The difficulty of separating the share of the excretions from the total furnished by the muscular and nutritive activities is too great to allow of a definite conclusion. Rosenfeld observes: "It has not been shown that the chemical changes in the brain, which are not necessarily processes of oxidation, have a recognisable influence upon common metabolism, nor can it be proved that the changes in the composition of the urine noted by some inquirers are the direct result of these chemical changes."

Rosenfeld then goes on to inquire whether alterations in the composition of the urine have been found to follow pathological conditions of the brain.

He cites many investigations by various authors; amongst others Koppen has constantly found albuminuria in acute deliria and sometimes propepton. The specific gravity was about 1030, but there was no constant relation between it and the quantity of albumen. Albuminuria was in delirium tremens and other cerebral disorders. Peptonuria has been frequently observed in general paralysis, but in this disease Rosenfeld has neither found this nor albuminuria constant. Tuzek could find no albuminuria in insane patients during periods of abstinence, and Schäfer failed to find it in circular insanity. Acetonuria has been observed in some cases of paralysis and other mental derangements, probably the result of low nutrition. Glycosuria has been frequently observed in insane patients, but not in any special form of insanity. Raimann has made inquiries into the assimilation of sugar in different forms; he has experimented on the assimilating power shown by the appearance of glycosuria after the administration of so much grape sugar calculated upon each kilo of the body weight. In idiocy this assimilative power was calculated at 4·7; in maniacal patients it was from 3·9 to 6·6. In acute confusional insanity from 2·7 to 1·4, and in melancholia from 1·2 to 1·9. This low grade in melancholiacs he regards as owing to the slowness of the vital processes.

WILLIAM W. IRELAND.

Mental Degeneracy [*De la Dégénérescence Mentale*]. (*Rev. de Psychiat.*, *October*, 1905.) *Marchand.*

Morel employed the term "degeneracy" to indicate any departure from the primitive human type, apart from such as resulted in a better adaptation to the environment. He considered its principal character to be hereditary transmission, and that it became progressively more accentuated in the descendants, ultimately leading to sterility. The cause was to be found in various ancestral diseases and intoxications. He classified the cases into two groups: those with physical malformations and intellectual enfeeblement (idiots, imbeciles, cretins); and those with various psychical affections (obsessions, eccentricities, distortion of moral sense, etc.), but without intellectual enfeeblement.

Magnan attaches less importance to heredity. He thinks that all the manifold varieties are reducible at bottom to one psychopathic mode—a failure of psychical equilibrium.

The term "mental degeneracy" is accepted by modern psychiatry, nevertheless it is difficult to apply in practice. One must recognise

that it groups together disparate states, completely opposed in their anatomical formulæ. This is due to a confusion between degenerate and "abnormal." Every degenerate is an abnormal—but the converse is not necessarily true. Certain abnormals are not, strictly speaking, suffering from disease—the anatomical basis is simply a deficiency of cerebral tissue without real lesion. In the degenerate, on the other hand, the mode of development often differs completely from the common form. Thus there are degenerate idiots and abnormal idiots.

It is generally taught that whether or no an individual is a degenerate is to be determined by examination of—(1) hereditary antecedents; (2) physical stigmata; (3) mental stigmata. The author, however, does not think that heredity plays the same *rôle* in mental degeneracy as in insanity proper, nor that degeneracy is necessarily progressive from one generation to another. Individuals without taint arise from degenerate parents, and degenerates occur in otherwise irreproachable families. In these cases some morbid condition of the mother during pregnancy is often an important factor. Charrin and Lévi found numerous spinal-cord lesions, principally hæmorrhages, in the children of women ill during pregnancy. Charrin and Delawarre have also shown in these children the presence of various abnormalities—diminution of the alkalinity of the blood, hypothermia, increased toxicity of the urine, cellular alterations, etc.—which allow a more definite conception to be substituted for the vague word "predisposition." Certain affections of childhood may also cause similar constitutional alterations.

The author, therefore, concludes that the clinical syndrome "mental degeneracy" may sometimes arise from causes to which the term "degeneration," in its generally accepted significance, is not applicable.

BERNARD HART.

Eschars in General Paralysis [*Les Escarres dans la Paralysie Générale*]. (*Rev. de Psychiat., October*, 1905.) *Vigouroux, A.*

In general paralysis eschars of various kinds occur—different in their aspect, seat, and evolution. What is their relation to the primary disease?

Till recent times eschars were considered to be trophic affections, forming part of the clinical picture of the last stage of general paralysis. Voisin pointed out that they often occurred in parts not subject to pressure—and opinions have latterly varied considerably as regards the *rôle* to be assigned to tropic changes and to lack of hygiene. The author considers that this diversity is due to the fact that eschars have been considered *en bloc*, without reference to differences in aspect and position.

Eschars on the buttocks.—These sometimes appear as a sequel to a seizure, and are then analogous to the "acute decubitus" described by Charcot in various brain diseases.

Sacral eschars.—Less deep, but of greater superficial extent than those occurring on the buttocks. They are usually connected with foci of acute myelitis in the region corresponding to the second sacral nerves. This view is corroborated by the fact that concomitant lesions have been described on the antero-external surface of the leg and the dorsum of the foot—regions likewise innervated by the second sacral.