Widal's test was negative, and she gave no reaction to tuberculin by v. Pirquet's method.

We were thus left with a possible case of general meningitis, probably confined to the vertex, as there were no localising symptoms and no signs of paralysis or paresis.

The optic discs were a little congested, but otherwise normal. Kernig's sign was not present, nor was Babinsky's. From this time—that is, three days after admission—she gradually became less excitable and restless, and relapsed into a state of stupor, from which she could not be roused.

For eight months she lay on her back with her eyes wide open, but apparently seeing nothing. Each day as I passed her bed she was in the same trance-like condition. Her eyes did not close at night, temperature and pulse normal, and her limbs were inclined to be flaccid, but occasionally there was some resistance to movement.

Her reflexes, both motor and sensory, were normal throughout.

It was thought she had some chronic meningitis, which had destroyed or impaired her mental faculties, but this proved to be erroneous. After remaining in this helpless condition for eight months she suddenly turned on her side and said, "Where am I, nurse."

She was reassured that all was right, and on being offered a cup of milk she drank it without a stop and asked for more. I saw her within half an hour of this time, and although she did not know who I was, she talked in the most rational and sensible way on subjects relating to her before her illness. I tested her memory regarding general subjects of interest in Liverpool, and she remembered all details of many events I then asked her to write her name and address, which she did correctly, and then she wrote for me from dictation quite accurately; she could read from print and writing quite properly, and she could repeat long passages of poetry.

I can vouch for the fact that she had never spoken or seen print or writing for eight and a half months, and she was under observation in a ward both night and day.

She made a complete recovery, and is now engaged in her former work without the slightest knowledge of what occurred during her long illness.

(1) A paper prepared for the Quarterly Meeting of the Medico-Psychological Association held on November 7th, 1909, in London.

A Case of Aggravated Hysteroid Movements.(1)

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THE patient was a strong, healthy young man at the onset of his illness. There was no family history of mental or nervous disease; the patient was one of ten children.

He was quite well until his twenty-first year, when he began to have "jerky" movements of his head, in which it was drawn backward and

to the left. He is said to have "strained" his neck while lifting stones in competition with his fellow workmen.

Three weeks after the onset of these head-movements, which rapidly became worse, he attended the Paulton Cottage Hospital at Midsomer Norton, and was admitted there as an in-patient on October 26th, 1906.

On admission he was a strong, well-nourished young man, over 6 ft. in height, well-developed and healthy. His head was drawn back and to the left by strong clonic contractions of the trapezius. These contractions occurred every few minutes, and only ceased during sleep. There was no tenderness in the neck. On one occasion he complained of pain in the left side of his neck, which seemed to be in the region of the spinal accessory nerve. When the head was prevented from moving the shoulder was drawn up. The clonic movements were always worse when the patient was at all excited or fatigued. There was no visceral disease, fever, or mental symptoms.

He improved slightly under treatment (*i.e.*, rest in bed, massage, bromides, and arsenic), and after four months was discharged.

He then went up to Guy's Hospital, was admitted, and remained there for twelve days. His symptoms were the same as when he was in Paulton, and the diagnosis was spasmodic torticollis. He returned from Guy's unchanged, but was able to do some work for about seven weeks, after which the movements of his head became worse.

He then went to London again and was treated as an out-patient at St. George's Hospital from June till October, 1907. When examined there he had backward jerking movements of his head, without pain, and absent during sleep. The right sterno-mastoid muscle was found to be very weak, the right trapezius quite strong, and the left trapezius weaker than the right. The other muscles were normal, those of the back on the right side being better developed than on the left. The movements were clonic, stronger, and rather more frequent than when the patient was in Paulton Hospital. There was some dorsal curvature of the spine. The knee-jerks were increased, and a pseudo-clonus was obtained. The case was diagnosed as spasmodic torticollis. While under treatment as an out-patient he improved at first, but became worse towards the end of September, 1907, and was admitted as an in-patient in October. He continuously lost flesh from about this time, and there was no improvement in the head-movements. While in the hospital he developed an attack of mental disorder which lasted for ten days. In this he became apprehensive, hid himself under the bed-clothes, and had delusions that people coming into the ward were going to shoot him. He gave no trouble during this attack, and did not attempt to get out of bed. Before this apprehensive state he was taking potassium bromide, gradually increasing up to fifty grains *per diem*.

He was discharged from St. George's on December 27th, 1907, recovered from his mental symptoms, but without improvement in the clonic movements of his head. This attack of insanity occurred about one year after the onset of his illness.

He returned home but was unable to work, though he had a partial remission of his symptoms for three or four months. Then he became worse again, spasmodic movements of the trunk began to occur in

addition to those of the head, and in September, 1908, he could hardly walk.

The patient was re-admitted into Paulton Hospital on September 12th, 1908. He could just walk in a jerky manner with his hand steadying his head. He could not lie still in bed, but was continually arching his back, jerking his head backward, and making spasmodic, purposeless movements with his arms and legs. He remained in the hospital for about one month, and was discharged "not improved." While there he was treated by rest in bed, massage, chloral hydrate, and suggestive treatment, with only very temporary benefit. When partially anæsthetised the patient would lie quite still when it was suggested to him that the movements should cease. Finally, after repetition of this treatment, two or three drops only of chloroform on the mask accompanied by the suggestion would cause him to lie still for half an hour or so, after which he would often go to sleep. No permanent benefit resulted from this treatment. He became steadily weaker and more emaciated, though his appetite remained good.

He next went into Clutton Union Workhouse, and from there to Bristol General Hospital, where he was admitted in February, 1909. Here he exhibited the same symptoms as on his second admission to Paulton, in an exaggerated degree. He could not lie on a bedstead, but had to be bedded on the floor. He was quite rational in his mind during most of his stay there, but on February 27th he threw a chair through the window, and owing to this was discharged.

He returned to the workhouse, continued in the same bodily state, but became depressed, emotional, and violent. He tried to injure himself, said he would shoot himself if he could obtain a gun, and that he wished he were dead. He smashed the windows and the crockery, and was violent to the attendants. On these grounds he was certified as insane, and was admitted to Wells Asylum on May 12th, 1909.

On admission to the asylum he was wasted, anæmic, and sweating freely from his movements. He could not stand up without support. He was executing similar movements to those he showed in the Bristol Hospital. These were very forceful, continuous, and appeared to be as much voluntary as spasmodic. They are, perhaps, best described as "writhing." He would rotate his body, arch his back, throw back and twist round his head, and execute purposeless movements of his arms and legs. The arm movements were chiefly rotatory, those of the legs chiefly extension, and at times purposive, *e.g.*, he would try to steady himself by planting his feet on the wall when lying down. He could control his movements to a considerable extent when firmly ordered to do so. He could stand up, supporting himself against the wall with his arm, and remain fairly steady, with only an occasional jerk of his head or shoulder, for some minutes. The movements were complicated, of no definite constant type, and continuous for some hours; they apparently had no localised beginning, no constant order of involvement of the different limbs or groups of muscles, and they were not rhythmical.

He had no pain or tenderness except in his knees, which were superficially sore and red. The hair on the back of his head was worn away

by previous friction (on pillows, etc.) due to his movements. There was apparently no visceral disease in the chest or abdomen.

Mentally he was quite collected and rational apart from his ideas about his movements. His memory was good; orientation, comprehension, and realisation of the general situation were normal. He could converse sensibly and calmly about general subjects, but became emotional and wept when encouraged to control his movements. He said he could not help it; that it was due to "disease of the spinal column" and "curvature of the spine."

The subsequent progress of the case was marked by a continuance of these movements at intervals of some hours, with steadily increasing weakness. He was able to feed himself and to drink; he would seize the cup, control his movements partially for a few seconds and take a rapid gulp. He would continue the generalised movements for some hours at a stretch, sometimes all day, and then when utterly exhausted would sleep for nine or ten hours, during which he would be motionless. At intervals he would lie awake for short periods perfectly still and quiet, and would account for this by saying he was "tired out." On one occasion he wrote a letter to a relative; it was just legible. He was clean in habits.

About a month after admission as he became weaker, the movements began to grow less vigorous. He would sometimes sleep in abnormal, most uncomfortable attitudes, at other times would lie on his back or side normally. While in the asylum he was treated in a single room with mattresses on the floor. He was given bromides, chloral hydrate, arsenic, and hyoscin hypodermically, with only very temporary benefit. His appetite remained good throughout the course of his illness. His mental condition continued as on admission; he showed no tendency to violence or suicide.

He developed a subacute pleurisy on the left side, had two syncopal attacks (due apparently to heart failure from exhaustion), became weaker, and died on June 28th, 1909.

The duration of the illness was thus just over two and a half years. At the *post-mortem* examination nothing of importance was found. The skull was extra hard but normal in thickness. The brain and cord were apparently normal, except perhaps for some slight softness; the former weighed 40 oz. There was a sero-fibrinous pleurisy on the left side and a deficient amount of fat in the abdomen, *i.e.*, omentum, etc. Nothing else abnormal was found. No microscopic examination was made.

I am indebted to Drs. Costobadie, Friend, and Moore for notes of the case while in Paulton, St. George's, and Bristol Hospitals respectively.

(1) A paper read at the Meeting of the South-Western Division, held at Fishponds, Bristol, on October 22nd, 1909.