CLINICAL NOTES AND CASES.

Syphilis and Mental Alienation; further Cases illustrative of their Relationships. By W. Julius Mickle, M.D., M.R.C.P., Medical Superintendent, Grove Hall Asylum, London.

(Concluded from No. 75, Oct., 1879, p. 398.)

Case IV.—*History of Syphilis: namely, venereal sore; sore throat; and subsequent general "rheumatic" pain. Later on, melancholia and suicidal propensity. Severe and prolonged cranial, and mainly nocturnal pain, with local tenderness, relieved by specific treatment. Hepatic disease; incipient pulmonary phthisis. Recovery.*

A case somewhat similar to the last will now be briefly recorded.

J.S., admitted in May, 1875, had been a private in the 69th Regiment, was 30 years of age, and had been 12 years in the service. Mental derangement had existed for a year before his admission here; had been vaguely attributed to "predisposition," and had been treated at Gibraltar and Netley. The patient was said to be suicidal. His character in the Army had been good, and his habits temperate. It was stated that "he appeared to have had syphilis." Always thought to be eccentric and unsociable he was never supposed insane until he attempted suicide when in hospital for bronchitis, and was then found to be the subject of hallucinations of sight and of hearing, and of delusions as to designs on his life by poisoning, and as to his incessant torture at night, by means of mysterious agencies, and effected by men, of another regiment, who followed him everywhere. These symptoms, with dulness of perception and memory, continued up to the time of his admission.

On admission.—Melancholia still existed, and a suicidal tendency. Delusions similar to the above were still evinced; the patient said that clocks ticked in his head, that his persecutors followed him as spirits, and that poison was placed in his food. Hallucinations of hearing existed as before; "voices and trumpets," he said, "were blown into his head." The memory was impaired.

Height, 5ft. 8in.; weight, 138lbs. Omitting details; the conjunctivæ were yellowish, and he said he had been jaundiced several months before. There were signs of incipient pulmonary phthisis. The second heart-sound was accentuated, and the apex-beat was below and slightly to the left of the left nipple. Small old cicatrices were seen on the nuchal, interscapular, and gluteal regions. The patient gave a history of two or three attacks of gonorrhœa, whilst

in the army; of several venereal sores; and of a sore-throat nine or ten years previously. No decided chancre-scars were found. He suffered, he said, from pain in the temples and top of the head by night, and sometimes by day, and had been thus suffering ever since his admission into hospital a year before. Occasionally he had pain about the right side; the liver was enlarged, but not very definitely tender. Subsequently, when better, the patient gave a history of several simultaneous sores, incurred about the year 1864; of sore-throat, about a year afterwards; and of general "rheumatic" (perhaps syphilitic) pains, about the year 1869.

℞. Potassii iodid., grs. viii.; ammon. carb., grs. vi.; sp. chlorof. m. xx.; ter in die.

This he took for more than three months. He was also ordered a mixture containing cod-liver oil, perchloride of iron, and dilute hydrochloric and hydrocyanic acids.

The cranial pains disappeared gradually under this treatment.

The headache complained of after admission varied in character. Sometimes it was continuous for a day or two, at others sharp and intermittent. It affected principally the temples and the vertex, and was accompanied by great tenderness. At first, he sometimes said it was worse by day, at others he said it was worse at night, but when mentally better his testimony was that the pain had been mainly nocturnal.

The patient was obstinate and inclined to make mischief; the depression and melancholia lessened very much, and finally disappeared, certain of the delusions remaining for a time thereafter.

Six weeks after admission he had gained thirteen pounds in weight during that period; five months later he had lost eight pounds of this increase, and the cod-liver oil, omitted for some time, was resumed.

Nine months after admission the phthisical signs were greatly improved, the pulmonary disease being arrested, and, in part, resolved. The liver was now of normal size, and almost free from tenderness. The delusions and hallucinations were partially in abeyance.

Subsequently, he continued for a long time more or less peevish, discontented, and apt to trump up charges against attendants; but was finally discharged, recovered, nineteen months after admission.

Remarks.—Probably the syphilitic disease only acted in concert with other causes in the production of insanity in this case. Incipient pulmonary phthisis, hepatic disease, and slight cardiac displacement were present.

This paper will now be concluded by the recital of two cases in which syphilis apparently caused mental disease as well as inflammatory changes in the cranial bones, in the dura-mater, and, to a less extent, in the soft meninges.

In the former case syphilitic toxæmia, cachexia and painful lesion evidently played an important part, not by causing any acute outburst worthy of mention, but a slow and prolonged depression of the psychical powers.

In the latter case active inflammation of the cerebral meninges brought about acute symptoms, and cerebral lesions from which only a very gradual and incomplete recovery was made. Thus the acute symptoms of the onset (mania, stupor), and the chronic symptoms of the succeeding period (incoherence, hebetude, irritability), each possessed features sometimes assigned to separate forms of syphilitic mental disease.

CASE V.—*"Rheumatism"; anæmia; "meningitis"; melancholia. No signs of syphilis on, or for long after, admission. Cerebral and general anæmia; syphilitic cranitis, pachymeningitis, and pericranitis; slight local palsy; hemiplegia. Syphilitic disease of liver. Death from pulmonary and abdominal tuberculosis, ascites, and peritonitis.*

P.M., 60th Rifles, admitted June 15th, 1872, then aged 35; single; previously a potter; said to be suicidal, but not epileptic. This, the first, attack of mental disease had existed since Feb., 1872, and had been treated in India, and, during seven weeks, at Netley, before his admission here. An attack of *meningitis* was the cause assigned.

When under treatment for rheumatism in India meningitis was said to have come on, and to have been followed by melancholia. Extreme mental depression and hallucinations of hearing were the principal clinical facts reported from Netley.

On admission.—Height, 5ft. 10½in.; fairly nourished; somewhat feeble; tongue clean; pulse 48; respiration feeble; equal and dilated pupils. Brown scars on the shins; scar of bubo in left groin, which he attributed to a simple traumatic bubo incurred eight or nine years previously; small scars on the arms, which he accounted for as the traces of anodyne hypodermic injections for "rheumatic" pain a year or two before he came to us. No cranial pain or tenderness; no throat cicatrices.

The patient was depressed and apathetic; he sat by himself; never spoke unless previously addressed, and took no apparent interest in his surroundings. His ideas were limited and confused, and his memory was defective, especially as to dates and to lapse of time since certain occurrences in his recent history. He fancied he heard strange blowing noises and shouting from over the walls at night. At this time neither syphilitic history nor signs were before us, and the patient was placed on quinine and perchloride of iron.

Under this treatment there was considerable physical improvement,

and slight amelioration in the mental state. Towards the close of the year a mixture of morphia and quassia was tried; and, again, morphia alone in 1873; and, subsequently, perchloride of iron. There was some improvement during this year, 1873, but once an outburst of mental excitement supervened.

1874, Feb. He suddenly rushed into a room and smashed a mirror and some panes of glass with his boot.

March. Slight signs of pulmonary phthisis were observed. The patient now refused medicine.

Later on, in the course of the summer, he became extremely depressed, miserable; feeble, even to prostration; was sleepless; lost appetite entirely; and complained of severe pains below the liver. Chloral was employed as a hypnotic, then morphia, and, finally, chloral hydrate dissolved in brandy, which seemed to act better. Wine, ammonia, and iron were also ordered.

Aug. 16th, 1874. Was sallow, anæmic, emaciated, and complained of pain about the lower part of the left side of the head, which he sometimes said was worse at night, and sometimes said was not. The pain was localised, sharp, "shooting," "stooning," as he described it, and not increased by the heat of the bed, and, in fact, he covered up the head at night. No tenderness was elicited by percussion over the site of the pain. The infra-hepatic pain was far less severe now than formerly. The left pupil was dilated. A mixture of potassium-iodide and ammonium-carbonate was ordered. The wine, morphia, and quassia he was then taking were also continued.

Under this treatment the pain soon disappeared, and cheerfulness, appetite, and muscular activity returned in some degree. The iodide of potassium was discontinued, and, on Oct. 13th, the morphia also.

Oct. 26th, 1874. Ordinarily the pupils are wide, especially the left, but they contract almost normally under a bright light. The eyes are pallid, the face pallid and somewhat sallow; the heart-sounds are deficient in force and loudness, the second sound at the base is thin and short; the pulse is 96 and feeble; the hands are chilly, but not livid. Occasionally the patient sighs; he is drowsy by day, and his sleep is deficient at night, but dreamless, he says; pains in the flanks occur at times; and also pain in the left side and front of the head, both by day and night, a somewhat constant, "stooning" pain, he says. There is disinclination to move, muscular lethargy, or "paralysis of energy," accompanied by pains "all over his insides." There is no vomiting, and now no constipation and no palpitation. The expression is one of sadness and misery, and he says he feels depressed about his ill-health and detention. He states that he drank, and perhaps had syphilis, while in the army.

Simple melancholia and anæmia cerebri were, therefore, the more obvious conditions then present.

Towards the close of 1874 he again refused to take any medicine. The signs of pulmonary phthisis were now more obvious, the left

pupil generally, the right occasionally, was the larger; and once the tongue pointed slightly to the right when protruded.

1875. Still refused medicine; later on, severely affected by "bizzing" cranial, and other pain, he took the remedies already mentioned, including the potassium-iodide. For some time slight right (lower) facial paralysis was noticed, and the left leg, he said, was slightly the weaker. The pupils were sluggish and irregular; the left generally, the right occasionally, was the larger. The skin presented the same dull, lustreless, sallow pallor. Again, he improved under treatment.

1876, Feb. Slight palsy was now observed about the mouth, tongue, and lower part of the face, on the right side. A pericranial node had appeared on the right side of the occiput. Refused medicine. Left pupil larger.

April. He suffered from a sudden attack of right hemiplegia, preceded for some days by pain in the limbs, and pain and a node at the cranial vertex. While walking he fell paralysed, but without loss of consciousness or convulsion. For several days afterwards there was occasional vomiting. From this hemiplegia he gradually made an almost complete recovery. Right pupil now the larger.

July 2nd, 1876. Recently had again been taking K.I., and, with it, brandy; and iron, also, was again ordered. Had now a pericranial node at the occiput, and cranial pain, but was improving in respect of both. There were still slight traces of the right hemiplegia of the common form; the right pupil was dilated, both were sluggish, and the left one was of irregular shape. During July painless abdominal tympanites occurred, and fluid effusion in the peritoneal cavity. The decubitus being nearly always sinistral, yet tenderness and a puffy swelling were observed to the right of the umbilicus. The skin became slightly jaundiced, and the liver-dulness was $2\frac{1}{2}$ inches in the nipple line. Purpuric stigmata appeared on the legs. The urine was non-albuminous, and ample in amount.

During the several succeeding weeks the patient was frequently tapped by the aspirator, and from 6 to 18 pints of peritoneal fluid were withdrawn on each occasion. Occasional mucous diarrhœa was succeeded by stools of a "dysenteric" character. From slight peritonitis some abdominal pain was now also complained of, and vomiting occurred at times. Restlessness was extreme, and delusions were evinced as to the hostility, the desire to injure and annoy him, and the general malevolence, of those attending him. The skin was dry and covered with whitish, shining flakes and scales. Finally, dark-green fluid was vomited; the appetite was still bad; the pulmonary tuberculosis was making advances. The patient gradually sank, and died on Oct. 4th, 1876.

Abstract of necropsy.—Calvarium unduly thickened, dense, and heavy, the portion removed weighing $19\frac{3}{4}$ozs. There were numerous areas of syphilitic caries, and some of necrosis, on the external surface

of the skull. One was an inch above the middle of the left supra-orbital ridge, forming an irregular depression on the surface of the bone, of the area of a sixpenny piece, with shelving borders marked by radiating lines, the central and deeper portion being occupied by a yellow fibrous material and soft granulation tissue. From the central parts minute sequestra disjoined themselves, and here the outer table of the skull had entirely disappeared; there were fibrous adhesions between the skin and the tissues in this depression. Similar depressions existed: one, an inch higher up; another, one inch to the left of the median line; another at the summit of the frontal bone; four on the right parietal bone; and four on the left. Several, also, were observed on the occipital bone, especially a large one on the right side of the bone, and opposite to this the *internal* surface of the calvarium was irregularly carious, and the dura-mater was adherent thereunto; while, externally, the pericranium was adherent opposite to the same area. On the internal surface there was also a thick, yellowish-white, adventitious membrane, rather larger than a 5s. piece, adherent to the bone above and opposite to the right parietal eminence, the bone beneath being superficially eroded. On the left side there was a similar, smaller area of erosion, but there the false membrane was firmly adherent to the dura-mater. There were also other smaller areas of erosion affecting the internal surface of the left side of the occipital bone and of the left parietal. The dura-mater was somewhat thickened, and unduly opaque, and was firmly adherent to the calvarium at parts, especially at the vertex. The basal arteries had a healthy appearance.

The frontal and parietal convolutions of the superior and external surfaces were slightly wasted, and the pia-mater covering these parts was œdematous, the arachnoid faintly opaque. The meninges were fairly vascular. The cortical grey matter was of fair depth; its external layers were rather pale in the frontal region, its deeper layers of a faint lilac hue, while the sections of the posterior part of the cerebral cortex yielded a pale hue throughout. The white matter was moderately vascular, the consistence of the brain generally was lessened. The basal ganglia were alike on the two sides. Considerable vascularity existed about the floor of the fourth ventricle. The cerebellum was rather pale. Weights:—Right hemisphere, 22½ozs.; left, 22ozs.; cerebellum, 6½ozs.; pons and med. obl., 1oz.

For the rest, it may be briefly stated that the *heart* weighed 8½ozs.; the aortic valves were slightly coarse and thickened, and the corpus Arantii of one segment was enormously hypertrophied; on the right and posterior aspect of the commencement of the aortic arch was an irregular, rough, projecting, yellowish-white, and partly calcareous mass beneath the inner coat of the aorta. The heart-muscle was rather pale, yellowish, flabby, and friable.

The apices of the lungs were both puckered, partly cirrhotic, partly occupied by encapsulated cheesy masses. Around the latter, and

scattered through the upper parts of both lungs, were clusters of grey and dirty-whitish granulations, which also invaded the upper parts of the lower lobes. Old pleuritic adhesions at the apices; bronchial glands enlarged. Right lung, 25½ozs.; left, 23½ozs.

Abdomen. Peritoneal tuberculosis and slight peritonitis, with fluid effusion, and a few lymph-flakes.

Mucous membrane of large intestine thickened, congested, of dark hue, and the site of superficial erosions, especially in the cœcum and sigmoid flexure.

Spleen firm, large, 21ozs., of a deep chocolate hue; local yellowish thickening of its capsule.

Kidneys; each weighed 5½ozs.; the left was of a dull, yellowish-fawn colour, its capsule slightly adherent; in the right a white depression, filled with fibrous tissue, traversed the cortex.

Liver cirrhosed, lardaceous, and fatty (microscope). On the upper surface of the right lobe was a deeply puckered cicatrix extending into the parenchyma of the gland, and a smaller one on the upper surface of the left lobe. Weight, 39ozs.

Remarks.—In this case, besides other and non-syphilitic morbid changes, were found :—Syphilitic ostitis, ending in caries and necrosis of skull; syphilitic pericranitis, syphilitic pachymeningitis externa, and traces of syphilitic gummata of the liver. No syphilitic history is recorded of the conditions leading to brown scars and stainings of the shins. But the so-called "rheumatic" pains, which had tortured the patient so much before he became insane, as well as the meningitis preceding his mental attack, and said to have caused it, and the anæmia whilst he was under my care, were, probably, all of them evidences of constitutional syphilis. So also were the severe cranial pains, from which he suffered from time to time during 1874, '75 and '76. These, even when most localised, had not always, however, the typical features of chronic syphilitic pain; but they were always relieved when the patient could be induced to take KI. The obstinacy of the patient as to the taking of medicine and of food was a source of much difficulty in the case.

There was no history of syphilis obtained with the patient, and no sufficient evidence of its existence when he was admitted. It was not until 1874 that other symptoms arose which suggested syphilitic disease, and not until 1876 that further indications proved its existence and activity. Nor could I ever ascertain when he had incurred the primary infection; certainly the patient himself never could tell. In, and from, 1874 the KI was used.

The course of events was probably as follows:—Secondary syphilitic lesions developing internally, rather than on the exterior of the body; general pains, syphilitic anæmia, syphilitic "meningitis," mental disease (melancholia), pulmonary phthisis, syphilitic periostitis, cranitis, and pachymeningitis, slight paralysis. Relief of these, and improvement of general health and mental state, under specific treatment; relapses, syphilitic pericranitis, hemiplegia, refusal of medicaments, pulmonary infection from the old caseous masses, tubercle of peritoneum, peritonitis, death.

Thus the features of this case differed widely from those of cases I have elsewhere * described, in which there was syphilitic disease of the arteries of the brain, both of the basal and of immense numbers of the *minute* cerebral arteries, together with local lesions, the secondary consequences of the arterial disease, and, in some cases, syphilitic infiltration of the cortical substance of the brain.

In explanation of the attack of right hemiplegia 5½ months before death, and of the preceding slight paralysis about the lower part of the face, on the right side, one can only refer to the greater amount of pachymeningitis on the left side, and the closer adhesion of the false membrane to the dura-mater, rather than to the cranium, at the left parietal region than at the right; hence, perhaps, a greater degree of compression of the subjacent, and left brain substance during the periods of inflammatory turgescence.

CASE VI.—*Attack of stupor and of other acute symptoms, promptly followed by profound dementia. Later; recurring pericranial nodes, and intense cranial pain, with mental dulness and insomnia. Ozæna; atrophied testicle with apparent fibroid changes, irregular tibiæ; cupreous psoriasis on calves of legs. Post-mortem indications of syphilitic intracranial inflammatory processes.*

J. M. Private 1st Batt. 60th Rifles; admitted November 1, 1873; æt. 33; married; service 9$\frac{4}{12}$ years. This attack of mental disease was stated to be the first, to have existed from June, 1873, and to have been previously treated from June to October, at Dover, and during October at Netley. The patient was stated to be neither suicidal nor epileptic, but to be dangerous to others. In the statutory "statement" the "supposed cause" reads thus:—"Believed to have been drugged in some public-house; he was found insensible in a court outside." There was, however, some discrepancy here, inasmuch as in the "abstract" of his case, forwarded with the certificates

* "Brit. and For. Med.-Chir. Rev." July and Oct., 1876. Abstract in "Journal of Mental Science," Oct. 1877.

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as to insanity, the attack is said to have "developed suddenly (as mania in the commencement) with homicidal impulses." This latter partially agrees with the statement made to me verbally that the patient was found naked in a brothel, in a state of great mental excitement.

At Netley he was restless, meddlesome, dirty in his habits, extremely foul and obscene in his language, utterly irrational, with loss of memory and confusion of thought, with incapacity to answer questions, and with occasional outbursts of excitement. Forgetful of his immediate surroundings, he fancied every night that he was "out of barracks on a pass."

On Admission. — Abstract of Notes.—Height, 6 ft. Extremely weak and emaciated. There appears to be slight palsy about the tongue and lower face of the right side; speech hesitating, and quasi-stammering; tongue a little tremulous when held protruded; gait slow and careful; pupils small, irregular, sluggish, the right slightly the larger; features small and shapely; venules dilated over the malar prominences; the edge of the aural helices withered and undulate.

The patient is fatuous, his memory an utter wreck. He wears a vacant, fatuous look, entirely fails to appreciate lapse of time, or to recognise persons or places; he imagines he is out 'on pass,' or that he has lived here all his life, or that he works regularly in the vicinity. He uses most profane and obscene language, and urinates in bed.

Abstracts from a few of the further notes of the case.—This patient was placed under perchloride of iron from admission in Nov. 1873, until March, 1875, during which period he improved immensely in physical condition, and very considerably in mental state, and latterly was usefully employed in his ward.

Oct. 17th, 1875.—The patient, now unusually dull and confused, complained of frontal pain, which he said he had had for several days, but he was too stupid to give any very trustworthy account of it; he said it was not worse at night, and was not increased by the application of heat. The forehead, slightly swollen, was tender on percussion. The very slight right facial paralysis persisted; the pupils, still sluggish, were of medium size. Tongue slightly tremulous, speech accompanied by faint occasional tremor of lip, and faint hesitation, but clear and distinct. Post-nasal and pharyngeal ozoena was also observed. An old scar on the shin was inflamed, deep red, and had a scaly surface.

℞. Potassii iodid., grs. vi.; ammon. carb. grs. vi; tr. myrrhae ʒ ss.; ter in die.

22nd. Temp. 98·2°; better, no pain in head.—23rd: slight return of pain. Weight 158lbs. — Dec. 7th. No pain since. Omit the iodide mixture.

Feb. 25th, 1876.—The tibiae were coarse and irregular. On outside of right calf, and over front of the middle of right tibia, were

coppery psoriasis patches. The skin of the lower limbs was dull, purplish, and mottled, especially behind. The testes were atrophied and irregular.

There was still great loss of memory, and the patient was occasionally irritable, quarrelsome, or excited, and his language was extremely foul and obscene. Later on in this year slight morbid signs were observed at the pulmonary apices.

Dec. 22nd, 1877.—For two nights he had had severe cranial pain, causing insomnia. The pain was worse at night, and was mainly frontal. There was tenderness all over the vertex as far back as the posterior fontanelle, but most marked about the forehead, and especially at the right temple. He walked heavily and unsteadily, and said the left leg was the weaker. The legs were much mottled by purplish discolouration; pulse feeble, soft, and rather frequent. Mental dulness and confusion were now more marked than usual.

℞. Calomel gr. $\frac{1}{4}$ every hour, for 16 hours. Also,

℞. Potassii iodid. grs. vi.; ammon. carb., grs. ii.; three times a day. This mixture was continued until May 6th, 1878, and, latterly, was increased in strength.

Under this treatment the pain and other symptoms rapidly cleared away.

While still taking the iodide he suffered in March, 1878, from a severe whitlow on the thumb. In April an abscess appeared in the right thigh, which was opened and dressed antiseptically. Subsequently, an enormous abscess appeared in the left lumbar region, which was frequently tapped by the aspirator under carbolic spray, the punctures being closed by collodion, until it disappeared. But simultaneously there were noticed the physical signs of bronchitis; also crepitation at the base of the right lung, and pleurisy at the base of the left. Evidence of tubercles still existed at the apices of the lungs. The patient was now taking quinine and brandy, also iron and quassia, and, subsequently, morphia. To be brief: he recovered from the active febrile condition, and the right leg, affected with stiffness sequential to the abscess, was treated by friction, bathing, and passive motion.

Sept., 1878.—Heart's pulsation somewhat irregular; also intermittent, omitting about every fourth or fifth beat: apex beat at about usual site. Weight, 147lbs. Still taking the iron and quassia mixture of April.

Jan., 1879.—Emaciation, general bronchial rales, signs of some consolidation and cavitation of the apex of the right lung, and of softening tubercles in the apex of the left.

April.—Œdema of legs; no albuminuria; irregular diarrhœa.

May.—Peritonitis; tympanites; "sharp" abdominal pain; dulness and fluctuation in the flanks, but not changing with change of decubitus; œdema of back of trunk and of legs; low temperature, 98·3° sinking to 94°; feeble, frequent, pulse; (morphia and terebinth). Died May 24th, 1879.

Abstract of Necropsy.—Body emaciated. Calvarium thick, especially in the frontal region, of worm-eaten appearance along either side of the grooves for the superior longitudinal sinus, and for the middle meningeal arteries; weight of portion removed, 15ozs. The arachnoidal villi were enlarged, and at the vertex the dura-mater was intimately adherent to them, to the visceral arachnoid, and to the skull. The dura-mater was thickened, and its inner surface, especially on the left side, was the site of rusty staining, and of slight adherent, though separable, delicate films of false membrane. These were observed in both anterior fossæ of the base of the skull, still more in the left middle fossa, and very slightly in the left posterior fossa. Laterally, and also beneath the vault of the cranium, the same condition was slightly more marked on the left than on the right side. The posterior tip of each lateral lobe of the cerebellum was attached by a false membrane to the external wall of the lateral sinuses.

The arteries at the base of the brain were apparently healthy. The olfactory bulbs were softened and atrophied, the olfactory tracts atrophied and flabby, The inner meninges were thickened, opaque, and œdematous. The opacity of the visceral arachnoid was patchy, and extended over nearly the whole of the superior and external surfaces of the cerebral hemispheres, and was slight on their internal surfaces. The fronto-parietal pia-mater was œdematous, and the sulci were widened there. The membranes stripped readily, except at the vertex adjoining the great longitudinal cleft, where their removal left the grey cortex eroded in a tract corresponding with the above-noted adhesive fusion of the several membranes, and comprising the upper ends of the ascending frontal, and ascending parietal convolutions, and part of the anterior $\frac{3}{4}$ inch of the postero-parietal lobule, on either side. Similar erosions were seen on the posterior $1\frac{1}{2}$ inch of the left first frontal gyrus. A few minute adhesions also existed on the left orbital surface, and over the second and third right temporo-sphenoidal convolutions. There was considerable wasting and flabbiness of the brain. The cerebral grey cortex was mottled, and was somewhat wasted in the superior fronto-parietal region.

There were: yellow softening of great part of the corpus callosum as seen from above; a patch of yellow softening on the anterior part of the ventricular surface of the left optic thalamus; and yellow softening, with surrounding slight induration, in several minute portions of the left cerebral cortex.

The medullary substance of the brain was flabby and moderately vascular; the cerebellum flabby and soft, its cortex rather pale. Each cerebral hemisphere weighed $17\frac{1}{2}$ozs; cerebellum, $3\frac{1}{2}$ozs.; pons and med. obl., $\frac{1}{2}$oz. Four fluid ounces of blood and serum escaped from the skull and brain.

Heart: weight 11ozs.; heart muscle pale, friable, and fattily degenerated (microscope); apparent hypertrophy of right ventricle; slight atheroma of aorta.

Right lung, 31ozs; old adhesions; advanced phthisis; with some pulmonary cirrhosis at the apex. *Left lung*, 23½ ozs; a few adhesions; traces of lateral pleurisy; less advanced phthisis than right lung.

Abdomen.—Small intestines much distended; large intestine less so; numerous tubercular ulcers in small intestine, and several in the coecum, of which one was perforating, and was evidently a source of the peritontis with serous and lymphous effusion. A few tubercular ulcers were also found in the colon. *Liver*, lardaceous and cirrhotic; weight, 70ozs. *Spleen*, 15⅓ozs; large, rather firm, somewhat "sago-like," the orange-red sections exhibiting somewhat translucent spots, but only a few patches turned of a mahogany hue with the iodine solution. Traces of slight former perisplenitis were also observed. *Kidneys*, each 4¾ozs; not lardaceous; cortices mottled, pale; capsules slightly adherent.

Remarks.—In this case a patient who had had a sudden attack of stupor, probably followed by maniacal excitement, was admitted in a state of extreme dementia, and with persistent pupillary changes and slight right facial paralysis. Two years afterwards severe cranial pains and tenderness, and slight pericranial nodes were observed, and other evidences of syphilis both past and present; and the existence of syphilis was then for the first time indicated, and an anti-syphilitic treatment was adopted with prompt relief. Similar symptoms again arose two years later, and were relieved by similar means. In due course the patient died of another affection. After death, the following lesions were assigned to syphilis: internal and external cerebral pachymeningitis; partial arachnitis and meningitis, and, perhaps, the traces of perisplenitis. Unfortunately, the irregular and atrophied testicles were not examined. No doubt of the syphilitic nature of their lesion was entertained during life.

The course of events was probably in this wise:—During the late secondary period of syphilis, pachymeningitis, and to some extent meningitis, produced acute symptoms, and were followed by extreme dementia due to cortical impairment, from which partial or incomplete recovery was made as the meningeal morbid processes subsided. Subsequently, recurrences of pachymeningitis and of pericranial nodes, with mental heaviness and dulness, were relieved by anti-syphilitic treatment.

The patient was admitted here during what Mr. Jonathan Hutchinson would call the third stage, or "interval of latency or of relapses" of syphilis; but subsequently tertiary symptoms arose.

In each of the above cases have been recorded the history and traces of any venereal affection from which the patient may have suffered, and without prejudice to the distinctions usually drawn between true syphilis and mere venereal sores.

Myxœdema and its Nervous Symptoms. By GEO. H. SAVAGE, M.D., Lond.

In this short paper I have no idea of adding one to the already too numerous class-names of insanity, but I am anxious that asylum physicians should have their attention called to a clinical type of disease which may exhibit mental symptoms, and may thus add to the small store of useful knowledge of the subject.

Physicians practising among the insane rarely have good chances of seeing the slighter and earlier mental symptoms, and thus often have difficulties in comprehending the development of the symptoms, and physicians to general hospitals have but scanty experience of insanity, and so the borderland is neglected, yet this borderland is the region where most may be learned and where most good may be done.

Insanity, till recently, was looked upon as a disease of the brain, and not of anything else, and that a man being mad, was so primarily from disease of his brain. But, as Sir W. Gull said to me one day, the brain, like a gentleman having many servants, was often badly served. The brain suffers more or less in all bodily diseases, as seen in the melancholy with some cases of mitral disease, and the suspicion in some phthisical cases. Indigestion may colour a man's views of the world, and repeated gout may affect a country's welfare through its statesmen.

Authors have already begun to notice that many of the physical disorders of the body have special ways of affecting the brain, and no longer do we hear that kidney disease is never seen in the insane.

Most useful results must follow such work as that of Dr. Ord, to whom we are indebted for a careful examination of the disease he calls Myxœdema. I presume that most of my readers do not know the disease, and I will therefore refer them to Sir W. Gull's first paper in the report of the Clinical Society for 1873, "On a Cretinoid State supervening in