cal; and that the physical is known to us only through the psychical.

As Huxley said, "the speculative game is drawn; let us get to work."

(1) Read at the Quarterly Meeting of the Medico-Psychological Association, in London, November 16th, 1905.—(2) In every case of insanity there is a negative lesion causing sensory or motor paralysis (Hughlings Jackson).

Multiple Lipomata in General Paralysis. By CONOLLY NORMAN.(1)

THE following case presents certain points of interest. The extreme prominence of pain crises in the beginning is unusual. Suicidal tendencies in general paralysis are sufficiently uncommon to be noteworthy, though they are by no means as uncommon as is generally supposed. The same may be said of delusions of conjugal infidelity. Finally, multiple lipomata occurring in this disease have not, as far as I am aware, attracted the notice of any English author.

CASE 17,391.—Male, æt. 40. Married for some years; two children, æt. respectively 4½ years and 5 months. The man had been manager and part owner of a shop in Dublin. He was said to have been a sober and industrious person. I saw him first in March, 1895, in consultation with Sir Thornley Stoker, who desired my opinion as to whether the case was probably, as he deemed it, one of general paralysis in the tabetic form. I expressed my concurrence in his judgment. The history showed no known taint of insanity in the family. Patient had had syphilis about sixteen years before and believed that he had been thoroughly cured. His wife was healthy and had had no miscarriages, and his children were healthy. The first sign of the existing illness was tremor in the right hand, which appeared about two years ago. In consequence, his writing became gradually worse and worse, until it was wholly illegible. This interfered with the performance of his business. He said that his left hand was not at first affected, but after a time it became as bad as the right. (Possibly the condition was simultaneous in both, but first attracted attention in the right.) Then he began to suffer from agonising attacks of pain in the

region of the bladder, shooting down the urethra into the *glans*. His wife believed at this time that he used to masturbate at night, but it appeared probable that what she thus interpreted were merely *attouchements* produced in the effort to relieve the pain described. I have known a not dissimilar mistake made by those who might have known better than this lady, and an unfortunate lunatic blistered on the prepuce by way of curing him of a "habit" which was but the expression of the fact that the poor wretch was dying of a stone in his bladder.

In the case before us Sir Thornley Stoker, when consulted, at once recognised the existence of bladder crises and found that there were other unmistakable signs of tabes dorsalis—slight ataxy, Rhomberg's phenomenon, lightning pains in the legs, etc. Occasional stomach crises (intense epigastric pain, with vomiting, etc.) occurred later. Mental symptoms were first noticed in January, 1895, when failure of attention, confusion, and loss of memory were added to a certain unreasonableness, which had been till then supposed to be merely the fretfulness of an invalid. He desired to return to his business, for which he was unfit; did sometimes go to his place of business but could attend to nothing, and was liable to wander vaguely away from the house. He had had two "fits" of epileptiform character within the preceding year, and had been unable to speak for some time after each. When I saw him in March he presented well-marked speech trouble of the general paralytic character, well-marked general tremors, and was clearly tabetic. He complained bitterly of bladder pains, and was besides lachrymose and low-spirited. He was very amnesic, not remembering the events of the previous day. He was jealous and suspicious of his wife, without any distinct delusion. About April 10th he had another "fit" (his third), and was speechless after it for about two days, then very restless and rather turbulent. He got steadily worse mentally and developed delusions that his wife was poisoning him. On April 21st he told his wife to put away his razors lest he should commit suicide. In the early morning of the following day (April 22nd) he rushed out of the house, wearing only his night-shirt and calling for an emetic—an antidote to the poison that he said had been administered to him. When he was brought in he seized a table-knife and strove to cut his throat with it. The same day he was admitted to the Richmond Asylum.

On admission.—Fine tremor of the facial muscles. Jerking about naso-labial folds when he speaks. Tongue presents fine tremor. Pupils unequal, left larger; light and sympathetic reflexes gone. Skin of face greasy. Cheeks flaccid and expressionless. Hands tremulous. Ataxic gait. Knee-jerks cannot be obtained. Speech drawling, nasal, slurring, tripping, catching (*i.e.*, typically general paralytic). He is somewhat incoherent, and accuses his wife of poisoning him. Says: "I am poisoned; I am sure it was poison my wife gave me; she did it under the pretence of giving me medicine; do you remember me a little child? What o'clock is it? Oh! Lord, I am sure she has killed me." He also complains of pain in bladder region, of incontinence of urine, and of impotence, attributing the latter to his "wife's unfaithfulness."

When he was examined on admission three tumours of probably lipomatous character were discovered. One lay just over the angle of the left scapula, was circular in outline, about an inch and a half in diameter; another in the left lumbar region, irregularly oval, four inches by three inches; the third on front of right side of chest in the nipple line, the lower edge just above the costal margin, irregularly circular in outline, roughly an inch and a half in diameter. They had all these common characters: they were inconspicuous to the eye, they were freely movable on the subjacent tissue, and the skin was freely movable over them; they were non-fluctuating, soft, and somewhat nodular.

General progress of case.—Tremor and ataxy of upper extremities slowly increased. Loss of co-ordination was more rapid in the legs. Facial and tongue tremor, irregularity of pupils, and peculiar speech engagement continued. His memory was extremely bad; he never knew the day and rarely the season; forgot the events of his life from day to day. He often answered from the point, and occasionally was quite incoherent. He was uneasy about his health in a fatuous way, complaining feebly that he was "diseased." He was also in the habit of complaining of incontinence of urine at a period when this symptom did not exist. He tended to return to the belief that his wife poisoned him, and also that she was unfaithful, though he could give no details or connected account of his reasons, and though when his wife visited him he was most friendly and satisfied with her. He had several attacks

of pain in the bladder region (bladder crises), similar attacks of epigastric pain, with vomiting (stomach crises), and on two occasions attacks of intense pain in the lower bowel, with tenesmus and watery diarrhœa, which I believe to have been rectal crises.

In August, 1895, synovial effusion in both knee-joints appeared without known cause and seemingly suddenly and painlessly. One feared the more familiar form of Charcot's disease, proceeding to destructive changes in the joints, but after about six weeks the effusion, which had been considerable, disappeared rather quickly, leaving the knees apparently normal. Epileptiform seizures occurred in June, when he had three or four in quick succession, in July (one), in August (one), and at the end of December, 1895, when he had two successively. The earlier seizures were followed, after the stupor passed off, by curious aphasic phenomena. Thus he was for some hours, unable to speak at all, then used wrong words or mere gabble, and slowly returned to the use of language. On two occasions while he was in this state I wrote numerals for him or their names and endeavoured to induce him to count. He made an effort to speak but only produced unintelligible sounds. When I spoke aloud the names of the numerals, asking him to repeat them, he had better success, uttering words, sometimes numerals, sometimes other words, but rarely correctly. When, however, I spoke the name of a numeral under ten and held up a corresponding number of fingers he repeated the numeral correctly. After the seizures in December his condition was very much worse. He was very stupid and hard to get to converse. He lost flesh, the arms and legs wasting and the general strength declining rapidly.

For some time after his admission no particular attention was paid to the subcutaneous tumours. It was then found that they had increased in number and had appeared on the abdomen. They were obviously painless, and the patient was unconscious of their presence. They cannot be said to have been symmetrical. In July, 1895, the original tumours had somewhat increased in size and were rather more prominent. About a dozen others had appeared on the back, the sides, and abdomen. These were of various sizes and various degrees of definiteness of outline. Some were firm and almost fibroid in consistence; others were soft, and some had edges so ill-defined

that they appeared to be merely local accumulations of subcutaneous fat without any capsule. As the case went on the tumours rapidly increased in number, giving a curious appearance of stoutness to the trunk, contrasting remarkably with the wasted extremities. They occurred on the front of abdomen, in the lumbar region, all over the chest, back, front, and sides. They did not occur on the face, neck, shoulders, arms, forearms, gluteal or sacral regions, thighs, or legs. They were most visible over the lower portion of the chest, where their uneven prominence gave a curious knobby contour that was very noticeable. Elsewhere they might easily enough have escaped superficial observation. It could not be perceived that they caused inconvenience of any kind.

On April 1st, 1896, the patient had nineteen epileptiform fits. Thereafter he never quite rallied, but lingered till April 28th, when he died, just over a year after admission.

Owing to the opposition of his relatives it was impossible to obtain an autopsy, but an opportunity was taken to secure a portion of one of the smaller and more defined tumours, which was found to present the structure of a lipoma.

Although this case presents, as aforesaid, many somewhat uncommon and interesting points, there is no individual feature which one has not seen before, save the condition of multiple lipomata. The association of this condition with general paralysis is, as far as I am aware, mentioned in only one treatise, the short but admirable work of Magnan and Serieux in the *Aide Memoire* series, where the coincidence is casually referred to. In the casuistry of general paralysis I am aware of but one pertinent case, described by Targowla in the *Annales Médico-Psychologiques* for the year 1891 ("Lipomes Symétriques Multiples chez un Paralytique Générale"). Targowla, while alluding to the occurrence of lipomata in tabes dorsalis, seems to regard the combination as hitherto unobserved in general paralysis. His patient is not noted as belonging to the special tabetic form of general paralysis. The mental troubles displayed were chiefly general mental enfeeblement, loss of memory, and vague notions of persecution. Inequality of pupils, tremors of tongue, and speech peculiarities were the leading physical signs. Diagnosis of general paralysis was made by Magnan, Marandon de Montiyel, and others. The patient was alive when the description was written. The lipomata were symmetrical, and

were found in the zygomatic, submaxillary, mastoid, clavicular, deltoid, and sacral regions on both sides of the body, as in my case; some were diffuse, some circumscribed, but all evidently of the same essential nature. Targowla inclines to associate this condition with the tropho-neurotic conditions occurring so frequently in tabes dorsalis and sometimes in general paralysis. Its occurrence, in the example just described, in combination with general paralysis and well-marked tabes seems to point in the same direction. The explanation, to be sure, is not very complete, and may be merely a re-statement of our ignorance.

In concluding my observations upon this case, I must thank my friend Sir Thornley Stoker for giving me an opportunity of seeing the patient before he came into my asylum, and also for kindly giving me some valuable notes of the patient's condition during the short period when the latter had been under his care. I have further to thank my friend and former colleague Dr. D. F. Rambaut, now Medical Superintendent of the Shrewsbury Asylum, for some case-book notes, on which I have drawn in the above description.

Since the date when the above case was under notice I have seen a case which recalled it to my mind. A patient was introduced to me by my friend Dr. Travers Smith with a view to obtaining my opinion as to whether the case was one of general paralysis. There was slight involvement of speech. The patient presented vague neurasthenic symptoms, and was extremely hypochondriacal, without distinct delusion. There was a history of losses of consciousness of brief duration, without convulsion as far as could be ascertained. Patient was an army reservist, æt. 36. He denied syphilis, but he was quite untrustworthy in other matters, so that no value can be attached to this denial. I formed the opinion that he was probably suffering from early general paralysis of a somewhat unusual type. He was subsequently sent to a county asylum, whence he was discharged to his wife's care in a few months. He was a patient under my care in the Richmond Asylum from February 6th, 1905, to May 19th, 1905. To the somewhat indefinite symptoms which he had presented when I saw him before there were now added suspicions as to his wife's fidelity. Nevertheless his wife removed him from the asylum. During his stay his essential symptoms were stationary, though he gained

sufficient self-control to make him say that his suspicions of his wife were groundless. This man presented a number of small, subcutaneous, painless tumours, which were apparently lipomata. One occurred on the front of the left thigh, one on the left flank, one on the outside of the left arm, one on the inside of the left arm, one on the inside of the left elbow, and one on the inside of the left forearm. They did not appear to increase in size while he was under my observation, and Dr. Travers Smith had drawn my attention to them about two years before. At the latter date the patient said they had come on while he was serving in South Africa, a couple of years earlier.

There is probably some connection between the nervous trouble in this case—be it general paralysis or not—and the existence of lipomata. Less close, perhaps, but still probably existent, is a similar connection in the case of a patient whose case has been communicated to me by Sir Thornley Stoker. This patient, an elderly lady, wife of a barrister, sustained surgical injuries in a motor accident. On examination she was found to suffer from numerous painless lipomata of old standing on the arms, legs, and trunk. She is a person of bad nervous heredity, two of her sisters and one of her daughters having been insane.

The nervous connections of Dercum's disease have, of course, been pointed out.

(1) Read at Irish Divisional Meeting, July 6th, 1905.

Discussion

Dr. Leeper said that he had a case of typical general paralysis which about two months ago developed a series of cutaneous tumours, first on the clavicle, and then all over the body, which broke down into ulcers. There was a syphilitic history, and the patient got well as regarded the cutaneous lesions after a week or two of treatment with biniodide. Could the lipomata have any bearing on subcutaneous gumma?

Dr. Drapes asked if Dr. Norman meant that general paralytics were more subject to lipomata than sane persons. He had himself had a case of general paralysis who suffered from multiple adenomata, but had regarded this as merely a coincidence.

Dr. Fitzgerald, speaking of general paralysis at large, inquired whether it was Dr. Norman's experience that melancholic symptoms are commoner in females than in males suffering from that disease. He also mentioned the case of a general paralytic in his practice, suffering from urinary incontinence, who suddenly regained control of his bladder and never lost it again.

Dr. Norman, replying, said that he did not think that Dr. Leeper's case had any bearing on that described by him, in which the tumours were true lipomata. He had not seen any other case of lipoma in general paralysis, but Magnan and Serieux mentioned lipomata as a tropho-neurosis of the disease, and others as

occurring in tabes. It was said that melancholic symptoms were commoner in females, but he himself had met with them oftener in men. One general paralytic had tried to hang himself, but no general paralytic woman had attempted suicide in his experience. Female cases were often quietly weak-minded. He had had several cases of general paralysis in which the control of the bladder had been regained.

Some Clinical Notes upon Urine-Testing and Results.[1]

By ROBERT JONES, M.D.

THIS fragmentary paper is to suggest rather than to inform. It is a bedside analysis of the urine in 969 female patients consecutively admitted into Claybury Asylum, and the notes cover a period of several years. Although the facts are many, the deductions are few, and although possibly nothing new is related, yet these notes involve an extensive collection of common details, and there has been some labour undertaken to present them. The summary may, I venture to hope, serve as an incentive to others to contribute more detailed statistics upon an aspect of mental diseases which is at present much talked of and much written about, *viz.*, the relation of insanity to auto-intoxication and its dependence upon changed metabolism, particularly in an alteration through this changed metabolism of the normal functions of the kidneys, and I propose to run somewhat rapidly through the following headings. And first as to—

(1) *Quantity.*—The amount of urine secreted in each case during the twenty-four hours has not been noted, and therefore I will make no statement whether, as is asserted, there may be any greater amount of urine passed in cases of mania than in cases of the depressed form of insanity, attributed as it is to the relatively greater activity of the metabolic (or the katabolic) process believed to occur in this form.

(2) *Colour.*—Again, although no tint test has been used, the impression gained by the record is that the colour of the urine is darker in the insane upon their admission into the asylum, when the mental condition is somewhat acute, than it is in normal persons. It must be remembered, however, that the tint of the urine fluctuates widely, even in health, and that this depends not only upon the degree of dilution but also upon the

https://doi.org/10.1192/bjp.52.216.62 Published online by Cambridge University Press