CLINICAL NOTES AND CASES.

A Case of Disseminated Cerebral Sclerosis. By W. Bevan Lewis, L.R.C.P. Lond., West Riding Asylum.

J. H., æt. 33, widower, admitted into West Riding Asylum, August 6th, 1877.

It was stated by his friends that he had exhibited great depression of spirits for about twelve months subsequent to the death of a favourite child of his, but there was no evidence of decided mental aberration until a week ago, when he became restless, excited, and eventually outrageous in conduct. These outbursts of excitement have been increasing in frequency and violence up to the date of admission, and were characterised by noisy incoherent raving and shouting, aggressive behaviour, and dangerous and destructive propensities. The facts of his history prior to this attack, as given by his friends and the Relieving Officer, were too conflicting to be closely relied upon. There was good reason, however, to suspect that for some years past he had been living a somewhat loose and dissolute life, and lately had become very intemperate in his habits. There was no history of cranial injury, or of any severe illness prior to the attack; a distant relative was said to have been insane.

Such were the facts given on his admission. He was at this period greatly agitated, throat dry and husky from incessant raving, restless, gesticulating, and obstinately refused his food. He remained in a state of acute delirious mania for the ensuing week, when a note in the case book states—"He still remains excited, raving incoherently, and wandering restlessly about his room. His speech is at times foul and profane, and his habits generally revolting. His attention can be arrested only with great difficulty, and then so momentarily as to elicit no rational reply." The more significant features of his case were as follows:—"Extreme emotional disturbance, manifested by frequent weeping or fits of the wildest terror, in which he shrieked wildly, trembled in his limbs, and indicated by his gestures the presence of hallucinations of special senses. His whole demeanour was indicative of intense suspicion, occasionally manifested by violent aggressive conduct. On physical examination it was noted that his pupils were equal, sluggish in action, and not contracted. His tongue was moist, protruded straight and steadily. There was a profuse flow of saliva from the mouth. Respiratory and circulatory systems were normal. The pulse 92 and soft. Ten days after admission he was still incoherent; sleep could be obtained only upon the administration of chloral. He required feeding by the funnel. There was retention of urine necessitating catheterism. He was at this period taking

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drachm doses of bromide of potassium twice daily. This state of matters continued unchanged until a month after his admission, when his excitement suddenly disappeared and he became torpid, apathetic, and extremely feeble. His gait was tottering, nor could he walk unsupported. His skin was cool, being usually about 99°. His breathing natural, but pulse slightly quickened. He took food regularly. His face was flushed. For a couple of days he remained in an utterly prostrate condition, lying motionless in bed, making no response to questions, but not comatose. There was diminished sensibility over right side of body, most marked, however, in the arm. He remained thus for a week, gradually developed symptoms of hypostatic pneumonia, and sank five weeks after admission.

The following is an abstract from the post-mortem records:—

"The skull somewhat thick, of normal density, sinuses contain dark clotted blood. There is considerable wasting over all the lobes, especially the occipital. The membranes strip with difficulty, but nowhere is the cortex torn on their removal. There is slight opacity over the frontal and parietal regions. The pia mater is tough, thick, and congested, of a deep bluish appearance. The whole brain weighs 1461 grammes. The grey matter is rather thin. There is a distinct mottled congestion of the white matter, but with this exception nothing abnormal was presented in the naked eye examination of the cortical or medullary regions. There was no special focus of softening throughout the hemispheres, and the ganglia at the base were healthy. Three ounces of fluid escaped on removal of the brain. Microscopic examination revealed a condition of disseminated sclerosis of the white matter. The patches of sclerosis were very numerous and in constant connection with the vessels. There was abundant proliferation of the nuclei along the course of the vessels, and deposits of hæmatoidin crystals in the sheaths. The grey matter was unaffected, the nerve cells appeared normal, but the sclerosed patches extended up through the medullary strands as far as the spindle-cell or deepest layer of the cortex."

A Peculiar Case of Melancholia, with Cancerous Tumour of the Middle Lobe of Brain, Disease of Kidneys, Liver, Pylorus, &c. By T. S. Clouston, M.D.

Specimen shown at Edinburgh Quarterly Meeting.

History.—A. B., æt. 58, a lady of good education, cheerful and frank disposition, domestic and industrious habits, who had enjoyed good health, and had a family of several children. Temperament not neurotic. No hereditary predisposition to insanity. Predisposing cause of attack seemed to be domestic anxiety and a sudden alarm of fire. Had been falling off in flesh, appetite, and