Report of Three Cases of Short Attacks of Insanity with some Remarks on the Discharge of Recovered Patients. By J. A. Campbell, M.D.

Case 1st.—H. J. M. Admitted July 29th, 1872; female; 18 years; single. Hereditary predisposition existed in family; she had at one time been excited for a day or two, and been treated at home; she had lately been subject to considerable anxiety, and had to sit up frequently at night nursing a sick relative. Ten days ago became excited, talking much incoherently; was sleepless, and took food ill. For the two days previous to admission had got worse, more excited, had attacks of hysterics, and did not sleep at night. She had not menstruated for two months.

On admission. Was in a state of great excitement, most restless and noisy, but could speak coherently and answer questions correctly when she chose to exercise self-control.

Physically. She was a slight-built, healthy looking girl, of average height. Temp. in axilla 99.4°; pulse 96 weak. Examination of chest showed heart and lungs to be healthy.

July 30th.—Was restless and did not sleep during the night.

July 31st.—Was restless and noisy during the day, took food ill, ordered drachm doses of tr. valerian co. in water thrice daily.

August 8th.—Is much improved, well-behaved, rational in conversation. Sleeps well at night; at times complains of pain in head.

August 10th.—Is keeping well; was ordered an iron and aloes pill thrice a day.

August 29th.—Having kept well since last entry was to-day discharged recovered.

Case 2.—M. McG. Admitted Jan. 28th, 1875; single, 25 years of age. Had one previous attack of insanity, for which she was for a short time under treatment in an asylum.

Little was known either about her or as to her family history, except that at menstrual periods she was excitable and irritable. She had become suddenly much excited, tearing her hair, throwing the dishes about, singing and shouting.

She had not slept for two nights, she complained of pain in the side. Menstruating sparingly; said to have caught a cold at beginning of menstrual period.

On admission. Mentally she was depressed, emotional, crying; able to answer questions correctly; for most part coherent in her remarks; memory unimpaired; no delusions could be elicited.

Physically. A tall, dark complexioned, slight-built woman. An examination of chest showed a normal condition of heart and lungs; breasts bore evidence that she had been a mother.

Temp. 97.8°; pulse, 72; weight, 125lbs; pupils equal, abnormally dilated; tongue slightly furred.

Jan. 29th.—M. t. 97°.6 ; e. t. 98° ; m. p. 66 ; e. p. 96. Lay quietly during the night. Has taken food fairly since admission. Is to-day very nervous and emotional.

Jan. 30th.—Slept well last night; has taken food well, is quiet and dull.

Feb. 1st.—Is quiet and well behaved ; eats and sleeps well.

Feb. 3rd.—Had slight diarrhœa to day, probably caused by change of diet.

Feb. 5th.—Quiet, civil, reasonable, industrious and cheerful, eats and sleeps well.

Feb. 11th.—Having kept well up to this date, and an informality having existed in the medical portion of her admission order which could not be rectified, she was discharged recovered.

Case 3.—H. H., Commander R.N. Admitted August 7th, 1873 ; 64 years of age ; had been a sober, quiet going man. Several relatives had been insane ; he had once been under treatment in an asylum, and had a short attack when at home. These attacks had been of short duration, and at long intervals. He was said to have had a sunstroke when on foreign service.

He had been out of his usual health for a week, then became excited, fancied he was on board ship, broke the crockery, slept little at night, and took little food.

On admission. Mentally he was in a state of great excitement, talking incessantly in a loud voice ; fancied he was on shipboard, issued orders at pitch of his voice ; evidently has hallucinations of vision.

Physically. A healthy-looking, stout-built man. Temp. 99° ; pulse, 120 ; pupils equal ; conjunctivæ suffused ; reflex action dulled ; heart and lungs normal ; tongue furred, protruded straight ; articulation slightly slipshod.

August 8th.—Restless most of the night; shouting orders in nautical terms. Talking in an incoherent rambling manner to-day. Did not take food well.

13th.—For the last five days has been much excited and restless, has been out for a walk daily ; at night is most noisy and restless, piles his bedding and sits on the top of it naked ; says he is in his cabin on board ship ; shouts and issues orders ; won't take medicine as he is afraid of being poisoned.

14th.—Been better to-day ; slept six hours last night ; is more coherent in conversation ; took his food well.

23rd.—Since last entry this patient has slept well every night, and been daily getting better. Is now quite orderly, coherent in conversation, and apparently quite well.

Sept. 2nd.—Having kept well since last entry, was to-day discharged recovered.

The first was a case of hysterical excitement in a girl whose

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history showed marked hereditary predisposition to insanity. She had been excitable previously though never to such an extent as on this occasion. In all probability if treated at an earlier date for her menstrual irregularity, she might not have required asylum treatment. She was in the asylum 31 days. I saw no reason to detain her as she appeared quite well, and she has kept well ever since.

The second was a somewhat similar case; though I could not ascertain it as a fact, I have little doubt but that hereditary predisposition existed in the case. The attack was of very short duration; evidently the worst of it was past before she came under my care. An informality having existed in the medical certificate on which she was sent to the asylum, it induced me to discharge her at an earlier date than probably I would otherwise have done. She was apparently quite sane the third day that she was in the asylum. She was fourteen days in the asylum.

In the third case, the history showing a return of a very short attack of insanity, with a long interval of mental health, induced me to discharge the patient at the earliest possible date, in order to allow of his enjoying home comforts for as great a length of time as he could. I am aware that he kept well for a year. He was twenty-five days in the asylum.

I may mention that the short remarks I am about to make in regard to the discharge of recovered cases, are mainly in the hopes of eliciting the opinions of members of this Society, whose experience must necessarily be large.

It may be considered that when a patient has arrived at the recovered stage, the medical attendant may be thankful, and not trouble himself much more about the case, but practically this is not so, many considerations of a serious aspect have to be taken into account. Of these three have principally to receive attention, viz.:—

How long should the patient be kept under observation in the asylum?

What is the probability of a recurrence of the disease, and within what time?

In what manner are the patient's home surroundings likely to affect him?

The length of time after apparent recovery for which the patient should be kept under observation, must, of course, be much modified by the nature and history of the attack of insanity. I am of opinion that it may be reduced to the shortest limits in the following forms of insanity:—

Puerperal Insanity. The tendency of going on to recovery being almost certain.

Insanity of drinking of the acute form, where abstinence alone is necessary to prevent recurrence of the mental disease. Forms of insanity consequent on a debilitated state of health, such as from hyperlactation and starvation, where an improvement in the bodily and mental state has been gradual and coexistent.

Cases of excitement dependent on functional derangement, hysterical insanity.

Cases of recurrent attacks of mania, in which the history of the case distinctly shows a tendency to a short attack, and a long remission of the disease.

The home surroundings, the character of the patient's relatives, and in the working classes the facilities for the discharged patient at once getting steady work (this latter need not at present be considered, as anything in the shape of man gets work and is fairly paid) all combine either to militate against the patient's doing well out, or to aid in sending him back to the asylum.

I have known several patients, who appeared in every respect likely to remain well, have to be sent back to the asylum apparently from having to contend with home difficulties and circumstances which even a person who had not been insane must have found very trying indeed.

There can be little doubt but that the probability of a recently recovered case of insanity continuing well, is greatly increased by going to a well-ordered home, where the influences tend to increase self-control, and to put in use the laws of health. Many discharged patients, in whom hereditary predisposition is strongly marked, have, on recovery, to put up with considerable annoyance from their supposed sane relatives. There are at present several patients under my care, in whose case it has been a matter of wonder to me what mode of selection sent them to the asylum and left at large the relatives that visit them.

The class of cases which necessitate being kept for a considerable period under observation, are those in which melancholia has been a prominent feature, where impulsive actions have been very noticeable, and cases in which recurrence of maniacal attacks has been frequent and uncertain.

To arrive at a conclusion as to when it is safe to discharge patients whose mental state presented these phenomena, is undoubtedly a subject which demands the most careful con-

sideration from the medical man, both as regards the safety of the patient and the public. In many cases the deceptive appearance of recovery would, I have no doubt, have caused a little anxiety in the mind of Solomon had he been in the practice of this branch of the profession.

In many of these cases of a doubtful nature, which one clearly recognises as requiring to be kept for a considerable time under observation, especially in those where a suspicion of a tendency to injure themselves has existed, one finds it most difficult to avoid discharging them at too early a date. The pressure of the patient's daily solicitation for discharge, his complaints of being quite well and kept in the asylum doing nothing for himself; the opinion of his relatives frequently backed up by that of, in their minds, a very wise neighbour, after an interview with the patient of about 20 minutes; all these, joined to the medical man's wish for as many recoveries as possible, and, perhaps, for room for an acute case, have their effect.

The tendency at present is, I think, undoubtedly rather to discharge patients who might be better kept in the asylum, than to detain persons who ought to be outside.

The question of testing the patient's mental state, by allowing him freedom in the asylum grounds or outside of them on parole, and discharge on probation, are subjects on which I should like to hear the experience of others. As regards granting parole outside the grounds, the system does not act well at Garlands; the class of patients that have to be dealt with are too deficient in a sense of honour, and it appears to me that suitable steady work seems more beneficial than relaxations that are insufficiently appreciated. To those patients who have shown a tendency to self-injury, I think it is well to be guarded in granting parole, because, if an error in judgment occurred, and an unlooked-for self-injury took place, the result would be worse if it happened while the patient was an inmate of the asylum than if it occurred at his own home.

Discharge on probation seems to act very well in many ways. It facilitates the immediate return of the patient if unfit for life at home. It assists the patient to exercise all his self-control, to be aware that for a given time he is only on probation, and in certain cases it assists the relatives in dealing with self-willed convalescent patients.

The chief drawback about discharge on probation is that

it adds greatly to the anxiety of the asylum physician, who gets his fair share of that commodity.

To have to keep on the asylum books, and enter as would be done with a patient in the asylum, any accident that may befall a person who has been nearly a month a hundred miles from the asylum, is, I think, almost more than should be required.

A Visit to a Turkish Lunatic Asylum. — By JOHN H. DAVIDSON, M.D. Edin., Medical Superintendent of the Cheshire Asylum.

In the course of a tour, last autumn, through Greece, Turkey, and Asia Minor, I had the pleasure of making the acquaintance of the Physician-in-chief of the Asylum of Constantinople and neighbouring provinces, and through his courtesy and kind attention I was not only enabled to visit the *Timar-khané*, or *Dari-chifa*, as it is sometimes called, but also to obtain some interesting information respecting the care and treatment of the insane by the Turks more than three centuries ago. Up to a recent date, the insane were taken care of in the Asylum of Suleimanié, situated near the mosque of that name, but in consequence of the building being unable to meet the demands made upon it, the patients were removed to the Asiatic side of the Bosphorus, and lodged in the Asylum of Toptaschi in Scutari. The asylum, which is situated in the most Oriental and most beautiful suburb of Constantinople, on being approached, presents a rather dilapidated and neglected-looking appearance, and this aspect has been all the more heightened by the recent ravages of fire in the immediate vicinity; but the situation is most salubrious, as it catches the pleasant breezes from the Bosphorus and the sea of Marmora. The building is quadrangular, consisting of two storeys and surrounding a court, in the centre of which there is placed a fountain at which the patients perform their frequent daily ablutions before prostrating themselves in prayer at the calls of the muezzims from the minarets of the neighbouring mosques. The day and single rooms on the ground floor open into an arcade or colonnade which surrounds the entire building. The upper floor is used for dormitories which open into a corridor. In these the better class of patients sleep, and the more tur-