Refusal of Food in the Insane, with a method of Artificial Feeding not generally known.

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THERE are several causes which may induce refusal of food, and these have to be carefully considered before attempting to forcibly feed an insane patient.

Anorexia is one of the earliest and most common symptoms of general bodily disease. It is always present in anæmic conditions and severe affections of the stomach. It may arise from nausea, the food not being properly digested, fœtid eructations are produced, and so the patient loathes the idea of food.

The insane are generally in a very low state of vitality, and are frequently suffering from various forms of dyspepsia when brought to the asylum. The insanity may be due to a process of autosepsis caused by want of proper assimilation of food; I fancy I have seen several such cases.

Refusal of food may arise from general apathy or indifference as to what is required for the proper sustenance of the body. It may also be due to illusions in some instances arising from disturbance of the digestive organs, or may be the result of delusions. The most trying cases are those who persistently refuse food with a determined suicidal purpose.

In febrile states over-feeding will do harm, and where there is ulceration or malignant disease of the stomach or intestines it may even cause death.

Going without food for a time may in some cases be actually beneficial. Disease of the liver, so frequently met with in insanity, is best treated by giving as little food as possible, so as to afford rest to this organ.

The value of active purgation in insanity is almost universally recognised; abstinence from food for a few days has practically the same effect and often proves as beneficial.

In fact the danger of voluntary abstension from food has been much exaggerated. Dr. F. Siemens, in an article written in 1888, holds "that the dangers from forcible feeding, are, on the whole, greater than those which follow prolonged abstinence.

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Besides the risk of injury in pushing a tube into the stomach, he thinks that there is danger in forcibly introducing quantities of food without considering the patient's diminished powers of digestion and assimilation." He surrounds his patients with all kinds of delicacies till they are tempted to eat secretly or openly, and affirms that the majority of them will never abstain so long as to put their lives in danger. Prof. L. Meyer has acted on similar principles for many years.

If these patients remain perfectly at rest,—and rest in bed is in many cases the soundest form of treatment in refusal of food, as Dr. Rayner has pointed out—Dr. Siemens says that they can do without food or water for fourteen days, and without food but with water for forty days, as has been proved by the exhibitions of fasting men. There are, however, few physicians who would carry out this heroic practice, for, if death occurred, it might be difficult to convince the coroner's jury that the death was not due to want of nourishment.

Much may be done by firmness; some attendants have the happy persuasive power of getting the most refractory patient to eat. A male patient may sometimes take food from a female nurse though persistently refusing to do so from a male attendant, or *vice versâ*. If the delusion of poisoning is prominent, it may be advisable for the attendant to partake of the food offered.

When a patient obstinately refuses food for two days, and there does not appear to be any organic or other disease to account for this refusal, and especially when it is evidently due to a determined purpose, then it becomes an absolutely necessity to compel him to take it.

There are various methods adopted for artificially feeding patients, and these may be briefly considered before explaining the plan adopted at Haywards Heath Asylum. (1) By the stomach pump. (2) By a funnel and œsophageal tube. (3) By a tube passed through the nares. (4) By administration of nutrient enemata. (5) By intra-venous injections of salt or nutritive fluids. (6) By spoon or cup feeding.

The use of the *stomach-pump* has been frequently discussed at various meetings of the Association, and many members have spoken highly of its value, having used it several hundred times with success. But it is a crude proceeding, as a rule very unpleasant to the patient and to those who are charged with

the responsibility of the case. There is always a certain amount of risk attending its use, and I have noticed, as have others, that patients thus fed are liable to gangrene of the lungs. In order to pass the stomach pump or œsophageal tube with comparative safety in a violent patient, four or even six nurses are required. In thus feeding a patient, therefore, there is a great drain on the resources of the asylum. More deaths than have been recorded have occurred from the use of the stomach pump.

The *œsophageal tube and funnel* have some advantages over the stomach pump. For instance, the fluid runs down the tube by gravitation and is not injected by force. Dr. Yellowlees' bottle is a further improvement on the funnel, but I consider that it is not an advisable apparatus for forced alimentation, for the reasons above stated.

As regards *nasal feeding*, it seems to me, after some experience, to be a most unpleasant operation, and not uniformly successful. Various ingenious devices have been designed to overcome the difficulties and objections to its use. In 1877 Dr. Anderson exhibited a pipette he had designed, and in 1888 Professor Cera, in a work on artificial feeding, described his elaborate apparatus; but it is very doubtful if either of these is now in use. Dr. Jules Morel in a letter to the JOURNAL, January, 1896, describes a method he adopts of pouring food "down either nostril, little by little, by means of a small spoon. Patients," he adds, "do not like this method of feeding," which no doubt is only too true. In spite of what Dr. Drapes said at a meeting in 1895, that "he would much prefer to have a nasal tube used on himself," I think it is very painful and undesirable to administer food by the nose, especially so when the patient is very resistive.

The administration of *nutritive enemata* is, of course, the usual routine practice in cases where patients who are not insane cannot take food, and it has been repeatedly advised in lunacy practice, especially by Dr. Needham (1879). Dr. Newington suggested in 1877 plugging the anus after giving the enema, previously washing out the bowels with soap and water. Probably in many cases enemata are the most satisfactory methods of saving life when food cannot be taken, especially if there is severe gastric disturbance.

Dr. Ritti in 1877 suggested putting a bolus of food in the mouth and causing deglutition by stimulating the muscles of

the gullet by means of *electricity*. But this requires a considerable amount of skill and the employment of elaborate apparatus. The patients, too, get accustomed to it in time, and then resist the effects of the stimulation.

In the German retrospect for 1893 there is an account of a new treatment of patients refusing food by Dr. G. Ilberg, of Heidelberg, who advises the subcutaneous *injection* of common salt in water.

Dr. Lilienfeld (*Zeitsch. f. Diat. u. Physikal-Therapie*, 1899) thinks that there is a possibility of sustaining life in desperate cases by injecting solutions of grape sugar or albuminoids into the veins. Probably the injection of warm milk into the peritoneal cavity, as is done in some cases of inanition from hæmorrhage, might be more successful than the adoption of such a dangerous procedure.

Feeding by a *spoon or cup* has the disadvantage of the force used in opening the mouth frequently causing fracture of the teeth, and that the patient if obstinate will retain the food for a time and then spit it out.

The method that has been in use, to the absolute exclusion of œsophageal tubes and other mechanical appliances, in the Haywards Heath Asylum for over thirty years, that is, so long as I have been connected with it directly and indirectly, is so simple and easy that any one can employ it. It is also perfectly successful, and has never been attended with the slightest unpleasant or untoward consequences. It is rapidly performed and fewer attendants are required; in fact, I have fed most troublesome patients in this way with only one nurse to assist me.

The patient being placed in the recumbent or semi-recumbent position, the person who administers the food steadies his head with his left arm or by holding it between the knees. A sheet is wrapped round the patient's leg, and a nurse kneeling on either side of the patient's legs, holds down the hands by the wrists, avoiding pressure on any part of the patient's body or limbs. Then the forefinger of the left hand is introduced into the cheek, which is stretched to its fullest extent. This prevents the orbicularis oris and the buccinator from acting, and thus the patient is quite unable to spit the food out of the mouth. Liquid nourishment in quantities of about two tablespoonfuls at a time is poured into the pouch thus formed by the distended

cheek, and trickles gradually down the throat. There is no need to open the teeth, for if some of the teeth are not absent, which is generally the case, there is plenty of room behind the last molar, or even between the teeth, for the liquid to reach the pharynx.

If, however, the patient obstinately refuses to swallow the food, a gentle pinch of the nose, so as to obstruct nasal breathing and compel him to breathe through the mouth, will overcome this, as he is bound to swallow in order to breathe. After feeding in this way for a time, the patient finding he is perfectly helpless in the matter, soon gets tired of resisting and takes food voluntarily.

I have not only frequently used this method on the insane in general practice, but have also employed it on young children with the most satisfactory results; and I feel sure that if it were generally known and had a fair trial, the œsophageal tube would be little heard of in the future.

Insanity and Marriage. By G. E. MOULD, M.R.C.S., L.R.C.P.Lond.

IN giving advice concerning the marriage of a person who has had an attack of insanity or who belongs to a family with a hereditary predisposition to insanity, on what considerations should our opinions be based? Firstly, on the welfare of the individuals who are about to marry and of their families present and prospective. Secondly, on the welfare of society. Our advice might have far-reaching consequences if we were only agreed on common principles.

We must bear in mind the well-being of posterity in general, for although the first is the most important and personally responsible set of considerations in regard to which we can estimate the probabilities with some degree of certainty, we must not feel satisfied unless we can reconcile the immediate future with the remote. In developing a somewhat optimistic opinion favouring the permission of marriage to persons with insane histories I hope to give some facts in favour of that opinion, not