is chiefly a psycho-motor excitation should be termed either "Impulsive Insanity" or better "Motor Obsessional Insanity."

Ætiology.—The chief factor was undoubtedly the psychopathic heredity which showed itself primarily in an unstable and somewhat weak mental development. Another factor of some importance must have been the physical exhaustion of the mother entailed by rapid and numerous pregnancies. Including the patient, she had eight children and two miscarriages within fourteen years. A miscarriage occurred both before and after the patient.

Prognosis.—It is extremely unlikely that this is the last attack, but it would be interesting to know the nature of the next impulse and how soon it will occur. The prognosis is very grave. An interesting question will eventually arise, unless further symptoms develop, as to whether she can legally be kept in an asylum.

Her secretiveness and deceitfulness almost suggest latent criminal tendencies, and the dividing line between obsession and criminality must often be very indistinct.

Clinical and Pathological Notes.—III. By Dr. M. J. NOLAN, Resident Medical Superintendent, Down District Asylum, Downpatrick.

CASE 8.—*Disseminated sclerosis; hydrocephalus; epilepsy; extreme tenuity of skull; dementia.*

W. M—, æt. 29, admitted to asylum October 28th, 1903; died January 6th, 1908. Patient had no family history of insanity or allied neuroses. He led a steady, regular life, married early, and worked mainly in coal-pits. About fifteen years ago—when he was fourteen years of age—he fell on his head and was unconscious for several days, and ever afterwards complained of pain in his back. Ten years later, and four years prior to his admission, he got a fit, and immediately preceding it he said to his wife that he felt the pit to be falling in on him. From that time to date of admission the fits recurred at irregular intervals, he became gradually spastic in gait, and his temperament varied from dulness to marked irritability, and his mental faculties became obscured. He was then treated in the Union Hospital, and finally became so violent that he was removed to the asylum.

On admission the following particulars were noted: Body well-nourished; weight 12 st. 4 lb. Expression fatuous. Pupils irregular and eccentric, reaction to light and accommodation normal; nystagmus. Exaggerated knee-jerks; gait spastic; volitional tremor. "Scanning" speech; mental state dull and confused; irritable when questioned.

No knowledge of epochal life events, time, or locality. Subsequently the fits—epileptiform in character—recurred at frequent intervals. He became steadily more feeble in body and mind. At times complained of "a weakness of the spine." Locomotion became more difficult; he could take little exercise, and increased in weight to 13 st. 6 lb. In October, 1907, the fits increased in frequency, and so affected him that it became necessary to confine him to bed. This was the beginning of the end. A month later he had bladder troubles, and developed enormous bullæ on left hand, left ear, ankle and hip. Later still his right elbow-joint was the subject of the typical Charcot syndrome of spinal arthropathy, and he died on January 6th, 1908.

Post-mortem examination.—Heart enlarged, dilated, and infiltrated with fat. Lungs large, heavy, firm, and deeply mottled with pigmentation, showing an advanced stage of anthracosis. Liver congested. Spleen enlarged (weight, 10 oz.), and mottled with melanotic spots on surface and on section. The skull was at once remarkable for its size and the extreme thinness of the bones, so thin that in the temporal region it was easily pricked through with a pin, and when later divested of its coverings it was found to be quite translucent. On the base of the skull the natural land-marks were much accentuated, and the ridges in part were spiculated. The brain weighed 43 oz., the membranes adherent, and the ventricles dilated, causing flattening of the convolutions; a great excess of fluid about brain and in ventricles. The spleen's capsule was thickened, and the organ was the subject of general fibrosis.

Microscopic examination showed no marked change of the pulp or corpuscles, but the vessels in many places showed thickened hyaline walls.

Observations.—The case would seem to be of interest in regard to the following points:

(1) The history of early cerebral injury, and its possible association with the subsequent development of organic cerebro-spinal disease.

(2) The extraordinary thinning of the cranial bones as the result of pressure and absorption.

(3) The advanced anthracosis in so young a subject, and the melanotic pigmentation of the spleen.

(4) The very early and progressive dementia following the first epileptiform seizures; and the psychical aura of the latter reflecting a subconscious daily apprehension.

CASE 9.—*Intra-cranial tumours; endothelioma; epilepsy; optic neuritis; staccato articulation; dementia with exaltation.*

J. A—, æt. 61, admitted to asylum June 21st, 1902.

Patient, a single woman, lived all her life with relatives, and enjoyed good general health up to two years ago, when her brother died suddenly in her arms. She then had a "weak attack," and since then had

various syncopal attacks, due, it was supposed, to her diseased heart—as she suffered from mitral regurgitation. Her general health began to fail, she lost sleep and memory, and it became necessary to treat her in hospital. Then she became delusional and so troublesome that she was transferred to the asylum.

On admission she was in a state of nervous excitement, very garrulous, emotional, expansive, and delusional. She could not be kept from talking of property she had been deprived of, of her great expectations, and her generous intentions. Her memory for recent events was very bad, and of remote events somewhat better; but in reply to questions she rapidly became incoherent and wandered into vague reminiscences of early life.

For six months subsequent to her admission she was quiet, cleanly in habits, and capable of sewing a little. At the end of that time she had an epileptiform seizure, after which she was dull and irritable, and distinct persecutory delusions became prominent. Though she ate and slept well she lost weight. A few weeks later complained of lightness in her head, and she developed some paresis of her left arm. About this time she began to lose the sight of her right eye. The fits recurred at irregular intervals. She complained that her head was open in two places, and sat patting it in a searching manner, as if fearing to come suddenly or roughly on the open spaces. She also complained of the increasing blindness. Her delusions again became grandiose—she spoke much of her wealth, social position, and benevolent projects. At the same time she persistently stated that no one would ever see her die, as she would pass away in sleep. Her deafness and blindness rapidly increased, she became noisy and destructive, then feeble and filthy, and passed away as she had anticipated, in sleep, subsequent to repeated epileptiform seizures.

With the exception of the two tumours (exhibited) there was nothing of special interest in the pathological conditions as revealed in the *post-mortem* examination. The larger of the two was distinctly spherical in shape, the size of a small orange, and weighed 100 grms. It was found on the left temporo-sphenoidal region, well encapsuled, and adherent on the outer surface to the dura mater and to the inferior angle of the parietal bone. It measured 3 in. in its longest diameter and over 7 in. in circumference; on section it was firm and tough.

Microscopic examination showed that it was of spindle-celled tissue arranged in well-marked concentric arrangements of cells around small blood-vessels, and contained many calcified psammoma bodies. It was well encapsuled. The smaller tumour was small and vascular looking, the size of a pigeon's egg, and sprung from the optic chiasma region. It was somewhat kidney-shaped, weighed 12 grms., and measured $\frac{3}{4}$ in. in shorter and $1\frac{1}{2}$ in. in longer diameter. Microscopic examination showed it to be of practically the same structure as the larger tumour, but the cells were not so elongated and the vessels were more abundant. Endothelial and perithelial proliferation in connection with the small vessels could be seen at the edges.

The tumours sprang from the pia-arachnoid and did not directly engage the brain tissue.

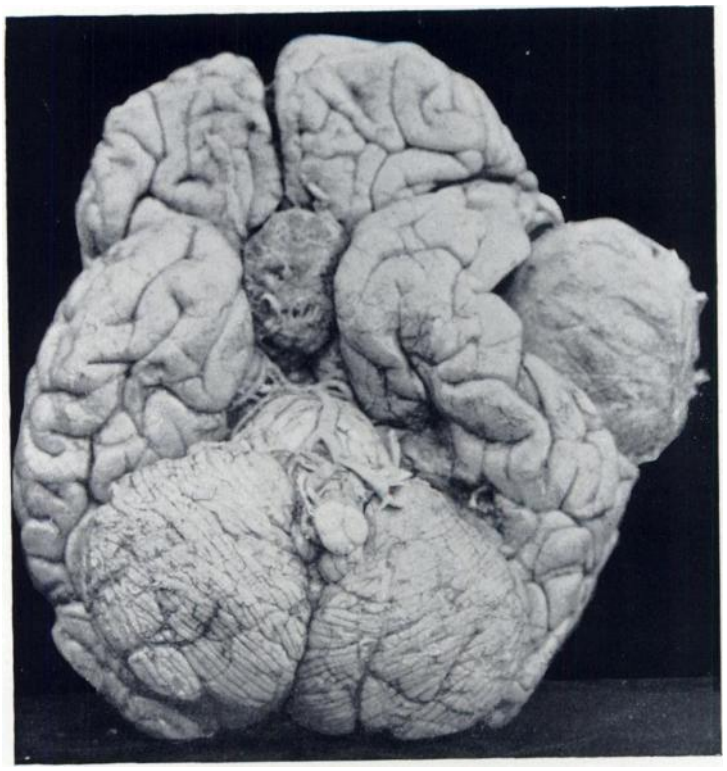

FIG. 1.—CASE 9. J. A—. Endothelial tumours of left temporal sphenoidal region and the optic chiasma.

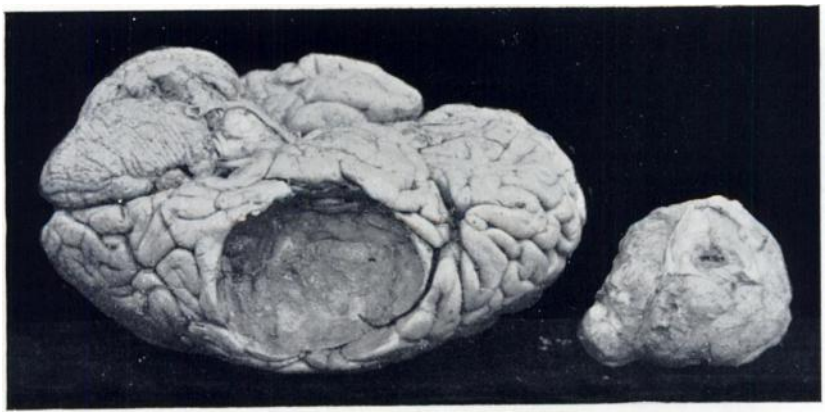

FIG. 2.—CASE 9.—J. A—. The encapsuled endothelial tumour of left temporal sphenoidal region removed from its position.

To illustrate Dr. M. J. NOLAN'S paper.

Adlard & Son, Impr.

Observations.—It is of interest that the two prominent physical symptoms, tremor, and speech disturbance, combined with excited reflexes, were the same in this as in the preceding case, and that in the two cases there was intra-cranial and intra-spinal pressure due to entirely different causes. How far the pressure caused these symptoms is a matter of some speculation. The special sense and local symptoms were, of course, accounted for by the individual conditions involved in each case, as well as the epileptiform seizures which were manifest. The early dementia in the one case and the late exalted delusions in the other afford also an interesting contrast of psychical disturbances from association with organic disease.

And in view of such grave morbid changes and growth—in themselves beyond the reach of physicians' or surgeons' skill—it must strike one how absurd it is to level charges of non-progress in the successful treatment of mental disease, which experience shows is so often merely associated as a symptom with organic and incurable disease. Many such cases are no doubt recorded as cases of "epileptic insanity," and as such swell the bulk of a class for which curative treatment is sought in vain. The epilepsy and the insanity are but the concomitant symptoms of gross disease of the great nervous system.

In Case 8 the psychical condition was one of gradual stupor, following on the acute mental failure ushered in by a fit; in Case 9 the acute mental failure, marked by recurring fits, was of an hallucinatory type, and the stupor, so often stated to be one of the chief clinical symptoms of brain tumour, was never in evidence until it followed the group of fits which immediately preceded her death.

Occasional Notes.

Delayed Lunacy Legislation.

The prospect of lunacy legislation in the present Session is almost hopeless, but the "deferred hope" should not have the saddening effect on this Association which is usually supposed to result from such an emotional state.