her in her tea at breakfast time. A 15 m. dose of the solution in about an hour-and-a-half renders her quiet and manageable; she speaks when spoken to, and walks about the ward without tearing and destroying articles as she formerly did. The duration of the attack of maniacal excitement is not at all prolonged by the administration, for after a certain period (generally about a fortnight) she gradually settles down and remains quiet, until after a little excitement, or without any known cause, she becomes noisy and destructive again. The hyoscyamine is then again resorted to, and a daily dose of 15 m. has the desired effect. In this case also no toleration appears to be established by its continued use, for a 15 m. dose administered daily never fails in its effect. It has never produced any unpleasant symptoms—no nausea or vomiting; she does not lose flesh, and never refuses a meal. The pupils, as in the other cases in which its action has been tried, are widely dilated, and the patient is able to discern near objects. Of all the drugs tried, hyoscyamine is certainly the most satisfactory, for to render her at all peaceful by the administration of other sedatives, such as chloral, bromide, opium, and its preparations, &c., large quantities had to be given and repeated during the day; her digestion then became impaired, and there was a disinclination for food. This state of things has not yet manifested itself while she has been taking hyoscyamine, and her health does not seem in any way to be affected.

Case of Acute Dementia of rapidly Fatal Termination. By Bonville B. Fox, M.B., Resident Medical Officer, Brislington House.*

Cases of recent insanity having a speedy fatal termination in young and fairly healthy subjects are fortunately sufficiently uncommon to claim some attention when they do occur, and more particularly so when the co-existing mental symptoms would place the case in a series in which, as a rule, life is but little endangered. This is my reason for venturing to bring before this society to-night notes of a case of what appeared to be acute dementia in a young woman, ending in death in about six weeks from the commencement of the malady; and if I go somewhat minutely into details, I must plead as my excuse my desire to make it plain, that this case, which presented in the first instance, some anomalous symptoms, could not, upon the whole, have been correctly assigned to any other class.

* Read before the Quarterly Meeting of the Medico-Psychological Association, March 9th, 1881.

A. M. A., a governess, aged 18, unmarried, was admitted into Brislington House on August 4th, 1880.

Her previous history was fair. She was a good, hard-working girl, who had given no anxiety to her mother, with whom she was on very good terms. She had grown fast, and recently had not been strong, but had suffered from no severe physical disorder save an attack of what was termed "Pleurodynia" three years ago, since which she has always been rather weakly. It should be stated, however, that she has felt "pains in the spine" for some years, much worse at the monthly periods. For these Dr. Ringer, three years ago, prescribed blisters and zinc, and she was much benefited. She has had no previous attack of insanity, and has shown no nervous tendency, though she has always been inclined to be solitary, and to form strong attachments and antipathies.

The family history is poor. Her paternal great grandfather and three paternal great uncles were insane. Two of the latter cut their throats. Her father is very "excitable," and a paternal aunt is described as being very "queer" and a great spiritualist. There is phthisis in her mother's family, but not affecting any near relatives.

The cause of her insanity is a little uncertain. With her mother she had for some time past been fighting a hard battle against adversity, and recently it had seemed as if brighter days were in store for them, as the mother had high expectations of gaining a position in which they could have lived together in comfort. Their hopes had quite recently been entirely frustrated, and while the mother bore up bravely, the daughter, overgrown, weakly, and hereditarily tainted, drooped, and never seemed the same person.

For the history of her disease prior to admission I depend on her mother's account. The first symptoms appeared about the middle of July, when she paid an unusually protracted call on a stranger. She gradually showed great self-will and hostility to her relatives, and became more or less unmanageable. She expressed a special dislike to her mother, to whom she had always been very affectionate. She wished to sell her clothes, and had distinct delusions—at first that men had violated her and that she was a widow, and subsequently of a distinctly exalted nature—viz., that her mother was lady-in-waiting to the Queen at Windsor, and that owing to an exchange of infants at birth she (the patient) was really Princess Beatrice. It may be worth while to notice two points in passing—(1) that menstruation which should have occurred a fortnight before the commencement of her insanity, was delayed for three weeks, and appeared at the same time as the ideas of her violated virginity, so that these may have had a physical basis in the disturbance of her generative organs; (2) the exalted ideas in one who had been for long struggling with poverty, and doubtless building castles in the air, which, her judgment once unhinged, thus lost their shadowy appearance, and assumed real tangible forms. Her mother went on to state that she was

feverish, and her nose and mouth seemed to swell. In four days her mind appeared to be quite gone. Her sleep was poor. She refused all solid food, but took milk. She became weaker and thinner. She had no cough.

On admission she answered to the following description :—

She is a tallish, overgrown, and strumous-looking girl, fairly well nourished. She cannot walk, but totters along between two attendants. She can do nothing for herself, is absolutely unemployed, and lost to what is passing around her. She sits all day in an arm chair, with a peculiarly silly and vacant expression on her countenance, her very large mouth wide open, and between her coarse lips saliva either dribbles away or accumulates and dries. Her face is of a greyish and most unhealthy hue; the skin is coarse and greasy; her eyes, half concealed by the drooping lids, lack lustre. Her head, large, round, and flattened, lolls from side to side as if too heavy to hold erect. Here, indeed, the muscular power was "the pulse of the mental affection." The glance is wandering; the pupils are dilated, but equal and active. Her imbecile restlessness made attempts at ophthalmoscopic examination fruitless. No strabismus; no heat of head or of general bodily surface. Partly does not hear, partly does not understand what is said to her, and answers either not at all or in a very slow and unintelligible manner. There is considerable failure of articulation, and beyond a statement that she is the Princess Beatrice, and an occasional monosyllable, nothing can be made out of what she says, though she is constantly jabbering into space or to any one near her. She looks at one in a half imbecile, half loving way, and is fond of taking one's hand and gazing into one's face. She is quite inattentive to the calls of nature, and it is hard work to get her to take any food. There may be a real difficulty in swallowing from her enlarged tonsils, and her lips are swollen, as we sometimes see in strumous persons. Her tongue is tremulous, red, dry, and fissured. The bowels are constipated. Pulse 120, very feeble; urine healthy. A careful physical examination was made, especially of the heart and lungs, but no disease was discovered here or elsewhere. There is certainly no spinal curvature, and no tender spot either in the back or cranium. No complaint of headache. Her back is covered with acne.

Her mental condition seems to be acute dementia, with alarming asthenia.

August 10.—Six days subsequent to admission weaker in body and mind. She can't support herself for a moment on her legs. Pulse 140, very small and compressible. Coaxing has induced her to take some food. This has been supplemented by the stomach pump. Rarely tries to speak; never articulates. She is so lost that the stimulus of food in her mouth fails to excite deglutition. Lies passively in bed, apparently often asleep.

August 11.—Worse. Countenance more ashen; eyelids more

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drooping, and muscular relaxation and other signs of debility more pronounced. She is kept in bed, and as warm as possible, but despite all efforts her extremities are cold, and large bullæ have appeared on each heel. Her evacuations are all passed under her. She is immediately changed, and every care taken to keep her dry and clean. Fed with stomach pump thrice daily—once with fresh milk and twice with the strongest essence of beef and vegetables. Each injection also contains dissolved Brand's essence of beef, Sp. Vin. Gall., ℥ j. Tr. Digitalis, ♏ x.; Sp. Ammon. Aromat., ʒ j.

From August 12 *to* 18 the same system of treatment was pursued, and she appeared to respond slightly to it, to just hold her ground, and to become, perhaps, a little more animated. The pulse, however, did not improve, and bullæ developed on the anterior surface of both legs, on the anterior and inner surface of both thighs, and on the back. The catamenia appeared, and lasted four days without seeming to affect her state appreciably. From time to time she took a little milk and jelly voluntarily.

August 19.—Took enough food; no stomach pump necessary.

August 20.—Refused all food. Alarming prostration, in the face of which the pump was resumed. To-day a threatening abrasion, of the size of a five-shilling piece, appeared over the sacrum, with a tendency to spread to the left. Dressed with hardening lotion. Water pillow ordered, and quinine added to injection.

August 21.—Bedsore has increased in depth and extent. Patient appears weaker despite the quantities of nourishment poured into her. This consists daily of 1½ pint of fresh milk, 2½ pints of essence of beef and vegetables, three tins of Brand's essence of beef, brandy five ounces, and bark. The pulse has not been controlled by the digitalis, and is now 140, and very weak.

August 23.—No improvement. The bedsore is extending nearly to the left trochanter, and is of formidable dimensions. The right side is sound. There is no other unilateral symptom. The bullæ were equally distributed, and motion and sensation, such as they are—and both are diminished—are equal on the two sides. She was evidently sinking, and her friends, having a strong aversion to her death taking place in an asylum, removed her to day, on a water bed, to a neighbouring village. We were subsequently informed that she bore the journey of a mile and a half fairly well, but almost exactly 24 hours after her removal her breathing became hurried, and she quickly expired. As she was under the care of a medical man, no doubt all her necessities, including feeding, had been attended to. Under the circumstances we were unable to procure a post mortem examination.

I have already occupied so much time, that what few remarks I have to offer shall be as brief as possible. The first difficulty that met me was one of classification. Whilst under my observation, this case never presented any symptom which

would have entitled it to be called anything but pure dementia. I am aware that Griesinger states that nearly all cases of acute dementia are really cases of *melancholia cum stupore*, and in my short experience I have seen more than one instance of this disorder in which most rapid and alarming asthenia occurred, only stopping short of death. But there was never a sign of melancholy in our patient. Stupor to a considerable extent there was, but no sadness, fear, or terror in her expression or utterances, or any of the intense self-absorption and concentration in one overwhelming idea of woe that we see in the motionless gaze and attitude of the melancholic.* On the contrary, silliness and fatuity, a more or less "psychical void," with blunted perceptions, were plainly manifested, a condition, as I believe, of true dementia. Whether or not this state was really primary, or was secondary to brief mania, I cannot say. But I should think the former was the case. Dementia it certainly was when she came under our care, not one month from the commencement of her insanity, and it is rare, I should presume, for mania (especially of a sub-acute form as hers must have been if it ever existed) to merge into dementia in so short a time. And if it be allowed that the nomenclature is correct, is not the course of the case a very unusual one, and the co-existing physical symptoms extremely uncommon? From the point of view of mental recovery we do not look unhopefully on acute dementia, and for the life of our patient we have few or no fears. Gangrene is a danger hardly thought of, and is rarely seen save in association with the chronic dementia of general paralysis, or during or after an attack of very acute mania, or—and then generally as affecting the lungs—in melancholics who refuse their food. Feebleness of circulation and cold extremities were to be expected and were found, but they are to be placed in a totally different category to bullæ and bedsores, the evidences of great nervous degradation. What was the cause of the extreme rapidity of pulse? Why, in the absence of all visceral disease, should innutrition have advanced so speedily? On admission the patient was very weak, but by no means very emaciated, and after her arrival ample nourishment was administered—and every care was taken that warmth and attentive nursing could insure, and yet she steadily sank.

I much deplore the absence of a *post mortem*, and the morbid changes that were associated with the rapid decay must

* It should be also stated that there was no appearance of the trance-like, fixed, cataleptoid condition to be found in some cases of melancholia.

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be more or less matters of conjecture. As Dr. Bristowe has stated bullæ frequently develope in pachymeningitis of the cord or in vertebral caries, but no symptom of any such definite condition could be observed. Beyond a general muscular feebleness, which was doubtless increased by a want of "power to will" any movement, no absolute paralysis was recognised. There was no spinal tenderness. Sensation to touch and pain was but slightly blunted. There was no marked muscular atrophy. At no time was there any complaint of headache, any rigors, vomiting, squinting, convulsions or spasms. It may be pointed out that the bullæ formed on parts quite free from pressure, and it seems not a little remarkable in the absence of all hemiplegic symptoms that the bedsore should have extended so exclusively to one side of the back. That the posterior cornua and the central regions of grey matter behind the central canal of the cord, believed by Dr. Bristowe to be the trophic centres for the skin, would have shown some lesion, seems probable, but the whole pathology of the case is far from clear to me, and it is indeed with a view of having my difficulties explained that I have brought it before the notice of this society, and I trust that the narration of its symptoms and of my perplexities has not run to a very tedious length.

Note on Hallucinations in General Paralysis in reference to Cerebral Localization. By W. Julius Mickle, M.D.

The space available in this number of the Journal being insufficient for a paper I have prepared on hallucinations, and its publication being therefore deferred until the October number, it may be stated here that among the conclusions contained therein, are some to the effect that the views, at present accepted by many as to the exact localization of the cortical sensory centres of the cerebrum, are not supported by the morbid anatomy of general paralysis in the marked manner one would anticipate, supposing the localization in question to be so precise and exclusive as has been freely asserted.
