

We demur to the opinion expressed by the writer that this question is not one in which the public has felt vitally interested, and has only been excited into action by sensational articles in the general or medical Press. On the contrary, we believe that, rightly or wrongly, it is a fact that a large number of thoughtful men, quite independently of these articles, have grave and honest misgivings as to the theoretical justice of the present system of confining the insane in asylums in which the proprietor has a personal interest in their detention, these misgivings extending, though in a less degree, to other asylums; and our own observation has certainly been (to our surprise) that the tide of public opinion has not been allayed by the Report of the Select Committee of the House of Commons, reasonable as it would seem to be that such should be the case. Be this as it may, no harm, but good, must result from the temperate consideration of the whole subject; and to this end the anonymous author of these remarks has made a judicious and modest contribution.

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### PART III.—PSYCHOLOGICAL RETROSPECT.

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#### *French Retrospect.*

By J. G. McDOWALL, M.B.

*On Trephining in Epilepsy due to Injury of the Skull.* By Dr. M. G. Echeverria.

In this valuable paper, a reprint from the "Archives Générales de Médecine," Dec., 1878, trephining in cases of epilepsy after injury to the skull is advocated. Of five cases operated on by the author four recovered, and one was much improved. After injury to the head convulsions may be developed at once, but generally appear after a long interval, sometimes of several years. In cases where immediately after injury, convulsions are associated with inflammation of the brain or its membranes, operation has proved very fatal. The more a fracture is comminuted and circumscribed, the more probably will it be followed by convulsion.

Injuries may be divided into pericranial and cranial. In the former the scalp only is injured, in the latter the skull and its contents. That injuries of the scalp may give rise to epilepsy, is proved by the occurrence of cases where recovery has followed incision or cauterisation of the cicatrix. Injuries of the scalp may result in disease of the

bone and changes in the dura mater, although no wound has been made.

In true cranial lesions, epilepsy appears when they give rise to irritation of the brain or its membranes. The cause of irritation may be depression, hæmorrhage, laceration, or disease of the bone, as caries or new formations. In these cases, epilepsy is developed with other nervous disease, and has generally premonitory symptoms. These symptoms are giddiness, pain in the head and at the seat of the lesion, twitching, numbness or shaking of the limbs, sudden shaking of the body, changes in character without insanity, exaggerated need of activity, or irresistible craving for alcohol. The author has collected from various sources and tabulated 145 cases where the trephine was used. Of these 93 recovered, 18 were improved, five unimproved, one became aggravated, and 28 died. The left parietal bone was the most frequent seat of fracture. The causes of death in the fatal cases were suppuration over the surface of the brain, extensive effusion of blood on the brain, sloughing of the membranes with abscess of the brain, hæmorrhage from the longitudinal sinus, meningitis and erysipelas and meningo-encephalitis.

The following conclusions are arrived at:—Trephining is the best treatment for epilepsy due to injury of the head. The operation is nearly as successful when performed at the time of injury as later, while in both cases the presence of fever contra-indicates operation. Paralysis or insanity are indications for, rather than against the operation. Trephining succeeds equally well whether the disease of the bone be syphilitic and unaffected by specific treatment, or due to other causes. Statistics of a large number of cases in which the trephine has been used show that the fatal cases amount to 19·30 per cent., recoveries to 64·30 per cent., cases relieved to 12·41 per cent., and cases unrelieved to 3·44 per cent. It is of great importance that the membranes be protected as much as possible during the operation, that silver sutures be used, and that all bleeding be checked before the wound is closed. Pus should have a free exit. To secure rapid union, ice should be constantly applied to the wound, ergotine and hemlock given internally, the bowels kept open, while a moderate diet and plenty of fresh air must be supplied. An anti-epileptic treatment should be kept up for some time after the operation.

*Le Progrès Medical.* (Oct., 1878—July, 1879.)

*On Paralysis of the External Rectus.* By M. Gaston Graux.

M. Gaston Graux presented his thesis to the Société de Biologie, in which he arrives at the following conclusions:—

1. On the floor of the 4th ventricle there is an area, very limited (*eminentia teres*), pathological changes in which give rise to a characteristic symptom—paralysis of the external rectus of one eye, with conjugate inaction of the internal rectus of the sound eye.

2. The paralysis of the internal rectus is not, in certain cases,

absolute ; it appears or disappears with that of the muscle of the other eye with which this paralysed internal rectus acts.

3. The presence of this symptom shows that the nucleus of the 6th pair is affected.

4. Paralysis of the internal rectus of the healthy eye is never seen with affections of the periphery of the 6th pair.

5. Central paralysis of the 6th pair may be differentiated from paralysis due to an affection of the periphery of that pair, by saying, that in the first case the secondary deviation of the healthy eye is an external, and in the second an internal strabismus.

From an anatomical and physiological point of view, M. Graux formulates the following conclusions :—

*a.* The nucleus of the 6th pair furnishes not only the motor nerve of the external rectus, but also a band to the internal rectus of the opposite side.

*b.* The internal rectus is also under the influence of the 3rd pair. In fact, a bundle of nerve fibres connects, under the floor of the 4th ventricle, the nucleus of the 6th pair of one side with the nucleus of the 3rd pair of the opposite side.

*Tumour of the Ascending Parietal Convolution of the left side, in a Woman suffering from General Paralysis. Convulsions of the same side during life.* By M. Magnan.

In this case the symptoms of general paralysis were present, and during eight years the patient had suffered at irregular intervals from convulsions of the left side.

After death the membranes were found thickened and adherent over all the right hemisphere. On the left side there were only two points of adhesion, but a tumour the size of an almond was found on the upper part of the ascending parietal convolution. M. Magnan, who exhibited the specimen, thought that the tumour had been of slow growth, thus rendering functional compensation possible, while the convulsions were due to the diffuse meningo-encephalitis of the right side.

*Right Hemiplegia with Aphasia—Epileptiform Attacks—Cerebral Tumour.* By MM. Bourneville and Poirier.

C. Saintal, aged sixty-five, entered the Salpêtrière in May, 1872, suffering from right hemiplegia, aphasia, and epileptiform attacks. The attacks were first observed in her forty-third year. In January, 1871, she suffered an attack of apoplexy. She had been of temperate habits, and a hard worker. Before the apoplectic attack she had been very religious, and of but limited intelligence. During her residence in the asylum she lost some of the few words she could utter on entering it.

In April, 1877, her condition was as follows :—

*Face.*—Wrinkles of forehead and eyelids equal, pupils equal, cataract of right eye. Right labial commissure effaced, left well marked, no deviation of the tongue.

*Right Arm.*—Arm pressed against the thorax, forearm flexed to a right angle, hand similarly flexed on the forearm, the four fingers flexed on the thumb. The joints are all rigid, and sensibility to pinching is retained.

*Left Arm* —Normal.

*Right Leg.*—Thigh and leg are slightly flexed, foot normal. The hip joint is stiff, and the knee allows of further flexion, but not extension. Sensibility retained.

*Left Leg.*—The thigh and leg are flexed and the knee joint is rigid. Sensibility retained. The patient can raise the leg. There is no movement on the right side, but the left limbs can be used. There is no shaking or vermicular trembling.

There is no cardiac murmur.

*Intelligence.*—The patient can pronounce a few words. She understands most of the questions put to her, wrinkles her forehead, closes the eyes, puts out her tongue and laughs. She is emotional, crying when told anything unpleasant. She is dirty in her habits.

Since admission she has suffered four attacks of syncope, followed by vomiting. The epileptoid attacks are rare, and begin with a slight cry, the head is then turned to the right, and the mouth drawn to the right side. She does not bite her tongue.

In December she suffered an apoplectiform attack, and on the following day the sterno-cleido-mastoid muscle of the right side was observed to be contracted. There was no change in the condition of the limbs. She died on the following day.

*Autopsy.*—Skull slightly thickened and adherent in points to the dura mater, particularly in the line of the sagittal suture. Dura mater much thickened, especially over the anterior half of the left hemisphere, where it is cartilaginous in consistence. Sinuses distended with dark coloured blood. There are some adhesions of the dura mater to the inner membranes on both sides of the falciform process. At the level of the ascending frontal convolution and over the roots of the three frontal convolutions the membranes are very vascular, and adherent to each other and to the cortical substance. Cerebro-spinal fluid not increased. Vessels of pia mater injected over whole of convex surface, rather more on the left than on the right side.

*Brain.*—Weight 1170 grms. The arteries at the base are free from atheroma. The left hemisphere is evidently larger than the right, and in its anterior half presses on that hemisphere. The right hemisphere weighs 430 grms., the left 580 grms. On the right side the anterior cornu of the ventricle is partly effaced, and the posterior correspondingly dilated, otherwise the hemisphere is normal.

*Left Hemisphere.*—The middle of the ascending frontal convolution, and the posterior half of the second frontal convolution, present a surface of about three centimetres in diameter, of a deep red colour, smooth and of firm consistence. The first and third convolutions are pressed on, and are much wasted, particularly the third. The tumour has a

fibrillar appearance, and stretches towards the central ganglia without reaching them. The cerebral peduncles are normal. The left half of the pons varolii and the left anterior pyramid are slightly wasted. Cerebellum is normal.

*Remarks.*—The growth of the tumour has been very slow, the first fit occurring at 45 years, while the patient reached 71 years.

The association of the motor disorders with a lesion in the region where experiment and pathological anatomy have placed the motor centres of the limbs, is worthy of notice.

It is also to be observed that the sensory centres were normal, and during life sensibility was unimpaired.

Above all, the gradual and slow development of the aphasia corresponds perfectly with the gradually increasing pressure on the third frontal convolution.

*Aphasia and Right Hemiplegia.* By J. Déjérine.

The patient in this case was a woman of twenty-three. Three years before, while in good health, she was suddenly seized with aphasia. Two hours later the right arm became powerless, and on the following day the left leg and the face.

For nine months the aphasia was complete, but since then has gradually disappeared, and for a year she has talked readily. For some time before death, the facial paralysis was scarcely perceptible, the leg appeared much wasted, and its power greatly diminished. The arm was absolutely paralysed, and the forearm flexed on it. Some very slight power of movement remained in the fingers. Sensibility was unimpaired.

After death, from phthisis, the skull and membranes were found to be normal, on removal of the membranes, except that the anterior part of the left hemisphere, appeared smaller than the corresponding part of the right, nothing abnormal was seen. On cutting the brain perpendicularly, through the roots of the frontal convolutions on the left side, an old softening was found, with a cavity about  $2\frac{1}{2}$  centimetres in height, one in width, and two in length. The lesion beginning in the middle pediculo-frontal fasciculus, extended downwards through the inferior pediculo-frontal fasciculus and implicated the lenticular nucleus and anterior part of the internal capsule. The anterior part of the cavity of the ventricle was considerably diminished. The right hemisphere was healthy. The left half of the pons varolii was much atrophied, as was also the left pyramid. The posterior part of the right lateral column of the spinal cord was sclerosed. The nerves of the limbs on the affected side presented well-marked hypertrophic neuritis.

*Brachial Monoplegia.* By H. Leloir.

F. A., aged 52, suffered from syphilis fifteen years ago. Four years ago he began to suffer severe pains in the head, and some months later from numbness and emaciation of the right arm, the arm becoming paralyzed. In spite of anti-syphilitic treatment, the paralysis remained,

and the patient died of tuberculosis in Dec., 1878. Sensibility in the affected limb was unimpaired, and the other limbs were quite unaffected.

After death, the lungs, digestive canal, and cerebro-spinal membranes were found affected with miliary tubercle. There were no granulations on the convex surface of the brain. Over the upper third of the ascending frontal convolution on the left side, there was a gummatous patch where the membranes were adherent to each other, and to the cortical substance, but not to the bone. This patch extended to within six millimeters of the median fissure. On removing the membranes, the subjacent grey matter and a thin layer of white matter were also removed. The cord and nerves to the affected limb appeared to the naked eye normal.

*Revue des Sciences Médicales.* (Oct. 1877 to Jan., 1879.)

As this Journal consists entirely of abstracts of other works, anything of interest can only, as a rule, be translated or very shortly noticed.

*On the Cerebral Circulation.* By Cadiat.

The anastomoses of the small arteries of the pia mater are so numerous, that they form, according to the author, a network on the surface of the convolutions. The circle of Willis may be taken as typical of the cerebral circulation. The veins also form a network. This arrangement of the arteries may be observed not only in man but in all mammals and fishes.

Another result of Cadiat's observations is to show that the arterial areas communicate with one another. A common vermilion injection thrown into any branch of the circle of Willis, injects a whole lobe. He made these injections for the purpose of discovering in the pia mater those vessels connecting the arteries and veins, vessels other than the capillary network properly so called. Their existence was proved by the fact that the injection of tallow and vermilion return very readily, and in large quantity by the veins, without having reached the capillaries.

Duret opposes the view of Cadiat, with respect to the network of the vessels of the pia mater. With opaque vermilion injections, it is impossible to decide when the vessels cross each other, when they overlie each other, or when they unite. Transparent injections, as gelatine, should be used, and the preparations examined with very varied powers. Anastomoses between the vessels of the pia mater exist, but are of slight importance, for Duret has often completely injected all the capillaries of the cerebral substance in the area of the sylvian, whilst the neighbouring areas were but slightly penetrated. Further, if the anastomoses form so rich a network, how are the frequency and extent of cerebral softenings limited to an arterial area to be explained? That communications exist between arteries and veins, other than the capillary network, Duret does not admit.

*On the Cerebral Circulation in some Animals; Correlation of Motor Regions and Vascular Areas; Independence of Physiological Divisions and Lobulation.* By Duret.

In man, the dog, the cat, and the rabbit, there exists a remarkable correlation between the area of the middle cerebral and the region called motor by Ferrier. The middle cerebral artery might be called *the artère motrice corticale*. The anterior cerebral corresponds more particularly to that part of the frontal lobe, the removal of which, as effected by Ferrier in a monkey, leads to an enfeeblement of intelligence; this would be the artery of the *régions intellectuelles*. Lastly, the posterior cerebral occupies the parts of the cortex of the hemispheres, of which the cauterization, as performed by Ferrier, should give rise to hemianæsthesia.

There is no correspondence between the external configuration of the brain and the vascular areas. The lobes and convolutions are produced under physical, not functional, influences, and after studying the development of the brain from this point of view, the author arrives at the conclusion that the cerebral folding is due to 1st, the resistance of the skull; 2nd, the density of the nervous substance, and, perhaps, to the radiation of the fibres of the peduncular expansion; and 3rd, to a very slight extent, to the great arterial trunks.

In man there exists a special artery, a branch of the middle cerebral, for the third frontal convolution. In the dog, cat, rabbit, calf and sheep, there is a vessel with a similar origin and a similar direction and distribution. It is in the parts supplied by this artery, that Ferrier places the motor centres of the tongue, jaws and lips, both in man and animals. Duret extirpated the centres in dogs, to observe if phenomena analogous to those observed in man after lesion of the third convolution would arise. These animals were under observation only fifteen days, and appeared to have lost the power of barking.

This comparative study of the cerebral circulation renders a more natural co-ordination of the lobes and convolutions in animals possible. Thus, in the brain of the calf or sheep, the middle cerebral is relatively less than in other animals, one or two of its branches being absent, and there is nothing corresponding to the two Rolandic convolutions. It is in these convolutions, or, in the dog, in the sigmoid gyrus, that Ferrier places the motor centres of the limbs more particularly those of the fingers and toes. Again, it is known that ruminants execute scarcely any other movements than flexion and extension, and that they have only two toes on each foot. The delicate and varied movements of the fingers and toes being absent, it is not astonishing that the motor cerebral centres of the parts are very slightly developed.

These interesting researches show, as Charcot remarks, that too much importance may be attached to the name of any one convolution. The motor centres of the limbs are not always placed exactly in corresponding points in different animals. An absolutely regular geographical distribution need not be expected.

Charcot again remarks that in man the para-central lobule receives

blood from the anterior, and not from the middle cerebral artery. Now that part of the brain is motor, as lesions of its substance followed by hemiplegia of the opposite side have shown. This is an exception to the general law laid down by Duret.

*On the Means of Hardening and Colouring the Tissues of the Nervous Centres.* By A. Erlitzky.

After trying most of the liquids recommended for hardening the nervous tissues, the author has adopted the following solution:—Bichromate of potash, sulphate of copper, of each 50 centigr. ; water 100 grammes. These two salts, dissolved separately or together, form a solution of a greenish colour, paler than that of the bichromate of potash. The brain and cord of a dog forty days old, removed an hour after death, were hardened in eight days.

For the human brain the solution must be slightly modified, 2.50 per cent. of bichromate and half per cent. of sulphate of copper being used. The liquid should be changed every day during the first week, and every two days during the second week, after which the hardening is sufficient to allow of very clean sections being made.

As to colouring material, Erlitzky has adopted the green methylaniline in aqueous or alcoholic solution of a strength of 1.5 to 2.5 per cent. The aqueous solution colours better than the alcoholic. To produce colouration immersion from twelve to twenty-four hours is necessary.

The medulla receives a very pale green tint, while the axis cylinders remain uncoloured. The nuclei of the cells with protoplasm are also coloured green.

The nuclei of the neuroglia are of a more intense green, as also the nuclei of the blood-vessels ; the white blood corpuscles assume a green tint, the red become yellow. The cylindrical epithelial cells of the central canal of the cord are tinted a deep green, while nerve cells of all kinds remain uncoloured.

The author has tried the action of carmine on preparations coloured with the green methyl with the following result:—Weak solutions of carmine produce on preparations already coloured with green methyl several shades of colour. The nuclei and nucleoli of the nerve cells are red. The protoplasm of these cells, and the prolongations of the axis cylinder, assume a clear red colour. Connective tissue fibres are even clearer. The medulla remains of a greenish hue. The nuclei of the connective tissue, cylindrical epithelium cells, and the nuclei of the vessels have a violet colour. The large nuclei of cells with loose protoplasm become red, with a faint shade of violet.

To sum up, the green methylaniline is chiefly valuable in showing the nuclei of the neuroglia, and in making them easily distinguishable from the small nerve cells.

*On Cerebral Blepharoptosis.* By Landouzy.

Cerebral blepharoptosis, existing alone or associated with a monoplegia or hemiplegia, appears to depend on a central lesion, and acts as a cross paralysis. This latter character is important and new, for in



the classical cases the cause of a direct paralysis acted on a part of the nerve to the levator, between its origin in the orbit and its termination in the muscular fibres.

In the cases collected by the author there have not been lesions of the periphery, while central lesions have been constant. This central paralysis is partial, affecting only one branch of the third pair. It appears from the ten cases reported by Landouzy—

1st.—That the motor centre of the elevator of the eyelid should be sought in the posterior region of the parietal lobe.

2nd.—That this centre is not included in the motor centres of the limbs, since ptosis appears to exist as frequently alone as associated with hemiplegia.

3rd.—That among the nervous bundles which join to form the third pair, only those which reach the levator palpebræ appear to be connected with the hemispheres.

Like facial paralysis of cortical origin, cerebral paralysis of the third pair is always partial, which proves that if there exists for that pair distinct cerebral bundles, the motor centre of the branch to the upper eyelid is not more closely connected with the centre for the muscles of the eye than the centre of the inferior facial is with that of the orbicular, palpebral, and frontal muscles. From this point of view the clinique helps the anatomy, and proves that the fusion of the various bundles which form each third nerve does not occur in the hemisphere, for cortical or cerebral lesions, of whatever extent or situation, appear never to give rise to paralysis affecting both the levator palpebræ and the muscles of the eye.

Further, there do not exist two kinds of cerebral ptosis, the one cortical, the other central; central ptosis results, as central inferior paralysis of the face, from some central lesion which cuts the fasciculus to levator palpebræ between the cortex and the pons varolii.

As to the other branches of the third pair, they necessarily follow another course to the pons, for no lesion of the white fibres of the ganglia or of the cortex has produced complete paralysis of the common oculo-motor nerve. It is evident, then, that cross paralyzes of the third pair are always partial.

With respect to diagnosis and prognosis, these considerations are important. It must be discovered if the ptosis depends on a direct lesion of the periphery or on a crossed central lesion. This is to be ascertained by observing the motor disorders of the face and limbs on the same side as the ptosis, whether there be impairment of intellect or sensation, and whether these disorders have appeared with, before, or after the ptosis.

*On the Conservation of Associated Movements in Cerebral Hemiplegia.* By Simoneau.

It is known that in hemiplegia of cerebral origin the orbicular muscle and the fibres supplied by the superior facial escape paralysis. M.

Simoneau, while admitting the clinical fact, shows that there exists a slight paresis of these muscles. He argues from the fact, previously pointed out by M. Potain, that the closing of the eye on the affected side alone is generally impossible, while the patient can readily close both eyes at the same time.

The author, in support of this assertion, brings forward eleven cases where paresis of the orbicular muscle was evident. These facts, even in cases where a real diminution of contractility in some fibres exists, is explained anatomically by the existence of commissural fibres, which connect the halves of the central nervous axis. The nuclei of the facial nerves are especially connected, and the stimulus given off by one hemisphere acts at the same time on the organs of the nerve of each side. The habit which certain groups of muscles contract of acting together must also be noted, but this cause is not sufficient to account for the phenomenon, and reflex action alone fails to explain it.

Broadbent, elsewhere, has shown that this rule is applicable to the muscles of the pharynx, to the diaphragm, in fact, to all the muscles of which the movements are associated.

*Experimental Researches on some Points of the Physiology of the Medulla Oblongata.* By Laborde and Mathias Duval.

From these researches it appears :—

1.—That the medullary nucleus of the sixth pair contains and sends anastomotic fibres to the nucleus of the common oculo-motor nerve on the opposite side. These fibres, in causing the simultaneous contractions of the external rectus on one side, and internal rectus on the other side, make certain the associated movements of the eyes.

These associated movements appear to have their functional centre in the medulla oblongata, in the region where the above-mentioned nucleus exists, while it is in the cerebellum or in the medullary prolongations of the cerebellar fibres that the co-ordinating centre for the general movements of the eye resides.

2.—The constant production of complete anæsthesia, with trophic affections of the eye after a lesion deeply affecting the lateral pyramids in their upper half, demonstrates the existence of medullary fibres belonging to the descending or little root of the trigeminal.

*Note on the Results of Irritation of the Dura Mater.* By Duret.

Irritation of the dura mater causes convulsive movements on the corresponding side of the body, particularly in the eyelids, muscles of the face, and upper limbs. Sometimes the movements extend to the opposite side. The movements are much better marked if the animal is not under the influence of chloroform.

If a small quantity of an irritating fluid be injected between the dura mater and the bone, contracture of the muscles of the same side occurs and increases with the spread of the inflammation. This irritation of the dura mater appears to act also on the vaso-motor nerves of the hemisphere and eyeball of the same side.

It will thus be possible for the surgeon to recognise whether a splinter of bone or foreign body acts on the brain or its membranes. In the former case convulsions will occur on the opposite side to the injury, in the latter, on the same side.

*On Sclerotic Meningitis limited to the base of the brain.* By E. Labarrière.

This special form of circumscribed meningitis is nearly always secondary, succeeding a vascular lesion, or some change in the neighbouring parts, particularly in the bones of the base of the skull. It is a rare affection, and as yet has been incompletely studied.

Tertiary syphilis is the chief, and, in fact, the only demonstrated cause, alcoholism affecting the membranes on the convexity of the brain, and tubercular inflammation running too rapid a course to produce sclerosis.

The patches of sclerosis are chiefly seen on the middle region of the base of the brain, and may be numerous and small, or combined. The fibrous thickening results in vascular changes, which may affect the floor of the fourth ventricle, the characteristic lesion being chronic arteritis. Gummata are by no means rare.

The symptom which points to circumscribed meningitis is persistent, severe headache, to which localised paralyses are soon added. The paralyses are generally motor, occur at irregular intervals, and affect isolated nerves. They may be transient, or permanent. Clinically the disease presents two forms, according as the disease spreads from before backwards, or in the reverse direction. The disease generally advances very slowly, the various paralyses requiring several years for their completion.

The chief symptoms of lesion of the medulla are hesitancy of speech, trembling of the tongue, and sometimes difficulty in deglutition. The disease may closely resemble general paralysis, or labio-glosso-laryngeal paralysis. Neuro-retinitis is a common symptom, and with polyuria, which is also common, should aid in the diagnosis. Apoplectic attacks, resembling those which occur in general paralysis, have been observed in some cases.

*Bulletin de la Société de Médecine Mental de Belgique.* No. 13, 1879.

1. *Note upon the Relations existing between Erysipelas of the Face and Insanity; Clinical Case.* By Dr. Lammerts-Van Bueren.

2. *On the Classification of Mental Diseases.* By Dr. Lentz.

3. *On Insanity due to "Zwangsvorstellungen."* By Dr. Von Krafft-Ebing. Abstract by Dr. Lentz.

4. *Metalloscopy and Expectant Attention.* By Dr. Hack Tuke. Translated by Dr. Morel.

5. *Report on the Guislain Asylum for 1878.* By Dr. B. C. Ingels.

6. *Eleventh Report on the Lunatic Asylums in Belgium, 1878.*

7. *Report on the Condition of Lunatic Asylums in the Netherlands, during 1869 to 1874.*

It will be necessary to notice only some of the above articles, and these briefly. Nos. 3 and 4 being reprints, call for no notice. In No. 2 Dr. Lentz does little more than direct attention to the classification of mental diseases, adopted by Schule, and published by him in his article in Ziemssen's "Cyclopædia."

1. This is a curious case, and the author believes that it demonstrates the existence of intimate relations between erysipelas of the face and insanity.

S. M. M. was admitted in 1863. She was in her twentieth year, and had suffered mentally during the five previous years. She had also during that time been under treatment for spinal meningitis. Her mother had laboured under several attacks of melancholia. On admission she was well-nourished, and her chest was healthy. She suffered from constipation. Over the last dorsal and first two lumbar vertebræ pressure or the hot sponge gave rise to pain. Her gait was tottering, and for six months she had used a stick in walking. She was intelligent and well-educated for her position in life, but very emotional and with exalted ideas.

Antiphlogistic treatment was adopted, galvanism employed, and iodide of potassium given internally, but the paralysis continued to advance.

Two months after admission she became irritable and melancholic, and shortly afterwards suffered from an attack of furious mania. Her chief delusion was that she saw the devil. When this attack ended severe erysipelas of the face began. Since that time nine attacks of mania have been followed by erysipelas of the face, and attacks of melancholia, with irritability, have been followed by slighter eruptions. On one occasion, after a prolonged attack of melancholia, conjunctivitis and small ulcers of the cornea became developed in the right eye. Any painful emotion was sufficient to provoke an attack of erysipelas, even quarrelling with her attendants or fellow-patients.

When free from mania the patient is intelligent, and has a good memory.

5. This is really an asylum report, and as such calls for no notice. We have enough in our own-country. Still, there is one point that may be spoken of. It, like many other foreign asylum reports, contains most elaborate statistical tables. These might be of service to the members of a committee on statistics, appointed a year or two ago by our society.

7. This review, by Dr. Ingels, of an official report, is interesting, and may be consulted by any one anxious to know how asylums are administered in Holland. It cannot be said that the report points out any features of management which English superintendents would like to see adopted in this country. The Government inspectors report strongly against members of religious communities being employed as attendants.