand, Mr. Carswell, late Assistant Medical Officer at the Barony Parochial Asylum, Lenzie, relates in the "Glasgow Medical Journal" for Nov. 18th, 1879 (page 355), several cases of acute delirious mania which did well under perfect rest, quiet, and a darkened room, and he insists strongly on the importance of a correct diagnosis between acute mania and acute maniacal delirium, the pathology of the two diseases necessitating a different form of treatment. The prognosis in this disease ought to be better now than formerly, seeing the increased number and efficacy of remedies such as quinine, chloral, &c., which we now possess.

Thirdly, ordinary acute mania, "raving madness." The prognosis in the early stages of the disease is quite uncertain,

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and it is impossible to give rules applicable to individual cases, so much depends on the progress, history and course of the case.

Now, any case of acute mania, while it may yield rapidly to treatment, may end in death by exhaustion, may, after temporary recovery, recur as intermittent or recurrent insanity, or alternate with other mental states, or become chronic, or lastly may terminate in melancholia, stupor, or dementia.

Bucknill and Tuke state (*op. cit.*) that in ordinary acute mania the prognosis is most favourable, and that the disease is usually recovered from. The mortality of those admitted to the York Retreat in a state of mania was, in observations made for 44 years, about 4 per cent., certainly a very low mortality indeed for so serious a disorder. Griesinger, Maudsley, Pliny Earle, Dr. Clouston, and others, all tender evidence and opinion to the same effect.

Dr. Blandford (*op. cit.*) states the prognosis to be favourable. "Although, of course, our opinions will be modified by the duration, for if the disorder continues unimproved for some months our hopes will be less, but yet such patients often continue their noisy, violent conduct, and yet at last recover. Cases of recovery after three and even five years have come under my notice; then the character of the mania—if great noise and turbulent excitement are the predominant features with no very marked delusions, or with ever-changing delusions, we may have hope, but if the delusions do not vary, and, above all, if the patient hears voices, the cure is very doubtful.

"The age of the patients; the younger they are the greater is the chance of recovery, and it is noteworthy that men recover oftener than women.

"Then, if at the commencement of the attack, the patient be greatly debilitated, or if there be other disease, the violence and want of sleep will still further reduce the strength and interfere with the chance of recovery, and if in such cases there be much difficulty in getting the patient to take food the prospects are still more gloomy."

I cannot do better than use this summary of Dr. Blandford's as a text for a few additional observations.

The majority of the chronic insane in our asylums (how best to deal with whom constitutes one of the most difficult problems of the day) are cases of incomplete recovery from simple or from acute mania. Thus the prognosis in acute mania is of the first importance. As before stated, it is impossible in the early stages to say much more than that

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a high percentage of such cases recover, provided the subject be young and healthy, the more so as it is a disease very amenable to treatment, that such cases *should* recover, seeing that, even in the worst cases where death occurs, little or no obvious pathological change is found at the autopsy, and that it generally attacks the young and vigorous, although it may occur at all ages. So that when a case of acute mania is presented to us, we can most certainly give a favourable prognosis. The greater difficulty is when resolution having begun and the acute symptoms are passing off, a sub-acute stage is ushered in. Mere noisiness, dirtiness of habits, and destructiveness are not sufficient to guide us, for these often continue for long and yet the patients ultimately get well.

There are several points which will assist us in knowing if our case is going to recover or is going over to the list of incurables. First, one of which I see little mention in the books, viz., a peculiar and characteristic change in the patient's appearance, the most salient point in which is a loss of hair, a general thinning of it all over the head, chiefly so in the frontal and parietal regions, quite different from ordinary baldness of the vertex. The hair is sparse and coarse in persons who, according to their relatives' account, previously possessed fine heads of hair, even making due allowance for the difference produced by careless dressing. I have been struck by this in many photographs which I have taken of chronic cases which show a considerably increased prominence of the parietal and frontal regions chiefly on this account. This point is particularly noticeable in women, but also exists in men. After a time, when chronic mania is thoroughly established, the hair may grow luxuriantly again, or may remain dry and straight. Probably this condition of the hair is due to disordered nutrition, which is evidenced in another way by hæmatoma auris or the "insane ear." With the causes and varieties of the insane ear I have at present nothing to do; suffice it to say that Brown Séquard maintains it is due to an irritation of the base of the brain, and can be artificially produced in guinea pigs by irritation of the restiform body. These hæmatomata are usually regarded when occurring after the subsidence of acute mania, or in other forms of insanity, as a certain sign of incurability. That it is a very bad sign, showing evidence of grave cerebral disorder, there can be no doubt, but that it is a sign of absolute incurability is certainly not correct, even when not due to a blow.

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Three cases of mania under treatment at Camberwell House Asylum have recovered. Two were gentlemen and one a lady; one of the former relapsed and died here, but the other two are well and occupying good social positions since their recovery some five years ago. Of these cases I have been informed by Dr. Schofield, the medical superintendent, and have seen one of the gentlemen, a clergyman, myself lately; both his ears were quite shrivelled up, but their owner was perfectly sane.

In unfavourable cases we also note an alteration in the facial expression—gradual obliteration of the lines in the face, giving rise to a flat expressionless countenance.

Another bad symptom in the subsidence of acute mania is that whereas the delusions formerly were ever changing and evanescent, seeming to bubble up and effervesce, so to speak, from the heated brain, they now begin to assume a more fixed, definite, and purposive character. Such a symptom, if it also be accompanied by hallucinations, auditory or visual, especially the former, is indicative of serious mental changes. Dr. Blandford, in an able paper on auditory hallucinations, in the "Journal of Mental Science," January, 1874, states, "We are called, it may be, to pronounce an opinion on a recent case. The symptoms may be somewhat acute, and have begun suddenly; generally the health is fair, and youth may be on the side of the patient, there may be everything to lead us to give a favourable prognosis, yet time goes on, and although there may be apparent amendment, there is no recovery, and one time or other, perhaps not till after a considerable period, we discover our patient hears voices, and our prognosis changes from 'favourable' to 'most grave.'"

The retention of the memory is not *per se* of much value in the prognosis. I have seen the most hopelessly chronic maniacs exhibit wonderful powers in this direction, although it can be readily imagined that the converse is equally true—that if the memory become worse and worse, it is a sure sign of dementia.

Do physical signs in any way help us? On the whole our answer must be in the negative, unless it be body weight, for here as in melancholia increase in body weight if attended even with but slight improvement, is a good augury; yet stoutness without mental amelioration forecasts dementia.

There is nothing characteristic for prognosis in the pulse as to frequency or the sphygmographic tracings it yields, nor yet in the ophthalmoscopic appearances of the retina to guide us as to whether a case will recover or not. Dr. Clifford Allbutt and Dr. Hughlings Jackson, who have investigated these points,

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beyond showing their importance on the pathology of the disease, chiefly in coarse organic forms, do not contend for any special value in them in the question of prognosis.

When dementia supervenes upon mania, then practically all is lost; for, to quote Dr. Hayes Newington, true dementia is "the tomb of the mind," the bourne from which no errant intellect returns. Yet here we must be very sure of our diagnosis, for (especially in females) there is a condition of anergic stupor which, to the casual observer, is exactly similar to the ordinary secondary dementia, but there is an important difference in the result of the two conditions, viz., that anergic stupor, which is common in women after acute mania, is generally recovered from, while in dementia proper it is not. This anergic stupor is very different from the fatal stupor of exhaustion above referred to, and is chiefly to be distinguished from it by its very gradual onset after all acute symptoms have passed off. (See the "Journal of Mental Science," Oct. 18th, 1874).

From the above considerations it will be seen that the prognosis in mania is a very uncertain matter, and only by a careful watching and grouping of all the mental and bodily symptoms, can we hope to approach any degree of certainty in our forecasts, never forgetting that while on the one hand, the strong and young generally recover, on the other, in the middle-aged and weakly, whose cases may show the most unfavourable signs, cases of recovery, even after long periods, are not unknown.

Alternations of Depression and Exaltation.—It is not necessary to speak of the other forms of insanity due to functional derangements at the same length as I have done of the two great typical departures from mental health, Depression and Exaltation, but I will at once briefly consider the prognosis in alternating states of mania and melancholia—the *Folie circulaire* of French authors.

On consulting the text-books on this subject, I find but little mention of the patients' prospects in this disease, and must therefore base my few remarks on cases which I have seen. The prognosis is invariably bad. Not that the patients will die or become absolutely demented, but that the transitory states of mania, of comparative sanity, and of melancholia succeed each other with relentless certainty. All attempts to prolong the period of comparative rationality seem useless. Antiperiodics and other like treatment, from which one might anticipate good, are of no avail, so that when the case becomes a well-marked one of *Folie à double forme* or circular insanity, our prognosis must be in accordance with the unpromising

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nature of the disease. One typical case I have notes of—a lady aged 50, married, healthy and strong in body, has for 10 years regularly alternated between sanity, mania, and melancholia, each state lasting with wonderful regularity about three months, and always in the same order. It does not matter whether she be under treatment or not, whether she be at her home, which is a happy, comfortable country one, or in different kinds of wards (noisy or quiet) in the asylum. Many such cases have come and are under notice here, and we can prognosticate in all of them that the period of mania, with its sleeplessness, noisiness, dirty and destructive habits, will pass away, and the period of melancholic stupor also, but as surely will the transitory, though it may be perfect, state of mental health give way to one or other of these states and the disheartening cycle continue.

Different is it, however, with the purely recurrent insanity, whether it occur as recurrent primary dementia, recurrent melancholia, or recurrent mania, for all of the conditions obtain in the most pronounced and definite manner, although recurrent mania is the most common form of recurrent insanity.

The prognosis here is not so uniformly bad, and it is self-evident that when we talk of recurrent insanity it means that the patients get well of individual attacks, but that the recovery is not permanent; in fact, that it is a *Folie circulaire*, as it were, with only two states to alternate between, instead of three, as in true circular insanity.

First let me say a word as to the individual attacks themselves. These may be of the most prolonged and severe character, with symptoms which, if observed in an ordinary attack of mania occurring in a previously sane person for the first time, would augur badly as to the prospects of recovery; yet when these attacks are of a recurrent character, no matter how severe, or how weak or elderly the subject, recovery is almost certain.

In our present state of knowledge the prognosis is very unfavourable, the period of mental soundness intervening between the attacks becoming, as a rule, gradually shorter and shorter until a chronic condition of insanity is established. I have, however, notes of two or three cases which, at all events, have not recurred for over two years, and which at one time used to recur several times a year. If it be true that these recurring attacks are—in some cases at least—due to the accumulation of some deleterious matter in the blood or nerve

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cells, may we not hope in time to combat this, and so render the prognosis more favourable?

This form of insanity is most common in women, but appears in the cases which have come under my notice to have no special connection with the menstrual periods, &c., one or two having continued after the menopause. In one case the utter absence of any defined cause and apparently entirely idiopathic nature of the disease is well brought out in the case of a handsome, accomplished young married lady brought by her friends to Camberwell House every three months or so on account of recurring attacks of profound melancholic stupor. Inquiries were made if there had been intemperance, and the answer was a decided negative, while to the inquiry if there had been over sexual excitement the answer was that for the last six months she had not cohabited with her husband. Examination of her thoracic and abdominal viscera, urine, &c., reveals no disease. Menstruation natural, and showing no relationship to the disease. Yet all day she sits motionless on a chair in the ward, and having all the appearance of being stupified with some narcotic poison, utterly indifferent to her surroundings, abjectly filthy in her habits; not wilfully so, but being apparently unconscious that her evacuations pass. It is needless to add that she takes no notice of anything said or done to her, and, of course, she is unemployed. She has to be fed by the nurse like a child, and even then with difficulty. Then in a fortnight or so after admission, without any special treatment, convalescence begins, ushered in by a gradual loss of the blank expression, her countenance traversed at intervals by placid smiles, as if in a pleasant dream. She begins to take an interest in things around her, soon brightens up, and from an inanimate, heavy, dull, lifeless-looking object wakes up, so to speak, and developes into a sprightly, active, fascinating woman, joining actively in the asylum amusements and dances, a skilled musician and lively conversationalist. Now this person, who used to be subject to these attacks every six weeks or so, has not had one for six months, and this although at home and managing her household. May we not in such a case incline to an ultimately favourable prognosis, and more especially when we come to know the nature of and remedies for the cause of the attacks of transitory mental stupor from which she suffers?

Delusional Insanity and Insanity with Hallucinations of Sight and Hearing.—As Bucknill and Tuke state (page 136 *op. cit.*), "delusional insanity is not a hopeful form. Mono-

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mania in the sense of a deeply-rooted delusion or false conviction in respect to one class of subjects generally resists treatment obstinately. Still more unfavourable are the delusions of grandeur and riches. Hallucinations and illusions of one or more senses are unfavourable except when due to any acute or febrile state of the system." Little more than this can be said in elucidating to any practical extent the prognosis in such cases. The alienation is greater than is implied in the particular delusion or hallucination, and their apparent sanity on subjects unconnected with the delusion is not, as one would at first expect, favourable to their chance of recovery, for such patients seem less and less able as time goes on to realize the difference between what they call "the spiritual voices" and the real, material, spoken words.

An accomplished, highly-educated lady in this asylum converses freely and rationally on the subject of her hallucinations, and will relate that she knows a difference between real uttered words and the voices which she hears, but that she is apt to act on the promptings of this spiritual voice, which appears so real at times, and so frequent, that in spite of all her efforts she cannot drive it from her mind. Sometimes, according as she is above or below par in her general health, she gives way to the promptings of these voices, and thus constitutes a dangerous but much-to-be-pitied patient, for, although at times quite alive to the falsity of the voices, she is now in such a nervous hyperæsthetic state from irritation at her condition, sleeplessness, &c., that she is morbidly suspicious and ready to give way when a voice seems to proceed from a slanderer or anyone talking ill of her. For years she had been subject to these hallucinations, and she tells me, that in spite of her reason and its efforts, they increase rather than diminish.

If in such a case, where the intellect, comparatively sound, and, above all, capable of the admission and cognizance of the falsity of the hallucinations, recovery does not take place, how much more unfavourable will be the prognosis in cases of hallucinations and illusions of the senses, accompanied by signs of more general mental disorder. In the paper read before the Medico-Psychological Association some years ago, Dr. Blandford drew attention to a class of patients who have hallucinations of hearing, but who do not hear voices, but only sounds, and "this," he says, "is a less formidable and altogether milder disorder—one which we may hope with confidence will subside. Such cases are not very

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uncommon. The sufferer complains that he hears voices made in the next room for the purpose of annoying him, but this is a different state from that of the man who hears a voice commanding him to commit homicide or suicide and obeys it. I have known these voices subside for years and disappear, occasionally returning if the mental health of the patient for some reason or another declines."

Dr. Lockhart Robertson, writing 20 years ago in the "Journal of Mental Science," says:—"Their influence"—that is, hallucinations of hearing—"is most unfavourable. They are so apt to lie dormant for a time, and then reappear, that I should at any time be sceptical of the recovery of a well-marked case."

As an addendum to the above, I should note that the hallucinations of hearing and sight met with in the delirium of alcoholic insanity generally pass off; indeed, this is also true of all the acute forms of insanity in which temporary and varying hallucinations and illusions of the senses exist as a common enough symptom.

As will be alluded to hereafter, in the insanity from alcoholism it often happens that delusions and hallucinations remain after all the acute febrile symptoms have passed off. These, however, as a rule, gradually subside, although they may be long in taking their departure—in one case I remember lasting for a year.

In cases of weak-mindedness and what might be included under moral insanity, due to chloral- and morphia-excess and habit, illusions of the sense of sight are a common symptom; and although obstinate, they are generally got rid of when the habit is stopped, and the mind gradually gains power and strength from appropriate treatment, and is no longer drugged, irritated, and perverted by narcotics.

Dementia, Primary and Secondary.—Primary dementia is by many alienists considered to be generally recovered from. Bucknill and Tuke state broadly that dementia is, generally speaking, a hopeless condition, but they do not include under this head those cases which often pass as examples of acute dementia, but which are really nothing of the kind. I have seen many cases of so-called acute dementia recover, and the reasons for this are obvious. First, it is generally due to a moral, and not a physical, causation, such as fright or sudden calamity, these inducing, as in cases recorded by Dr. Handfield Jones in his "Functional Disorders of the Nervous System," a condition of temporary cerebral paresis; secondly, it gene-

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rally attacks the young and vigorous, whose recuperative and latent powers are great; and thirdly, there is no apparent organic lesion.

Dr. Blandford says in his book on insanity—"How are we to distinguish this primary from secondary or chronic dementia? In other words, how can we say whether the patient will recover or not? I confess this is not easy, for the general appearance of the patient in the two diseases is identical. You are shown a young man or woman in a state of fatuous imbecility, of stolid expression or smiling idiotically, lost and dirty —nothing can be less promising. But if you are told that this condition came on almost suddenly, and if you observe the symptoms indicate great prostration of the circulation, you may pronounce favourably as to the result; but if the patient has slowly, gradually, but steadily drifted into this state without any assignable cause, then you may state that although improvement may take place, recovery is impossible." In these cases, then, according to Dr. Blandford, the prognosis accords with the diagnosis, for if we diagnose primary dementia we prognose recovery, and, on the other hand, if secondary or organic dementia, the reverse.

There are, however, exceptions which have come under my notice, notably where cases of prolonged secondary dementia after acute mania have recovered, of which the following is a well-marked example, although some might call it a case of anergic stupor occurring after an acute attack:—

A young lady, H. R. S., aged 25, received some shock or fright. She fainted, being in a swoon for 15 minutes. On awaking she became hysterical, impatient, and excited, soon becoming wild and violent, having delusions of fear, and being sleepless at night. This happened about the beginning of the year 1879. She was at first treated at home, but her violence and noise rendered this impossible, and she was removed to Bethnal Green Asylum. She was transferred, "not improved," to Bethlem Hospital in July 1879. Here she was said to be the most destructive, impulsively violent, and excited patient in the asylum, conducting herself more like a wild beast than a human being. She remained a year at Bethlem, and as she did not improve, had, in conformity with the rules of that establishment, to be removed, Dr. Savage, however, hoping, I am told, that she would ultimately recover. In this same mental state she was admitted to Camberwell House Asylum in July, 1880. She became in three months' time less violent, noisy, or destructive, but none the less idle, and dirty.

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She had all the appearance of being hopelessly demented, sat silent as if deep in stupor, never spoke, never ate unless food were actually put in her mouth, and was filthy in her habits, passing all evacuations under her where she sat, or defiling her room at night by spreading her excrement about her clothing and room floor. This, then, was the state of the apparent secondary dementia, due to exhaustion and degradation, but not atrophy, of the higher intellectual centres after the prolonged excitement or maniacal state. This state of dementia, from which we never expected a return to health, lasted, however, only for eight months, when a gradual improvement began. This was very gradual, but certain. She became less dirty and neglectful, began to take notice of those about her, took up a little sewing and reading, and in two months was quite well, presenting to the *ordinary* observer no trace of the degraded and varying condition of mind she had been in for three years. She was discharged *"recovered"* towards the end of 1881.

This case will show, then, that we must be chary in prognosing ill in even the most apparently hopeless cases, for in the young, where the recuperative powers are great, there may be a return to health.

The cases which do recover may do so either exceedingly slowly or comparatively suddenly.

The duration of primary dementia varies, and depends greatly on external circumstances, and facilities for treatment, among which temperature may be particularized, for these cases suffer much from and their recovery is greatly retarded by cold, which acts prejudicially on the feeble circulation.

The ophthalmoscopic appearance in this disease is pallor of the discs, which improves during convalescence, so that this with other evidences of improved vascular tone and circulation generally, would aid us in our forecast during the progress of the case. Recurrence of primary dementia is rare, although the apparent dementia or stupor arising from alcoholism recurs with the drinking habit.

Of *Impulsive Insanity* I can scarcely speak at all, having seen only one really well-marked case—I mean of pure impulsive insanity as I understand it, for, of course, the acts and ways of the insane are commonly impulsive, more or less, but do not constitute "uncontrollable impulse." This never occurs in my experience *per se*, but in the cases of semi-demented patients, who are, as a rule, quiet, well-conducted patients. The case is that of a woman, aged 25, who is a most

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uncertain and dangerous creature. She is generally quiet and harmless, smiling and talking to herself, and apparently good-natured and happy. This girl has a daily outburst of the most sudden and violent kind; it occurs without any warning or premonition. It comes on by day or night. If at night she suddenly screams and yells very loud, tears the strongest rugs and ticking-blankets to ribbons, beats her face and head with her fists, gets into a perfect state of frenzy, and as suddenly becomes calm and tranquil, her face being very pale, suggesting the epileptic nature of the outburst (she is, however, free from all ordinary epileptiform seizures). If the attack comes on by day, she flies at her nearest neighbour, no matter how big or strong she may be, with lightning velocity, or she may take up a chair or anything at hand and propel it at windows, or even people. She has, of course, constantly to be watched; medicines have little or no effect on her, and she has no prospect of recovery.

The impulsive insanity associated with epilepsy will be found under that heading. I am of opinion that in this country true impulsive, homicidal, or suicidal insanity is a rare alienation.

Insanity Depending on States Normal or Pathological of the Generative System.

(*a*.) *The Insanity of Pubescence.*—The insanity observed and described by writers as occurring at puberty, must be considered comparatively infrequent.

Dr. Skae points out, in the Morisonian lectures for 1873, that the prognosis is good, and that it is generally recovered from, the disturbed mental balance being restored after the changes in the system at puberty are perfected, provided the habit of masturbation be not contracted, in which case, as may be readily imagined, symptoms of imbecility and dementia come on, and the usual return to health does not take place.

Dr. Skae is also of opinion that the influence of heredity on the prognosis is also greater in this alienation, for if it be very strong, it militates seriously against recovery.

In cases where epilepsy has come on at an early age, say under ten years, it is often found that the child may be able to increase in mental development in spite of fits, be able to go to school, learn to read and write like other children; but when puberty supervenes the epilepsy seems to choose, so to speak, this time to commence its destroying influence on the mind,

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producing, more or less, imbecility, culminating as years go on in incurable dementia.

(*b.*) *Gestational Insanity.*—The insanity of pregnancy is also a comparatively rare affection, although less so than the preceding form, especially if we take into account the many cases which never reach an asylum. It may be characterised by maniacal excitement or melancholic depression, or simple clouding or obfuscation of mind, and is in the second case probably only an exaggeration of the distressed and fearsome state which exists in many women, especially the unmarried and in middle-aged primiparæ at the thought and prospect of parturition.

I have seen four cases of well-marked mania with pregnancy, but, in spite of its description in books, I would have been at a loss to recognise it as the mania of pregnancy unless I had looked lower than the head for symptoms. In two out of the four cases, of which I have notes, recovery took place after child-birth, but in two others it did not. Of the two whom delivery did not materially affect one was excited and the other depressed; the birth of the child seemed to have no effect, either in tranquillizing the one or rendering cheerful the other.

Dr. Playfair, in his book on midwifery, quotes Dr. Batty Tuke to the effect that the prognosis on the whole is very favourable. Out of Dr. Tuke's 28 cases 21 recovered, five became demented, one died, and one remains under treatment. According to Marcé there is little hope of recovery until delivery is effected, for only two out of his 19 cases recovered soundness of mind before the birth of the child. The prognosis we must believe to be still more favourable when we reflect that only the very worst and most urgent cases are certified lunatics, for Dr. Playfair states that the great majority of these cases progress to recovery without having to be sent to asylums, and thus do not find their way into lunacy statistics.

I should add that the tendency to dipsomania and depraved appetites, occasionally met with in the insanity co-existing with pregnancy, usually disappears post partum, as it is simply a part of the general moral perversion and not a distinct mania as in true dipsomania.

(*c.*) *Puerperal Insanity.*—The period at which puerperal insanity ends, and the so-called lactational insanity begins, is an arbitrary one, but may be in accordance with the views of Bucknill and Tuke set down as two months from delivery. By

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this time involution should have taken place and the system recovered from the mental and bodily shock of child-birth, and on the other hand the anæmia and weakness arising from lactation is beginning to tell on those of weakly habit. The symptoms arising from puerperal insanity generally partake of an acutely maniacal character, although melancholia and stupor are not infrequent. We are anxiously asked at this more than usually distressing juncture, what the chances of recovery are, and the probable duration, so the prognosis here is an important matter.

Firstly, then, puerperal mania. If we look merely at the cases admitted into public and private asylums, and the percentages of their recoveries, it cannot be considered the very hopeful one it is generally stated to be, but it must be remembered that in this form of insanity especially it is only the very worst cases that are brought to an asylum, especially among the private class. Of the last 100 admissions of female patients to Camberwell House Asylum, there has not been one case of puerperal mania.

The two last cases of puerperal mania admitted died.

Of 73 cases at the Edinburgh Royal Asylum eight died, seven became demented, two were relieved, and 56 recovered. The cases of Dr. Ripping, of Siegburg, related by Bucknill and Tuke, were less favourable. Of 82 cases only 38 recovered, nine improved, 25 did not recover, four died, and six remained under treatment. Dr. Playfair quotes Dr. Batty Tuke to the effect that the mortality in such cases is 10 per cent. If they do not die in a short period, recovery takes place, chronic puerperal insanity being rare.

The unfavourable indications in cases which are likely to end unfavourably are these—great pyrexia, rapid pulse, foul tongue, lips and teeth covered with sordes, constant excitement and low delirium, and also refusal of food and drink. The mild cases and those almost certain to recover are where there are delusions regarding self or the child, inciting to suicide or child murder, accompanied with more or less excitement. After the acute and early stages pass off, the same generalisations apply to the existing delusions and hallucinations as in other forms of insanity.

The duration is a difficult matter to prognose, and is given differently by authors. Dr. Webster states, as the result of his statistics, that three of every five cases may confidently be expected to recover within a year, and 34 out of 53 recoveries took place within the first six months of the attack.

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Brierre de Boismont states that cases of puerperal mania, exclusive of melancholia, have recovered on an average under his care in about a week! In Dr. Savage's carefully tabulated cases the great majority recovered in a little under three months, but even after 18 months' duration two cases recovered.

Puerperal Melancholia.—It is an often quoted aphorism of Gooch's that "mania is more dangerous to life and melancholia to reason."

This is so far true that the mania is very dangerous to life; but the melancholia is no more dangerous to reason than the mania, in fact, less so. When puerperal melancholia, which is much rarer than puerperal mania, exists, the prognosis is much the same, the disease is more obstinate, the delusions more fixed and permanent, and relapse common, yet recovery generally takes place. One case I remember of a young married woman who became melancholic after her first child. She developed strong suicidal tendencies, and had dreadful delusions. In three months she got well, but soon relapsed, and, in spite of excellent bodily health, remained full of melancholy delusions for six months. She ultimately got well, and has remained so for a year and a half.

(*d.*) *Insanity of Lactation.*—This form of insanity is much more common than the insanity of pregnancy, but less so than true puerperal insanity. It is generally a state of melancholia brought on by the anæmia and debility induced by prolonged suckling. The causes being removable and amenable to treatment, the prognosis is very good; in all the cases which I have seen, recovery was effected. It must be noted, however, that there is a considerable tendency to dementia in some cases.

(*e.*) *Hysterical Insanity or Utero-Mania.*—I will not enter here into the question of the existence of either of these forms, especially the latter, *i.e.*, as to their being specific forms of mania apart from the ordinary types of mental alienation.

In many cases of women suffering from hysteria and maniacal symptoms, between which there is no distinct boundary, we recognise a peculiar sexual element which gives such a colour to the disease that it is known under the name of ovarian, uterine, or hysterical insanity.

Its symptoms are well known, silly, childish manners and actions, mischievous, purposeless, and irresolute conduct, sometimes kleptomania, besides the frequent presence of delusions connected with the sexual organs, together with a certain lewdness and lasciviousness of speech and action.

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Dr. Savage points out that such cases, if moral treatment is skilfully applied, get well, but if left to themselves in a crowded asylum where no curb or individual care could be enacted on their whims and propensities, being so plastic and will-less, they fit into niches, so to speak, from which it is impossible to move them. So, although the recovery-percentages are high, it must not be supposed that all get well.

I fear the good results obtained by the most modern treatment of hysteria by large magnets or plaques of metal, recommended by Prof. Charcot, and Dr. Müller of Graz, would not avail much here where the vagaries of mental alienation are superadded to a disease sufficiently irregular and strange in itself.

On Large and Small Asylums. By T. CLAYE SHAW, M.D., F.R.C.P., Medical Superintendent of the Middlesex Asylum, Banstead.

It seems to be generally assumed that asylums were built large, either on the idea that they could be more cheaply constructed or that they could be maintained at less average weekly cost than small ones, but I doubt if such is the true reason of the growth of large asylums, or of the development into large of small ones. Convenience would appear more to have determined the size than any other consideration, a thing not to be wondered at if such large counties as Yorkshire, Surrey, and Middlesex are regarded, where the visiting committees of magistrates are largely taxed as to their time in attending institutions placed often at long distances from each other. But all these considerations of convenience ought to, and no doubt would, disappear if it were abundantly manifest that the outcry raised against large asylums as causing a higher death-rate, lower recovery rate, and heavier weekly charge could be substantiated.

It is to be expected that those asylums that have most unfavourable statistics, taken from the averages in the blue book, should cost the most, because in proportion as the population is more feeble, the expenses for attendance and extra diet will be greater and the recoveries will be fewer; and there can be no doubt that in proportion as an asylum is large, so does it get filled with unfavourable cases in a greater proportion than would have been the case had it been

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