Those affecting temporal gyres, anterior mesial surface, and quadrate, are, however, well marked in a few cases of "B."

But, on the contrary, deviations at least as much, perhaps slightly more in "B" than in "A" as regards some points concerning parieto-occipital fissure; postcentral furrows; temporal furrows.

(*To be concluded.*)

Age in Relation to the Treatment of Melancholia. Therapeutical Notes. By J. R. GASQUET and JOHN A. CONES, Medical Officers of St. George's Retreat, Burgess Hill, Sussex.

On looking through some of the numerous observations on the treatment of melancholia by drugs, the most striking point is the diversity of opinion as to their use. This disagreement comes out perhaps most strongly in the case of opium, no doubt because it has been the medicine most widely tried. One leaves the study of the subject with the uncomfortable feeling that the whole drug treatment of melancholia is still quite empirical; for eminent observers press that opium should always be tried in every melancholic, while other no less eminent physicians are equally strong in condemning its use in every case. Our own excuse for adding to the over abundant literature on this subject is that we desire to point out some indication in the use of the two drugs, opium and sulphonal, to which we are convinced that more weight than is generally thought should be given. We have been repeatedly struck by the marvellous effects of opium in some cases of melancholia; and have as often been equally surprised at its utter failure in other cases closely resembling those in which we have been so successful. In hopes of finding some sufficient reason for such apparently contradictory results we have carefully examined the case books of this house for recent years, and have tabulated a sufficient number to warrant, we think, an examination of our conclusions by those who have wider opportunities. To these we have added a few non-asylum cases which we have been able to follow ourselves; which would go towards proving that these two drugs have an action independent of any advantage in any general

TABLE A.—MALES.

Name.	Age.	Treatment.	Duration of Treatment.	Remarks.
Ma.	60	Opium.	3 months.	Slight and irregular improvement, but no permanent change.
Ha. *Private.*	60	Opium.	3 months.	Marked improvement from first; good *recovery.*
Ola. *Private.*	61	Opium.	1 month.	Very striking improvement from first; perfect *recovery.*
Wh.	59	Opium.	1 month.	No improvement.
Re.	57	Opium.	6 months at intervals.	No improvement.
Br.	57	1st Sulphonal.	2 weeks.	No improvement.
,,	,,	2nd Opium.	1 month.	Marked improvement from first; complete *recovery.*
Ch. *Private.*	50	Opium.	1 month.	Improvement from the beginning; good *recovery.*
Wo. *Private.*	52	Opium.	2 months.	Steady improvement from the first; perfect *recovery.*
Gl.	49	Morphia.	3 months with some intervals.	Noticed usually to be better under the drug than without it; *recovery.*
Ca.	49	Opium.	3 months.	Slight and irregular changes for better; *improved.*
Gl.	45	Opium.	2 months.	The patient was made rather more restless.
Jo. *Private.*	40	Morphia.	1 month.	Improvement from the first; perfect *recovery.*
McK.	39	Opium.	2 weeks.	Patient decidedly more restless and melancholic.
Ry.	38	1st Opium.	1 month.	Some slight improvement.
,,	,,	2nd Morphia 12 months later.	6 months.	Steady improvement; good *recovery.*
Li.	38	Opium.	1 month at intervals.	No improvement.
Ba.	31	Opium.	7 weeks.	No improvement.
Ro.	28	Opium.	6 months.	No improvement; at times the patient was worse.
Ke.	27	Opium.	2 months.	Gradual improvement; *relieved.*
Jo.	18	Sulphonal.	5 weeks.	Improvement from first; good *recovery.*

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TABLE B.—FEMALES.

Name.	Age.	Treatment.	Duration of Treatment.	Remarks.
Cl.	69	Sulphonal.	6 weeks.	No improvement.
Ga.	69	Opium.	3 weeks.	Marked improvement during treatment; patient removed by friends as *recovered*, but soon relapsed.
Du.	68	Sulphonal.	1 year at intervals.	No improvement.
Br.	63	Opium.	7 months, at irregular intervals.	Improvement noted while taking opium, but progress to *recovery* was slow and irregular.
Ho.	61	Opium.	18 months at irregular intervals.	Some improvement noted when opium given; *recovered*.
Ppt.	58	Morphia.	1 month.	Slight improvement. Morphia was discontinued on account of obstinate constipation. *Relieved*.
Pa.	55	Opium.	2 years.	No improvement.
Tw.	54	Sulphonal.	3 months.	Improvement from the first; good *recovery*.
Fa.	52	Opium.	1 year.	Slight improvement.
Pa.	51	1st Sulphonal.	10 weeks.	No improvement.
,,	,,	2nd Opium.	1 month.	Marked improvement from first; good *recovery*.
Ma.	48	Opium.	5 months.	Improvement slight for some time; finally *recovery*.
De.	48	Opium.	9 months.	Slight improvement, but no progress.
Ch.	45	Sulphonal.	1 year.	Very slow improvement; *recovery*.
Ma.	44	Morphia.	3 months.	Improvement from first; removal by friends as *improved*.
McC.	37	Sulphonal.	13 months.	Slight, slow improvement to final *recovery*.
McCl.	32	Opium.	1 week.	The patient seemed to be more restless while taking opium.
Mo.	31	Sulphonal.	1 month.	Marked improvement from the first; *recovery*.
Ke.	27	Sulphonal.	5 months.	Improvement from the first.
McA.	26	Opium and Morphia.	11 weeks.	Seemed to make the patient more excited. She improved and went on to recovery when opium stopped.
Gl.	24	Opium.	2 days.	The patient seemed decidedly more excitedly melancholic and so it was discontinued.
Gle.	23	Opium.	6 months.	There was no improvement; at times the patient was worse during treatment.

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asylum here. We do not propose to go fully into each case, as this would be unnecessary waste of space, and our remarks can be readily followed by a glance at the tables. No attempt has been made to classify, to arrange, or to select the cases beyond choosing only those in which opium or sulphonal has been given. One selection indeed we could not avoid. The material on which we have had to work being almost exclusively drawn from the upper and middle classes, it was inevitable that our patients should be drawn from the same classes; but this will probably not invalidate our conclusions.

In considering the usefulness of any particular line of treatment in melancholia, due weight, of course, must be given to the tendency of this disease to recovery in the great majority of cases. But if the administration of any medicine can be shown to be followed in any number of cases by almost immediate or very rapid improvement, it would hardly be thought that this fallacy vitiates to any great extent our conclusions. We have found it hopeless to set down in figures the total duration of the disease, as the statements of relatives are usually so beautifully vague that figures based mainly upon them would be too untrustworthy. We have therefore contented ourselves with stating the duration of treatment. It must be understood, moreover, that treatment was on an average continued for two or three weeks after complete recovery, as a precaution. We will only add that we began the enquiry with perfectly open minds, and with no anticipation of what was to come of it. We may add that the character of the delusion, restlessness or the reverse, suicidal tendencies, refusal of food, constipation, etc., do not seem to afford any indication for or against the use of these two drugs. Taking then the indication suggested by the age of the patient for or against the use of opium, we have come to the conclusion that patients of fifty years of age and over react most strikingly to its employment, and rapidly improve under its use. On the other hand patients of about thirty years of age and under are made notably worse by it. Those between the ages of fifty and thirty react uncertainly to opium; and where such cases do improve the progress towards recovery is much slower than in older patients. It does not appear that the form in which opium is given is of much importance; our preference is for the usual B. P. tincture. The

dose should always be rapidly pushed to the limits of tolerance; and also continued sufficiently long to give it a fair trial.

In looking for a substitute for opium in cases of melancholia in the first half of life, no drug has given us such good results as sulphonal. Given in average doses of thirty grains each night it speedily acts not only by inducing sound and refreshing sleep, but also by what might be called its after effects. It makes a patient rather heavy during the day following its administration. This is an advantage; there seems less mental suffering, and suicidal tendencies and obstinate refusal of food are often relieved. This after-effect of sulphonal must be reached by increasing the dose with caution if necessary, and maintaining it for a few days in the full amount, then gradually reducing it, and only increasing again if there is any threatening of a relapse. It has hitherto been our rule to diminish the frequency of administration, but not the amount of the drug, when the patient seems to be drowsy during the greater part of each day, or when giddiness is complained of, the drug being finally dropped after gradually increasing the intervals between its employment. We have not found it necessary to give a larger quantity than thirty grains; we always begin with this dose, and never give it more frequently than every night. We trust that others whose opportunities are much wider than ours may be induced to consider the point and so either confirm or overthrow the conclusions at which we have arrived; we are only too well aware that these are based upon too small a number of instances for finally deciding the point.

Unfortunately we are unable to supply sufficient details of the body weights of these patients, to include them in the tables. But we are quite satisfied that those patients—the elderly ones—whose mental condition is benefited by opium are also greatly improved in complexion and general well-being. On the other hand those whom opium does not benefit sleep badly under it, and we believe lose flesh.