Part III.—Psychological Retrospect.

FRANCE.

By Dr. René Semelaigne.

Treatment of Epilepsy by Sympathectomy.—Dr. Lannois, of Lyons, relates some cases of epilepsy treated by sympathectomy. Only one was cured, a patient seventeen years of age, who had had frequent hysterical attacks and severe epileptic fits, which all disappeared after the operation of sympathectomy and stretching of the pneumogastric. Three patients improved, but they were hystero-epileptic; and Dr. Lannois' opinion is that in such cases the apparent improvement might be due to auto-suggestion or traumatic shock, &c. The condition of the majority of the patients remained stationary; in three the symptoms were aggravated, and one died.

According to Dr. Chipault, of Paris, a bilateral resection of the superior cervical ganglion of the sympathetic is quite harmless, and might prove, from the therapeutical point of view, very advantageous in cases of idiopathic epilepsy. Seventy-one operations have been performed without any subsequent accident. In these cases hygienic, moral, and medical treatment should specially be applied.

Dr. Vincent Laborde, of Paris, in a lecture to the Academy of Medicine, proved that a complete resection of the cervical sympathetic does not produce any appreciable result in cases of experimental epilepsy. Guinea-pigs had been induced to a complete state of epilepsy by a hemisection of the dorso-lumbar axis, and epileptic fits could easily be produced by an excitation of the left cervical area, or else they occurred spontaneously. Surgical intervention did not bring about any change.

Dr. Ricard, at Bicêtre, performed a resection of the superior cervical ganglion of the sympathetic on an epileptic æt. 24, after all medical means had failed. At the moment of resection no pupillary reaction or circulatory signs were observed. The patient recovered, but the operation was not successful, an attack occurring on the following night.

Dr. Maurice de Fleury, of Paris, thinking that epilepsy is often a result of digestive troubles and auto-intoxication, prefers hygienic and medical treatment to surgical—*e. g.* special diet, washing out the stomach, cardiac tonics, and injections of serum. These latter considerably help the bromides, are also diuretics, increase arterial pressure, maintain the integrity of the intellectual power, and improve the temper. In serious cases he advises phlebotomy and transfusion of artificial serum.

Transitory Delirium in Epilepsy.—Dr. Mabille, of La Rochelle, reports four cases of epilepsy with religious hallucinations and delirium; the hallucinations following the epileptic attacks, and more or less persisting. But the patients remain conscious, and are able to give a clear account of their hallucinations of sight and hearing, which seem to be

the source of a transitory mystical delirium, but which generally disappears along with the epileptic attacks.

Post-operatory Psychoses.—Dr. Rayneau, of Orléans, presented to the Congrès des Médecins Aliénistes et Neurologistes, held at Angers last August, a report on the psychical troubles which sometimes follow surgical operations. He believes that hereditary predisposition is the most important factor in such cases.

According to Dr. Régis, of Bordeaux, very few cases of post-operatory delirium last long enough to render asylum treatment necessary; hence an ordinary surgical hospital is the place for such study. He admits two great varieties of post-operatory delirium—1. Delirium in the degenerate. 2. Delirium occasioned exclusively by the surgical operation.

Such psychoses present various forms, but these forms have all a common type, viz. mental confusion. In all the cases observed, the delirium in slight cases begins at night and ceases in the morning; in severer ones it extends into the daytime, but with lucid intervals; while in the worst cases the delirium is continuous, followed by total amnesia. When the delirium appears immediately after an operation, its cause seems to be an intoxication from the anæsthetic; but if it does not appear till between the second and tenth day the cause is due to infection from the wound —a septicæmia or auto-intoxication—while if the delirium be delayed for weeks or months, it might be due to a psychical or physical asthenia, caused by prolonged decubitus, ill-nutrition, dressings, suppression of an organ the functions of which are internal, &c.

Professor Joffroy, of Paris, compares post-operatory troubles to hystero-traumatic palsies, in which are observed motor signs following traumatism, and which only appear amongst the hysterical. The origin seems to be a shock in the nervous system occurring amongst patients partly hysterical and partly degenerated. One explanation is the part played by the pre-occupation of the patient's mind—"rumination intellectuelle." In a case of hystero-traumatic palsy this "rumination intellectuelle" only begins from the accident, whereas in a case of post-operatory delirium it acts adversely from the moment that an operation is contemplated, thus running through the whole period both before and after the operation. Another proof of this is that such troubles are never observed in children, but only in adults, for the former are ignorant of the fact that they are to undergo an operation; and even if they are told, they do not realise its importance or seriousness.

Dr. Joffroy also states that there is a similar connection between the post-operatory psychoses from infection and puerperal insanity, the infectious agent being the same; and though it is more common amongst the latter, this is due to their greater degree of receptivity from the increased nutritive changes occurring during pregnancy. The pathogeny of post-operatory psychoses is most complex, the "rumination intellectuelle" not being the only cause, others probably being infection, septicæmia, auto-intoxication, &c. However, notwithstanding their complexity, these psychoses do not occur without a special predisposition.

Dr. Granjux, of Paris, an army medical officer, has not observed any such psychoses among soldiers—at least during peace—but this immunity is probably due to a special selection of soldiers, which eliminates

predisposition. This argument favours predisposition as the important cause, and also the view that the traumatic shock does not play an important part receives support from the fact that no case occurred amongst the soldiers at the battle of Freschviller, even though those wounded suffered much discomfort for eight days.

Dr. Picqué, surgeon to the Hospital of Paris and Asylums of the Seine, has observed some of these cases; not many, however, for we have to separate those who are true lunatics, but on whom an operation has to be performed; and, on the other hand, those whose delirium came on after the operation. These latter have hereditary predisposition, and their condition is either one of excitement or depression, the first variety being not always easily separated from some hysterical forms; but the second is always recognised as the true type of post-operatory psychoses, and it occurs soon after the operation (some days, weeks, or months), and often disappears without any appreciable reason or under the influence of a proper moral treatment. This variety must be carefully separated from the delirium by intoxication—meaning by this only septicæmic or pharmaceutical intoxication—as this delirium is only a secondary symptom. The state of the different viscera is of greater importance, but in genuine psychoses the delirium constitutes the whole illness. A post-operatory psychosis is cured without any treatment, and only requires admission to an asylum, but an alleged psychosis issuing from intoxication requires surgical treatment.

Transitory States of Delirium.—Dr. Charles Vallon gave a lecture on this subject, and gave as their generic characters an abrupt beginning, with rapid rise and fall, and an equally abrupt ending. They are accompanied by great disturbances of consciousness, loss of memory, excitement, and by abnormal impulses and dangerous reactions. From the pathogenic point of view one may consider—(1) Sudden variations in the pressure and distribution of the blood, following a vascular palsy or cramp (transitory mania) and transitory states of anguish (pathological emotions); (2) sudden and deep disturbances in the nutrition of the psychical organ, occasioned by qualitative changes in the blood, *e. g.* its mixture with various substances, or an overloading from excremental matters, or an insufficiency of some of its normal elements (toxical delirium, delirium of inanition).

Dr. Charpentier, of Paris, thinks that besides the delirium symptomatic of epilepsy, alcoholism, or degeneration, one must admit idiopathic transitory delirium. Every emotion and every passion is able to produce a transitory delirium without hereditary or acquired mental degeneration, traumatism, or appreciable illness.

Dr. Gilbert Ballet does not know a single case of transitory delirium affecting normal people.

Dr. Motet in his whole career never observed a single case of transitory delirium which could not be referred to epilepsy, alcoholism, traumatic, or pathological lesions of the brain.