on one-sided and restricted views, and deal more with the hysterical manifestations than with the particular constitutional condition of the hysterical subject, which is the foundation upon which the symptoms are produced. The peculiar features of the hysterical personality, the reason why the malady appears in some and not in all individuals, the cause of the persistence of determined psychic states, capable of producing the most diverse phenomena, the influence of different causes in the production of hysteria are essential questions which some have not even attempted to answer. From amongst the discord of theories two points emerge with regard to which there is a fairly general agreement: the seat of the malady, and the principal disorder which would give rise to all the morbid phenomena. All the scientific theories embody the fundamental conception that hysteria is a *psychosis*, or rather a cerebrosis of the pallium and the basilar nuclei. Next, the majority of the hypotheses ascribe the cause of the morbid manifestations to particular states of the cortical, transcortical, and subcortical reflectivity. Thus, various authors speak of disturbances in the cortical or subcortical reflexes (Raymond); of paradoxical psychic reactions (Tanzi); short circuit (Jelgersma); of suspension, exaggeration, or perversion of the function of one or more cerebral centres (Tamburini, Tonnini, Ferrari); of dysrhythmia (Organski and Joire); of polygonal activity (Grasset); dissociation of the personality (Janet); hyperactivity (Crocq), etc., all of which disorders must have their seat in the grey matter of the cerebrum. The hysterical personality would be associated with this disorder and manifest itself by an altered reactivity, *i.e.*, the transformation of an image into an idea or a movement, in either a rapid and repeated, or a slow manner, a suggestibility differing from other forms of suggestibility in its tendency towards a ready translation into action, and a mentality generally infantile. The hysterical personality is a degenerate one, a *minus valor* from both a biological and a social point of view, inasmuch as it loses and does not acquire dominion over certain psychic reflexes, especially those of an inhibitory nature. To arrive at a definition of hysteria it would be necessary to separate all hysterical states which are symptomatic of other morbid forms from the group of cases, perhaps not at all numerous, in which we find the full development of those symptoms which we call hysterical, the *grande hysterie* of Charcot. Perhaps it is only to the latter that the name of hysteria will in the future remain, while all the other states will be regarded as syndromes. J. H. MacDonald.

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2. Clinical Psychiatry.

Hallucinations of Hearing in Diseases of the Ear [*Gehörstäuschungen bei Ohrenkrankungen*]. (*Allgem. Zeitschr. f. Psych.*, *vol. xcvi*, *No.* 3.) *Kleineberger, O.*

Three examples of cases of marked hallucinations of hearing are given, in each of which there was found a condition of double chronic middle-ear catarrh. In the first case there is no mention of treatment. In the other two the hallucinations were diminished by treatment of the ear disease.

It is pointed out that the peripheral condition alone does not produce

hallucinations of hearing. It is invariably accompanied by commencing arterio-sclerosis of the brain, other brain disease, or it is found in persons of a psychopathic disposition. HAMILTON MARR.

An Attack of Pain originating in the Central Nervous System, and accompanied by High Fever, in a Case of Progressive Paralysis [*Zentral bedingte Schmerzattacke mit hohem Fieber bei progressiver Paralyse*]. (*Neurol. Zentralb.*, 1912, *No.* 12.) *Patschke, F.*

The case described is one of typical general paralysis occurring in a woman, æt. 38. She was suddenly seized with an attack of severe pain affecting principally the extremities on the left side. The temperature rose rapidly while the attack lasted. The duration of the attack was comparatively short, *viz.*, six to seven hours. There were no convulsive movements or motor paralysis. There was hypalgesia from the middle of the left femur downwards, and by piercing the skin of the calf no sensation was produced. Although the pains abated and the temperature became normal in a few hours, sensibility was not completely restored three days after the attack.

In spite of the fact that anatomical investigation was not possible, there can be no doubt that the pains were due to a disturbance originating in the central nervous system. No traces of a peripheral momentum could be discovered. HAMILTON MARR.

Anatomico-clinical Study of Presbyophrenia [*Étude anatomo-clinique de la presbyophrénie*]. (*L'Encephale, Feb.*, 1912.) *Marchand, L., and Nouët, H.*

Three cases presenting the presbyophrenic syndrome described by Wernicke, Kalbaum, Arndt, Kraepelin and others, were made the object of particular study, clinical and *post-mortem*. Whilst some authorities regard presbyophrenia as a clinical entity, others consider it a clinical form of senile dementia, and others again as an insidious and chronic psycho-polyneuritis similar to Korsakoff's psychosis. The patients were æt. 70, 84, and 71 respectively, and each presented the symptoms which, according to Kraepelin, characterise presbyophrenia, *viz.*, amnesia of fixation and of evocation, confabulation, disorientation and illusions of recognition. The first two patients had never been given to excesses of any kind, and the third was addicted to alcoholic excesses during several years before the commencement of his illness, and in his case alone was there any possibility of doubt as to the diagnosis between presbyophrenia and Korsakoff's psychosis. Senility and cerebral atheroma were the only ætiological factors discovered in the other two. Examination failed to reveal any indication of polyneuritis in any of the patients, and no history of former paralytic troubles was obtained. The continuity of the disorders of memory, the absurdity of the conceptions resulting from these disorders, the rapidity and facility with which the patients comprehended and responded to the questions put to them, the weakening of judgment, reasoning and affective sentiments, excluded the presence of mental confusion, and indicated a state of dementia related to diffuse and severe lesions of the cortex. Both macroscopi-

cally and microscopically the lesions found in the brains of all three cases were such as are met with in ordinary senile dements. The histological examination of the peripheral nerves revealed no parenchymatous or interstitial changes. The authors conclude that presbyophrenia is a variety of senile dementia which is to be distinguished clinically and anatomically from amnesic mental confusion with or without polyneuritis.

J. H. MACDONALD.

Anatomical and Clinical Study of the so-called Senile Plaques [*Étude anatomique et clinique des plaques dites séniles*]. (*L'Encéphale, Feb.*, 1912.) *Marinesco, M. G.*

In 1892 Blocq and Marinesco described the presence of little round nodules scattered throughout the cerebral cortex of an old epileptic and regarded them as islets of neuroglial sclerosis. Since then many other observers have detected such nodules, especially in senile brains. In 1906 Alzheimer described them in a patient, æt. 56, along with a particular alteration of the neuro-fibrillæ and a special degeneration of the cortical nerve-cells revealed by the method of Bielschowsky. The clinical picture differed from that of senile dementia, and there were no symptoms of a focal lesion or of any paralytic, syphilitic or arterio-sclerotic affection, and Alzheimer believed he had met with a disease that was still unrecognised (Alzheimer's disease—progressive dementia, aphasia and asymbolia.) In 1907 Fischer published the results of his examination of a large number of senile brains by the method of Bielschowsky. He found the so-called senile plaques in 12 out of 16 cases of senile dementia. They were absent in 45 cases of general paralysis, 10 cases of non-organic psychoses and in 10 normal brains. He came to the conclusion that these plaques were present in cases of so-called presbyophrenia, but absent in simple senile dementia. In a subsequent investigation of 37 cases of senile dementia he found them absent in 9 cases of simple senile dementia and present in 28 cases of presbyophrenia. In the brains of 50 paralytics, 25 mixed insane and 20 healthy people, 6 of whom were over sixty years of age, the plaques were absent. Fischer has been led to believe that the condition is a definite and special cerebral affection, which should be given a place to itself in the classification of the psychoses, and proposed the name "presbyophrenic dementia." Alzheimer regards the plaques, not as the cause of senile dementia, but as the accompaniment of senile involution of the central nervous system, and thinks there is no reason to look on the cases in question as caused by a special pathological process. Constatini examined the brain of a centenarian, who was regarded as mentally and physically sound, and died æt. 105. He found the cerebral cortex studded with senile plaques. With regard to the intimate nature of these plaques various opinions have been expressed. In the present communication Marinesco analyses the findings of other workers and gives the details of his personal investigations. He concludes that the hypothesis according to which the central nucleus of the plaque is derived from a pre-existing cell-element, neuroglial or nervous, does not hold good. Nor can it rightly be regarded as a sort of amyloid corpuscle. The theory that they are derived from nerve-fibres by a

metamorphosis, such as takes place at the end of a sectioned nerve, may possibly hold good in many cases, but not in the case of those that occur in the first layer of the cortex. In any case we have probably to deal with an organised proteid substance which has undergone a degenerative process. With regard to the other elements composing the plaques the author thinks they may represent chemical principles precipitated in the tissue of the cerebral cortex as the result of a disturbance of the colloidal equilibrium. This might be favoured by a disturbance of metabolism, which would exercise its influence in a progressive manner. If this conception be true the term "miliary sclerosis" would have to be rejected, for the neuroglial reaction observed in some cases would be secondary. Of the chemical nature of the precipitate one can only speak tentatively. It is neither crystalline nor crystalloid but is probably a lipoid substance or substances belonging to the class of mono-amino-phosphatides or amino-lipotides.

J. H. MacDonald.

Traumatic Neuroses, with special regard to the Indemnifiable Forms [*Le neurosi traumatiche con particolore riguardo alle forme indennizzabile*]. (*Riv. Sper. d. Fren., vol. xxxviii.*) *Morselli, E.*

In a communication to a congress on diseases of occupation held in Torino last year Professor Morselli expressed the following conclusions. By the term "traumatic neuroses" should be understood affections of a functional nature, so-called. Those dependent on a more or less definite and demonstrable anatomical lesion are to be excluded. The traumatic neuroses in general must be differentiated from those occurring in individuals subject to compensation, especially in the labouring classes affected by social legislation. The traumatic neuroses in this sense are of a psychogenetic nature and closely analogous to the hysterical neurosis. In the injured who present the picture of the neuropsychosis there is present at most a psychological predisposition, often of a degenerative character. The diagnosis is founded on objective signs, although these, as in hysteria, are usually psychogenetic. The development, symptomatology and course of the traumatic neuroses are dominated by two psychic elements, *viz.*, suggestion (auto- and hetero-suggestion) and simulation (conscious, unconscious, voluntary, automatic and involuntary). Five principal nosological and clinical varieties of the neurosis are distinguished, though these may pass one into another or be variously combined: the traumatic neurosis of Oppenheim, which should be considered by itself; the neurasthenical, the hysterical or hysteroid, the hypochondriacal and the paranoid or querulous varieties. Simulation goes from simple parading of the somatic and psychic disturbances and their exaggeration up to complete shamming. When this is not the outcome of pre-existing dishonesty or laziness, it is the logical and natural consequence of the idea of compensation propagated amongst the labouring classes and all workers liable to compensation, and of the notions concerning the laws of compulsory insurance and civil responsibility. Nevertheless, the traumatic neurosis is rather rare even in those occupations exposed to risks of accident, and has a less practical importance amongst the diseases of occupation

than is commonly believed. The prognosis, in the absence of medical or surgical complication of another kind, is favourable in 90 to 95 *per cent.* In cases which don't recover we must suppose the existence of true anatomical lesions of the nerve-centres and especially of the vascular network (arterio-sclerosis and secondary alterations). The traumatic neurosis, pure and simple, is to be regarded as a product of a two-fold obsession, that of the damage wrought by the injury and that of the compensation promised and expected. Where the existence of pathological consequences of the injury is disputed and legal proceedings are prolonged for months and years, the clinical picture of the neurosis becomes distorted and deformed owing to the defensive needs (in a judicial sense) of the injured party. We may then speak of a true litigation-neurosis of a psychpathological nature, akin to processomania or querulantomania. The treatment is essentially moral, or rather is summed up in a wise, rapid and efficient psychotherapy. Finally, the author remarks on the need of improvement in the laws affecting labour, especially in the direction of a more expeditious process for ascertaining the amount of damage sustained and liquidating the indemnity.

J. H. MACDONALD.

Inequality of the Pupil in Affections of the Lung and Pleura [*L'Inegalite pupillaire dans les affections pleur-pulmonaires*]. (*Le Progrès Medical, May*, 1912.) *Sergent, Emile.*

We are warned not to accept the statement that inequality of the pupil is always of syphilitic origin. There are two great classes in which cases of inequality of the pupil may be placed, firstly those with, and secondly those without, an alteration of the reflex, and in the former class is included the Argyle-Robertson pupil. Again, the latter class may be subdivided into those examples due to endogenous causes, cataract, pilocarpine, congenital defect, and secondly, those due to stimulation of the motor nerves of the pupil, basal tumours, meningitis, and intra-thoracic lesions such as aneurysm, mediastinal tumour.

Inequality of the pupil may be the only apparent sign of commencing lung mischief. It has been found in 58 per cent. of people suffering from acute or chronic lung disease. Chronic apical phthisis demonstrates this phenomenon most frequently.

The inequality of the pupil may be the only outward sign. It may, however, be accompanied by contraction on the affected side, a diminution of the palpebral fissure and an apparent retraction of the globe. Another variety has in addition to these symptoms vaso-motor troubles of the ear. Lastly, you may have dilatation of the pupil accompanied by vaso-motor troubles, but without any oculo-palpebral signs.

COLIN MCDOWALL.

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