Mitchell Clarke, Lieut.-Col. J., R.A.M.C.—"Some Neuroses of the War," *Bristol Med. Chi. Journ.*, July, 1916.

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(1) Paper read at Spring Meeting of the Medico-Psychological Association (Northern and Midland Division) at the County Asylum, Rainhill, April 18th, 1918.—(2) The Commissioners in Lunacy's Report for the year 1913, Table XIX shows that of the total male admissions into all institutions for lunatics during the five years 1907–11, general paralysis accounts for 12 *per cent.*—(3) Flemming's method was used as a control to the findings obtained by the original Wassermann method, modified by the use of human blood instead of that of the sheep and guinea-pig.—(4) Further observations on cases associated with "shell shock" have been recorded in another article, see *B. M. J.*, April 13th, 1918.—(5) Of this number only 101 patients had been resident twelve months.—(6) See letter to the *Lancet* of November 24th, 1917, by Sir Robert Armstrong Jones, Major, R.A.M.C.

Clinical Notes and Cases.

Clinical Observations on the Various States of Excitement in Insanity.(1) By R. M. Toledo, M.D., Assistant Physician, Government Lunatic Asylum, Malta.

Mr. President and Gentlemen,—Of the many hundreds of insane, remitted annually to mental hospitals, the majority are admitted in an "excited state." They all exhibit in common several of the characteristic signs of what is known as "mania," yet very few of them are really "maniacals."

My object this afternoon is to point out to you certain signs and symptoms which may help to decide, as early as possible, of the true nature of insanity from which a patient, brought to us in an excited condition, is suffering from. It is evident how this is important for the proper treatment of the patient himself and for the protection of others.

Very often a patient is received exhibiting restlessness, resistiveness, and incoherence of speech. He may answer to your questions rationally or perhaps not. He generally succeeds to give you his name correctly and those of his parents or children.

Another patient, "excited" as the first one, fails altogether to answer you; he is unable to tell you his name or from where he comes. He does not even take any notice of you and of his surroundings, he utters

incoherent words, and seems to see "objects." The first case is probably one of real mania, the second one of confusional insanity, or amentia, as it is often called.

The maniac very seldom loses all his power of attention, and, although he distracts himself easily from rapid fatigue, yet the doctors succeed in getting from him one or two sensible answers.

On the contrary, nothing can distract the ament from his "dreamy state," he is totally dissociated from the world, and he even fails to feel the stimuli of his "vegetative" life. He does not care to nourish himself, he wets his bed, and his habits are dirty.

The maniac is rarely of wet habits, asks for food continually, and everything attracts his attention. He makes remarks about your clothes, about the features of the attendants, about the books, lamps, and clocks he may have noticed in your office. He recognises familiar faces.

One of the most characteristic signs of "amentia" when the patient is not altogether lost to his surroundings, which happens when he is not at the pitch of the disease, are "mistakes of identity." I remember a seaman who after a fortnight of regular "dream consciousness" commenced to answer simple questions. He believed he was still on board, and mistook me for the master of the ship. He thought he was "sea-sick," and he was surprised of feeling so after "twenty years of seafaring."

The relatives of the maniac may inform you that some time previous to the attack the patient was dull, avoided his friends, and refused to go out; those of the ament, that the symptoms came on suddenly during the convalescence of influenza, measles, or rheumatic fever, or that he had just lost a considerable quantity of blood. I know a case that came on "twice" within three years after a most severe epistaxis. It may be the case of a woman nursing her baby.

While mania is of a toxic nature, amentia is due to an insufficient nutrition of the neurone and its exhaustion.

Our next patient is perhaps between the age of 50 and 60. He reaches the hospital screaming. He very often refuses to leave the cab. Looks frightened and stares at everybody. Has an anguished expression in his look. He is perhaps trembling. He will not sit down, but paces the room continually. If you question this man, he answers coherently, and if by way of introduction you ask him to put his tongue out or to feel his pulse, he very often tells you that he feels a pain in the region of his heart, one of the most distressing subjective sensations accompanying mental anxiety. This patient may think that you are the magistrate or the police inspector and the place he was brought to a prison or a court of justice. You should never, in the presence of such patients, go through their admission papers. They

think you are reading an order to send them to the scaffold or to burn them alive. Some hear distinctly the voices and the shrieks of their far-away children. The noise of an approaching cab, the ringing of bells, the working of an engine, increase their anxiety. Such patients may tell you that they have been falsely accused of the most horrid crimes, and that the neighbours have been gossiping about them for months. They refuse to keep their bed and to take nourishment. If their breath becomes offensive, feed them forcibly at once, as they exhaust themselves very rapidly. Needless to say, all this symptomatology points to "acute melancholia," as, although such sufferers are nearly always "very excited," yet one can see clearly that there is always a decided depression in their emotional attitude.

Now I must speak to you about a very serious disease which at its onset is very often mistaken for simple mania. I refer to dementia præcox, a disease which is unfortuuately very common and almost incurable. It is in what it is called the "predemented stage," that this disease is often taken for mania, or, if "hypochondriasis" prevails, for neurasthenia.

Patients are generally brought to the asylum in a restless condition. They are incoherent in their talks and troubled with auditory hallucinations. Very often the relatives will tell you that the patients have been smashing tumblers and plates at home without any motives and without exhibiting any anger or the least sign of emotion. This is characteristic of the disease, and differs much from the way the maniacal exhibits violent tendencies.

The maniacal fights those around him, especially if he is interfered with in any way, does not give reasons for his acts, at times he ignores them; the præcox finds an old man in a corner and slaps him, and if you ask him why he did it he perhaps tells you that the old man has been sneezing too much, or that he was an enemy of his grandfather. I know of præcox patients whose "silly" behaviour in prison has been mistaken for simple insubordination. As at times, there is very little apparently indicating "insanity," they are often considered as lazy and insubordinates and severely punished.

Both the maniac and the dement may commit rash acts, but while the former is unable to explain them, the latter is quite ready to find a "motive."

The following two cases illustrate how absurd these "motives" can be:

CASE 1.—A lad, while coming from England, jumped into the sea as the steamer was approaching St. Paul's Bay. It was a January evening and bitterly cold.

He was rescued by a fishing-boat not very far from the shore and sent straight to our asylum as "suicidal." I received him about mid-

night, and he laughed heartily on being told that he was sent to the asylum as the doctors thought that he wanted to do away with his life.

He assured me that he jumped into the sea to have a good swim before landing. In fact, he swam for a good distance, about a mile, before being picked up.

CASE 2.—A lad was sent to us as a suicidal. He was wounded in the face, having jumped from a high window. He told me that he did so to pick up a cigar which he had noticed on the pavement.

There was very little at that time to diagnose præcox; few months have sufficed to make of these two lads a complete mental wreck.

If one follows a maniacal and a præcox in the wards, he will soon notice how differently they behave in their excitement. The maniacal passes his time jumping on tables and dancing. The dement spends his hours going round the same chair for hundreds of times, or walking on tip-toe, or kneeling down. It is characteristic how they can keep for whole hours the same attitude, however uncomfortable this may be. They are very fond of corners, putting their faces against the wall.

The maniacal likes to kick, the dement to slap or to bite. Others spit in one's face.

At table the maniacal swallows his diet in a minute, the præcox takes a full hour to do it, some keep the last morsel in their mouth till the next meal.

While the maniac sleeps very often quite naked, the dement likes to muffle himself up with many blankets.

You should be very careful in approaching a præcox while he is in bed. He may strike you, simply to show you that he is not asleep.

One of the most characteristic signs of præcox is resistiveness. Try to bend the arm or the head of your patient or to open his mouth or hand you seldom succeed. You feel them hard as iron.

Laboratory investigations have proved that this muscle over-tension is due to a toxin similar to adrenalin, the effect of a disturbed gland metabolism, and at *post-mortem* examinations, degenerative changes in the supra-renal glands, testicles, and ovaries have been noticed.

Præcox gets generally very, very stout. Loss of weight should induce one to examine the patient for tubercle of the lung, as they are much predisposed to this disease.

I fear that my paper would be considered incomplete if I fail to refer to a mental condition resembling acute mania, which at times appears at the very onset of several infectious diseases. It is known as "acute delirium," and is characterised by extreme restlessness, incoherence of speech, and hallucinations of sight and hearing. It has nothing to do with febrile delirium. The temperature is never high, and is very often below the normal.

The acute delirium does not generally last long, if it lasts the general

condition of the patient gets worse rapidly, and collapse and death follow. The Germans call it "collapse delirium."

I have seen several cases in connection with Mediterranean fever and enteric fever. Three cases ended fatally, including a case of erysipelas of the arm.

The following two cases are of interest:

CASE 1.—A man was found by the police in the street almost naked. He was gesticulating and screaming and in the act of fighting imaginary objects. He was taken to the police-station, where he was very restless and clamorous. The doctors remitted him to our asylum as a case of mania.

On reception the temperature was 100° F. He was not clamorous, but he was muttering incoherent words. He was unable to answer questions. The examination of the chest revealed lobar pneumonia. His wife stated that the patient had returned from work on that day complaining of headache. The next day the delirium disappeared and the temperature rose to 103° F. The patient was quite sensible in his answers, and he was able to give to his wife important instructions. He died the day after from collapse.

CASE 2.—A private of the Royal Militia was sent to us from a military hospital for acute mania. He was received at 8 p.m. in a very restless state. He spoke incoherently, and passed fæces and urine involuntarily. Temperature on admission 99° F. He could not answer any questions. He passed a sleepless and restless night. Early next morning the delirium disappeared, and when I saw him about six o'clock he asked me where he was and how long he had been in. He remembered that on the previous day he vomited twice and that he was removed from Gargur Camp to Valetta Hospital. He did not remember anything else and wished to be left alone. He complained of pains in the back and headache. The case proved to be one of cerebro-spinal fever. The patient was removed to the isolation hospital of Imtarfa, where he made a good recovery, remaining, however, completely deaf.

Want of time does not allow me to point out in detail how often senile dements and alcoholics and sufferers of such neuroses as epilepsy and chorea are admitted to our wards in a state of excitement.

Each of these diseases has its own symptomatology, and there should be no difficulty in arriving at a correct diagnosis if a careful history is taken of the case.

(1) Read at the General Meeting of the Malta Branch of the British Medical Association on January 21st, 1918.