lies on the outer wall of the aneurysm, and is much flattened and constricted, its circumference, two inches from the auricles, measuring barely half an inch. The trachea lies behind and to the right. The aneurysm has ruptured through the anterior wall of the right bronchus at its union with the trachea; the opening is a ragged, transverse slit, more than an inch in length, and from its appearance necrosis must have taken place owing to the pressure of the aneurysm; all the neighbouring part is blackened and necrosed. The aperture from the sac of the false aneurysm lies at its lower and median part, and consists of a transverse slit about three eighths of an inch in length. The superficial venous distension which was such a marked feature of the case during life is not now visible, but on slitting open the various veins their large diameters can at once be seen. There is no evidence that the aneurysm has compressed any of the thoracic nerves.

Liver, 1515 grammes, congested and somewhat friable.

Spleen, 155 grammes, is very pulpy, but the connective tissue is increased.

Kidneys, 128 grammes each, congested; cortex, 627 mm.; density natural; a little fatty change. Renal arteries are somewhat thickened; there is a little early atheroma of the abdominal aorta.

The glands around the cœliac axis are very calcareous. The stomach contains a large amount of blackened blood; the small and large intestines are natural; the bladder is hypertrophied.

Cause of death.—Immediate: hæmorrhage from trachea. Rupture of a false aneurysm, secondary to a true aneurysm of the upper half of the ascending part of the arch of the aorta into the right bronchus, near its union with the trachea. Other pathological conditions: systemic syphilis, insanity with marked dementia.

The essential feature of the case was the extreme distension of the superficial veins of the chest. This was so extreme that in the absence of any definite sign clearly pointing to an aneurysm, it was impossible to definitely determine whether the patient was suffering from a thoracic aneurysm or from syphilitic affection of the mediastinum and its glands.

A Case of Status Epilepticus complicated with Scarlet Fever. By George Watters Greene, B.A.Cantab., M.R.C.S., L.R.C.P.Lond.; Assistant Medical Officer, Claybury Asylum.

M. L—, a lad of seventeen, was admitted into the asylum on October 20th, 1902, with a history of epilepsy.

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On admission he was pale, weak, and exhausted, but was slowly regaining strength when on November 1st he suddenly commenced with a succession of thirty-six fits. Two days later he had another succession consisting of seventy-three fits, and on the same day he developed an attack of scarlet fever. His temperature rose to 102·5°, and remained about that level or a little lower for several days. He had a bright red erythematous rash over the body, and the tonsils were inflamed and slightly ulcerated. Meantime the fits continued with increased severity, averaging from one hundred to two hundred a day. On November 18th the succession of fits ceased. They had amounted in all to a grand total of 1742, extending over a period of seventeen days. After the subsidence of the fits the patient became very feeble and collapsed. His temperature sank to 95°, and remained between that level and 97° for nearly a fortnight. His heart dilated, and the radial pulse was scarcely discernible. However, with digitalis and alcohol (whisky) the patient rallied. The former was administered in 5-minim doses every four hours, and the latter in half-ounce doses also every four hours. This treatment was continued with a few short remissions until December 24th, during which time the patient slowly regained strength, and at the end of that time was able to get up.

He was practically recovered when, perhaps, the most interesting feature of the case occurred. On January 1st he developed peripheral neuritis in both legs. There was pain on pressure, marked atrophy of calf muscles, foot-drop, absence of knee-jerks, and, later, of electrical reaction, and complete inability to walk or stand. The arms and hands were also somewhat affected, and unequally. The grips of the dynamometer show forty in the left hand and seventy in the right. There was anæsthesia in both legs, and more marked on the peroneal distribution. There was no marked anæsthesia in the hands and arms, although reaction was slightly retarded. Muscular pain was present on pressure in the legs. There was no characteristic mental reaction as accompanies alcoholic neuritis. The question to be answered is, what was the cause of this neuritis? Three factors were capable of producing it. Firstly, it might have been post-scarlatinal; secondly, post-epileptic; and finally, alcoholic. Of these post-scarlatinal seems most probable, as the fact that alcohol (whisky) was administered in moderately small doses for a period only extending a little over three weeks, and the duration of the neuritis was longer than is usual in post-epileptic cases. He is now, February 18th, quite recovered. He has gained considerably in weight, looks robust, and seems in perfect health. The fits also have entirely ceased.

Remarks.—As stated by Percy Smith,(1) Korsakoff, of Moscow, was the first to call attention to the fact that a special form of mental disorder which had previously been described as being typical in alcoholic cases, and was commonly associated with multiple neuritis, might also occur in cases where there was no history of alcoholism, but where there was polyneuritis from other causes. Dr. Robert Jones has seen three cases of

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asylum dysentery in whom peripheral neuritis occurred in both legs, and in whom there was analgesia and diminished electrical response. He has also recorded cases of lead insanity with neuritis, for whom the electric bath treatment was applied. Tiling, of Riga, quoted by Smith, suggests that polyneuritis might result from loss of blood, puerperal toxæmia, auto-intoxication, metallic poisoning, and other causes. Cases of typhoid fever with the condition referred to have also been described, but the amnesic mental condition of alcohol was not present. Whether a "polyneuritic psychosis" really occurs in association with multiple neuritis and characteristic of it appears unsettled. Kraepelin suggests that the mental disturbance in these cases is not due to the neuritis, but to the effect upon the brain of the same agent which had affected the peripheral nerves. In the case above described the peripheral changes were very marked, but there was no co-existing or characteristic mental condition.

(1) "Peripheral Neuritis and Insanity," *Brit. Med. Journ.*, August, 1900.

Occasional Notes.

The English Archives of Neurology.

The second volume of the *Archives of the Pathological Laboratory of the London County Asylums*, edited by the director, Dr. Mott, very fully justifies the hopes, that were expressed at the establishment of the laboratory, of most important help in the advancement of psychiatric science.

This volume is a monument of the vast amount of clinical and pathological matter that is at the service of Dr. Mott and his able coadjutors; of the huge amount of work achieved in the laboratory, as well as of the careful critical faculty and great ability in lucid exposition possessed by the editor and principal contributor.

The relation of syphilis to general paralysis, which Dr. Mott has, from the outset of his work, steadily pursued, is still the leading subject. Dr. Mott devotes an article of over three

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