where they were before their consciousness was seriously impaired. But although the peripheral trouble may take a share in forming the peculiar nature of the psychic disturbances, this share can only be a supplemental one. There can be no doubt that the confusion of mind is essentially due to disorder of the central nervous system, for when patients have to all intents entirely recovered from their peripheral defects they often still present very marked disturbances psychically, *e.g.*, amnesia and pseudo-reminiscence.

REFERENCES.

Serge Soukhanoff and Andre Boutenko, "A Study of Korsakoff's Disease," *Journal of Mental Pathology*, vol. iv, 1903, pp. 1—33.

Sydney J. Cole, "On Changes in the Central Nervous System in the Neuritic Disorders of Chronic Alcoholism," *Brain*, vol. xxv, 1902, pp. 326—363.

(1) The pathological features of this case are reported more fully in *Brain*, Spring, 1903. It is No. 32 in the article entitled "An Account of the Nerve-cells in Thirty-three Cases of Insanity, etc."

Notes on Two Cases illustrating the Difference between Katatonia and Melancholia Attonita.[1] By W. R. DAWSON, M.D., Farnham House, Finglas.

ONE of the most interesting points connected with the concept katatonia is its relation to the morbid phenomena included under the older term melancholia attonita. Many modern exponents of the former, especially in Germany, would deny the existence of stuporose melancholia altogether. Yet it seems to me that cases occur conforming to the descriptions of the latter which cannot be included in the category of katatonia without the merest straining of terms. In this connection I think the following two cases are instructive:

Married woman, æt. 30, admitted in June, 1902. It was ascertained that her brother had been alcoholic and had committed suicide, and that her sister had met her death in a manner that left no doubt that she had also taken her own life. The patient herself is said to have behaved in a peculiar manner some years before the present attack. She had no family, and sexually was out of health, menstruation being

https://doi.org/10.1192/bjp.49.207.686 Published online by Cambridge University Press

very profuse. Shortly before the present illness she became connected with one of the more emotional religious sects, and about a year previous to admission she took an inexplicable dislike to one of her clergymen, whom she believed to be preaching at her. A few weeks later, while at the sea-side, she suddenly became acutely insane; but this phase was very transitory, and during the summer of 1901 (in the course of which she underwent an operation) she was depressed and solitary, with fears that her soul was lost. She was at this time in poor physical health. By October she had greatly improved, but she then became nervous, flighty, and restless, lost her sleep, and showed a preference for men's society. On November 3rd she suddenly began knocking on doors, saying that God had called her, and became violently excited. This subsided, but two days later she had another attack in which she bit, kicked, tore, beat her head upon the floor, and the like. This gradually passed off, and she then became perverse and mischievous, and at the same time developed a high opinion of her saintliness. Later still she pretended to be lifeless, passed her motions under her, and had to be tube-fed. I saw her in consultation about this time, and found her unwilling to speak and full of somewhat exalted and mystical religious delusions. She then had a period of mutism for some weeks, but did what she was told. During the spring she was variable and rather depressed, and as she did not seem to be making progress she was sent to Farnham House. She is said to have been suicidally inclined. On admission she was in a state of resistive stupor, lying still and silent, often with her eyes shut, until she was wanted to do anything, when she at once resisted. She was muscularly strong, and showed no physical abnormalities except poor circulation, with somewhat livid skin, rapid pulse, and high arterial pressure, and also a trace of sugar in the urine, which proved only temporary. There was a tendency to constipation. Sleep fairly good. Temperature was slightly subnormal.

On a few occasions during the first nine months after admission she talked a little, but in the main lay silent and quiet with her eyes shut, and resisted violently when anything was done for her, spitting, biting, and striking. She had almost invariably to be tube-fed, had to be washed and dressed, was dirty in her habits frequently, and generally refused to wear any night-linen, though she usually allowed her clothes to remain on in the daytime. In the summer she was subjected to a course of thyroid feeding, but was only partially roused by it, and soon relapsed; and of the other drugs tried the only one which produced any marked effect was trional in 10-gr. doses thrice daily. Under this she always roused and showed improvement, but it soon lost its effect. Almost all through she seemed, so far as could be judged, to retain her perception of what was going on around her; and once (in February last), when frightened by another patient's screaming, she left her room (albeit in a nude state), and was more rational for the rest of the day. In February the menses, which had been in abeyance, reappeared, and she showed some improvement, but in March she relapsed, and, indeed, for a few days the stupor deepened into a condition resembling coma. After this, however, it began to pass away, and some elevation took its place, and in the course of the last three months the stupor has altogether disappeared. The patient is now usually cheerful and slightly

https://doi.org/10.1192/bjp.49.207.686 Published online by Cambridge University Press

elevated, but is inclined to be touchy and unmanageable, and sometimes loses her temper without any external reason whatever. She is fairly sensible, enjoys visits from her friends, and is beginning to be anxious for her discharge. On the whole, improvement is still progressing, but a certain element of mental weakness is still present, though this may not prove permanent.

We have here a succession of melancholia, mania, and stupor, followed by slight maniacal elevation and mental weakness, in an hereditary neuropath. The whole attack has lasted over two years. There were delusions and probably auditory hallucinations of a religious type both in the melancholic and maniacal periods, and at times also in the stuporose. The latter period was marked by many temporary and incomplete remissions, and the stupor was of a resistive type, with a tendency to negativism. Upon the whole, therefore, the case is a fairly typical example of katatonia, notwithstanding the absence of some symptoms (especially verbigeration and catalepsy) to which great importance is attached by many authorities. On the other hand, the following case, though showing these symptoms, cannot, in my opinion, be so classed :

CASE 2.—The patient, a married woman æt. 33, comes of a nervous family, though no neuropathic history has been elicited. She had sustained a severe fall on her head when out riding some fifteen years before, and had frequently suffered from headaches since. Just before the present attack she had had an abscess in one of her fingers. She is said to be naturally rather sulky and obstinate, but very nervous, and a gynæcologist has pronounced her to be sexually ill-developed. For about two years she has been worrying unnecessarily about a certain action on the part of a relative. Early in 1902 she became parsimonious, and then acquired delusions of having no money (even when she had £7 or £8 in her pocket at the time), and grudged necessary expenses. Next she thought that the police wished to arrest her for starving her household, and then began to dislike her husband and to refuse food. On one occasion she is said to have attempted suicide. Various measures, such as change, Weir-Mitchell treatment, etc., were tried without avail, and finally she was sent to Maryville. On admission she was very emaciated, looked much older than her years, and was stuporose and somewhat resistive, but no organic disease could be detected. Her physical condition has considerably improved under treatment, but mentally she remains much the same. Her state varies frequently between a quiet stupor, in which she sits or stands motionless and silent (mutism) and often allows her limbs to remain for a short time in any position in which they are placed (catalepsy), and a state of more or less acute restlessness and resistiveness, in which she looks intensely miserable and is very noisy, repeating one cry for hours in an automatic sort of way (verbigeration). Even in

https://doi.org/10.1192/bjp.49.207.686 Published online by Cambridge University Press

the latter state, however, there is still a great deal of stupor. She has frequently had to be tube-fed, is wet and dirty in her habits, and at times wakeful at night. Occasionally she recognises her relatives when they come to visit her, and seems glad to see them, but not always. Various forms of special treatment—thyroid feeding, lavage, morphia or opium hypodermically and by the mouth, and latterly over-feeding—have been tried without much apparent result, at least on the mental side.

It will be seen that this case, although showing a sometimes resistive stupor, with mutism, verbigeration, and a tendency to catalepsy at times, differs from the type of katatonia in the absence of marked heredity, of a maniacal stage, of exalted and religious delusions, and of any tendency to real remissions, while there has been marked depression all through. For these reasons (although I admit that further observation is required) it seems to me that this case cannot justly be set down as one of katatonia, but is a genuine instance of melancholia attonita, as distinguished from the former. If this is correct, the case is further interesting as showing that verbigeration may occur in an acute form of melancholia—a fact, if it be one, which has been expressly denied.

(1) Read at the meeting of the Irish Division at Enniscorthy, July 3rd, 1903.

Notes on the Treatment of Acute Cases. By R. R. LEEPER, F.R.C.S.I., Medical Superintendent, St. Patrick's Hospital, Dublin.

IF we trouble ourselves to look back and study the treatment of insane persons in olden times, we cannot but be struck by the fact that our forefathers regarded insanity as a disease which needed active treatment, and it generally received such at their hands; and that, however much the weird and sudden outbursts of religious frenzies, sudden seizures, and mad impulses were regarded as evidences of demoniacal possession, or God-inspired action, the patients so affected, and rendered conspicuous by their conduct, received at the hands of their fellow-creatures treatment which, however curative in intention, must have tended rather to elimination than recovery, and in

https://doi.org/10.1192/bjp.49.207.686 Published online by Cambridge University Press