differ among those who have the best opportunities of judging, and that these ulcers are certainly not common. In the case I have above recorded, the ulcer seems to have formed unusually early, and not to have been the *cause* of death, as the presence of effused lymph showed an effort at repair, and the adhesion partly formed to the pancreas prevented the escape of foreign matters into the abdominal cavity.

Speculation has long been rife as to the causation of these ulcers, and I do not presume to speak with any authority on the matter, but if I were to venture an opinion, it would be in this fashion. After a person is burnt or scalded, the effects of the shock are seen principally in one of three ways—either in some affection of the brain, the lungs, or the gastro-intestinal system, and according as one or other set of organs is affected, we get either cranial congestion, or bronchitis, or pneumonia, or vomiting and hæmorrhage. If the lungs are involved the other organs probably escape; and if the stomach is attacked, the head and the chest are not affected. If, in the revulsion that ensues after a severe scald, the stomach suffers, there is collapse, vomiting, and perhaps ulceration. The duodenum being as important a part as the stomach, and intimately concerned in the process of digestion, must be the most likely part of the intestine to suffer, and it seems to me that it is not merely from contiguity, but from similarity of function, that it is bound to suffer.

May it not be that the involving of the duodenum is a proof of the violence of the shock which the gastric system has received, and an evidence that the mischief has extended beyond the limits of the stomach, and that the duodenum, as next in importance to the stomach in the process of digestion, suffers accordingly? And may it not be that when the shock is so severe, the affection of the duodenum exhausts the vital energies, so that life becomes extinct before the rest of the small intestines can be implicated?

Notes of Cases in the Ceylon Lunatic Asylum. By J. W. Plaxton, M.R.C.P., Medical Superintendent.

In the happier times before the folly of exchanging England for Ceylon had overtaken me, General Paralysis had exercised its usual fascination.

Almost the first thing, therefore, to strike me after arrival was its entire absence in Ceylon Asylum.

Since then three cases have been admitted, which I am inclined to regard as of this nature. All died after but a short residence; two only came to the post-mortem room. One being a Mahommedan, a post-mortem was unattainable—Mahommedans being as unreasonable as Jews in the matter of post-mortem examination.

These cases at some length were—

1. Sappayab, æt. 40. A male. Tamil Cooley. Admitted June 14, 1879. He came to us from prison, where he had been confined for theft. No history was obtained; he was dropped at the door, as it were, foundling fashion.

His condition on admission was one of simple dull dementia; a feeling of well being pervaded him, but no delusions were present. His enunciation was thick. An ear showed traces of bygone slight othæmatoma. Mouth was asymmetrical. Gluttonous in eating.

Six weeks after admission further failure of motor power was noticed; his legs failed him, he walked with his knees half bent, and tripped and fell at the smallest obstacle. There was no one-sided weakness. His pupils were contracted. A fortnight after, I have a note that his tongue is unsteady, but that there is no quiver of it or of his lips. His face had lost all expression. After this he failed rapidly; his mind became an utter blank, and his muscles almost powerless.

He died October 31, 1879. Death was hastened by a diarrhœa. He was never noisy, violent, or excited; never had a congestive attack or convulsions.

Post-mortem Examination.—Dura mater somewhat adherent to skull cap. A thick recent blood clot covered right cerebral hemisphere. A thick gelatinoform new formation of the so-called arachnoid cyst covered both hemispheres. The whole of the inner surface of the dura mater was lined with a thin gelatinous film. Arachnoid was muddy and thickened; not very tough. It was adherent to many of the convolutions in front of the Fissure of Rolando, especially to the first frontal gyri and to the ascending gyri. Consistence of brain was good. Cortical substance thin. Vessels of the base normal to the eye. No foci of softening in the brain.

2. Don Salmon Aratchey, aged about 40 years. Male. Cingalese. Admitted August 4, 1879. No history obtained with him, but it was afterwards ascertained that he had been a hard drinker. He was admitted in a state of delirious excitement, and so continued to the end. He was restless and noisy, and day and night kept up a continuous current of indistinct words—usually a monotonous chant from the books of Buddha. His self-feeling was towards elation, but no predominant idea was ascertained. He was abominably filthy and destructive, and any approach to him caused him to uncover his genitals.

Questions seemed to awake no faculty of apprehension, he simply continued his chant. His words were slurred and usually unintelligible. His face was expressionless, *chap-fallen*, allowing the saliva to dribble down his chin. No mental change occurred, but his gait became more slovenly, and all his movements uncertain.

On October 18th he was attacked by pleurisy, and on October 23rd by dysentery, which proved intractable. He died, worn out, November 28, after a residence of four months.

Post-Mortem Examination, November 29, 1879.—Skull symmetrical. Bone dense. Dura mater adherent—inner surface covered by a thin pachymeningitic membrane, thin, and containing enmeshed blood. Middle fossa of base covered by the same membrane.

Pia mater thick, opaque, tough, adherent to the brain, almost universally rendering stripping impossible.

Brain exceedingly soft. Lateral ventricles large, and contained much fluid.

Grey matter of convolutions thin; no circumscribed softenings.

Other pathological changes were pleuritic effusion, right side. Cirrhosis of liver and kidneys. Ulcerations of the large intestines.

3. Sinne Lebbe Marikar, aged about 30. A Moorman petty trader. Admitted November 9, 1879.

In this case I was able to obtain a fairly good history (for Ceylon). The duration of his mental aberration before admission was probably about one year, and followed on great losses in his trading.

The onset was insidious, and marked by the development of ideas of wrong done him, and by fear of violence. He had hallucinations of sight too.

On admission he was excited, noisy, and restless. He had well-marked grandiose delusions, but the predominant emotion was towards depression. He complained and wept bitterly, because he had been defrauded of his money and property.

His tongue and all his muscles were tremulous. Pupils small, equal, and inactive. His excitement never ceased. In the course of his disease he had many strange sensory feelings in his nose, throat, &c.

I was never certain that the fibrillary quiver of G. P. was present in the lips and tongue. A quiver of the lips and face was almost always exhibited on my approach, but his tendency to weep always left me uncertain if the quiver were not due to restrained emotion, in part it certainly was.

February 22, 1880, at 5 a.m., he was found insensible on his mat, and shortly after had two convulsive seizures affecting both sides equally. The comatose condition, with only a slight interval of semi-consciousness, continued to his death on the following day. The coma was profound, but never absolute. It was unequal in the lateral halves of the body.

Died February 23, after a residence of nearly four months.

There was no post-mortem examination.

He is said to have been a smoker of Bang. Had marks of old bubos in the groins, and during his residence had some ulceration of his palate and tonsils, which may have been syphilitic. He would not permit full examination. Iodide of potassium was given, and he got well. No other trace of syphilis was exhibited.

These three cases possess in common one feature—failure of muscular power concurrent with failure of mind, and in the two which reached the post-mortem table adhesions of the pia mater to the cortex and pachymeningitis changes were common to both.

In life they differed, inasmuch as one (Suppayah) was marked by simple dementia and ultimately amentia, the others by continuous excitement.

Of these last, one remained respondent to the stimulus of external impressions (Sinne Lebbe), the other (Don Salmon) was not responsive.

Case 1 (Suppayah).—In the absence of a single tittle of history, it is not a little puzzling to assign this case to its proper place. Living, I had ventured the opinion that it was a case of pachymeningitis with hæmatoma.

The fact of pachymeningitis and hæmatoma was proved at death, but, superadded, were numerous adhesions of the pia mater to the cortex. On the other hand, the naked eye characters of the brain were not typical of General Paralysis.

Case 2 (Don Salmon Aratchey).—I think there can be no doubt of the correctness of assigning this case to General Paralysis. The brain was typical of the disease. Tough opaque membranes strongly adherent to the gyri of a brain, which, within its envelopes, seemed only to wait their rupture to flow out.

Case 3 (Sinne Lebbe Marikar).—No post-mortem examination was obtained, but the history of the case accords with the well-known course of General Paralysis. Overstrain, melancholic prodromata, grandiose conceptions, unbroken excitement with emotional weakness, and its termination in convulsions and coma, do not contradict.

I regret that I can say so little of the causation of the disease in these cases. In one there is absolutely nothing known; one was a drinker; the third was a smoker of Bang, had had suppurating bubos, and, from losses in his trading, had been deeply affected.

The microscopical characters of the brains of Suppayah

and Don Salmon agree in being studded, in countless numbers, by dots of miliary sclerosis, chiefly in the white substance and up to the third layers, and less frequently in the first layer. A drawing to Dr. J. W. McDowall's paper on "Diffused Cerebral Sclerosis," in January No. "Journal of Mental Science," 1880, would stand very well for these brains. A much greater number of diseased points would appear in my cases. He shows, too, the disease in the first and third layer of the cortex.

Cases contributed by GEO. H. SAVAGE, M.D., Bethlem Hospital.

1. *Cases of Contagiousness of Delusions.*

Cases in which a delusion is caught by one patient from another are sufficiently rare to be worth recording.

One not uncommonly sees melancholy patients seizing upon an idea which is brought before them by some one near. They are in a state of simple melancholy, and are looking about for some explanation of their misery; and that a neighbour complains of having committed the unpardonable sin is enough to cause their melancholy to crystallise round the idea presented to them.

The cases here recorded differ from this entirely. It has already been noticed that as a rule the patient catching the idea is in an emotional, weak-minded state, and is generally of much weaker mental character than the one propagating it. In my experience these cases have been suffering from exaltation of one form or another, and in the majority of my cases religious ideas have been the ones transmitted.

The first case reported is from the Berry Wood Asylum, near Northampton, reported, by the permission of Dr. Green, by Mr. H. Wynter Blyth. Dr. Green writes:—"The cases of the two O.'s are decidedly curious, and, in my experience, unique. It is, unhappily, common enough for father and son to be insane, but for both to have the same delusions must be rare. Sometimes a wave of insanity, like the Dancing Mania or the Crusades, passes over a country and affects thousands of people, but that is a very different thing from the cases in question. The older O. is still here, and seems cheerful and comfortable, as he well may be with his delusions. The younger man has never been here since the day you saw him."