the slightest tingling of pain. It is skin, luxuriant, healthy, extremely vascular, with its cellular substance loosened and evolved, so as to give a doughy feeling when the whole tumour is handled. . . .

"When she travels about on her begging excursions she carries her tumour in a sling made of an old tablecloth, as a sower of corn carries the seed in the bag before him. When she sits down, opens her cloak, and unfolds this disgusting and horrible tumour, you can hardly be persuaded that you do not see her belly open and her bowels in motion, for the rolls of skin, fleshy and red, roll over each other as she handles them, and the slightest handling at one fold of the tumour puts the whole into this vermicular kind of motion. The whole volume would roll over her knees but that she contains it in her lap by putting one or both her arms round it."

Two Cases of Abnormal Development of the Scalp. By John J. Cowan, M.B., C.M., Assistant Medical Officer, Roxburgh District Asylum, Melrose. (With Plate.)

(By Permission of Dr. J. Carlyle Johnstone.)

The two cases here noted and illustrated were referred to by Dr. McDowall, Morpeth, in his communication to this Journal of 1st January, 1893. One of the cases shows considerable resemblance to his.

Case I.—P. G., aged 39 years, was admitted into this asylum a year ago. He is a genetous and paralytic idiot. There is no direct hereditary predisposition to insanity; but his mother and brothers are distinctly neurotic.

The patient is an enormously stout, broad-shouldered man. He measures 50 inches round the chest, 14 inches round the arm over the biceps (at rest), 19 inches round the mid-thigh, and 12 inches round the calf, which is atrophied and wasted. His weight is 16 stone 5½lbs. He has never been able to walk, as he suffers from congenital double talipes egrino-varus. His mode of locomotion, when he is called upon to use it, is dragging himself along on his knees by means of his large and powerful arms. Estimating his height it should be over 6ft. (his brothers, one of whom is younger than him, are very tall and stout). His cranial development is notably small in proportion to his face and body generally; fore-

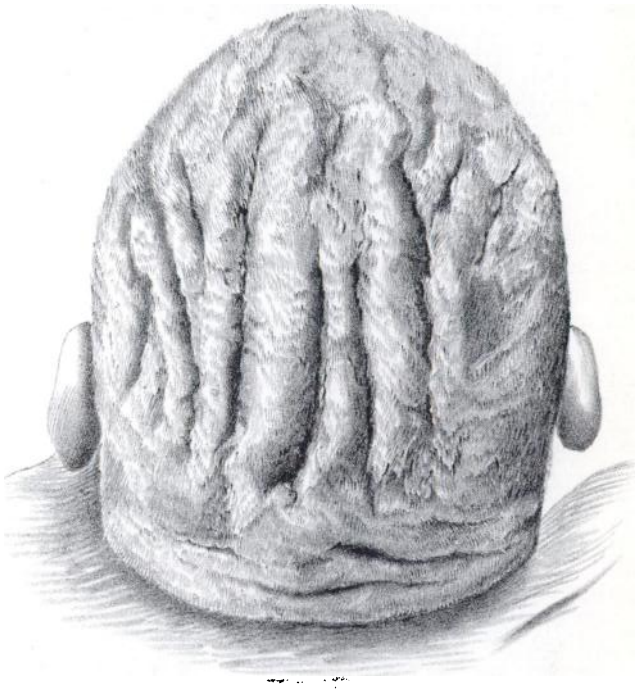
head sloping,* cranium oxycephalic. He is not, however, microcephalic. The cranial measurements are given later along with those of Case II. He suffers from alternating squint. The palate is broad and rather highly arched, teeth not crowded, fairly healthy and regular. His body organs are healthy, save that the circulation is weak, chiefly owing to his corpulence. In his movements he is clumsy and awkward; he has the paralysis above named, the legs being wasted and feet deformed; but there is no arrested development. The sense of touch and hearing are fairly acute, but sight, taste, and smell are sluggish. Superficial reflexes are exaggerated; knee-jerks much dulled.

On looking at the scalp one notices at once that it is abnormally lax and redundant, and can even be plucked up; its surface is irregular and furrowed. The hair generally is thin and fine; in the furrows, however, it grows quite thickly; on the crown of the head the hair is scanty and the scalp becomes smoother, the furrows being more shallow. The furrows are thirteen in number, ten of which run antero-posteriorly; these are roughly symmetrical, there being five on each side. The remaining three are transverse in direction and situated at the back of the head. The two central antero-posterior furrows commence three inches above the external occipital protuberance, and run forwards, that on the left side for $1\frac{1}{4}$ inches, and that on the right side for five inches, becoming more shallow as it nears the forehead. On either side of these central furrows, at intervals varying from $1\frac{1}{4}$in. to $\frac{3}{4}$in., run the other four antero-posterior furrows; these are more curved in shape and more irregular, and reach farther anteriorly. In length they vary from $2\frac{1}{4}$in. to $4\frac{5}{8}$in. The depth of the furrows varies from $\frac{1}{8}$in. to $\frac{1}{4}$in. There is also a short and shallow furrow about $1\frac{1}{4}$in. long, running back from the junction of the skin of the forehead with the hairy scalp on either side to the inner side of and behind the ill-marked frontal eminences. This furrow runs in between the diverging second and third furrows. On the left side of the head the antero-posterior furrows are markedly more shallow and ill-defined, the scalp being less redundant.

In the occipital region run the transverse furrows, which are long and deep, and quite unaffected by the position of the head, even if craned forwards. Beginning at the uppermost, they measure in length, respectively, $3\frac{3}{4}$in., $6\frac{1}{2}$in., and 3in.; in depth, $\frac{1}{4}$in., $\frac{3}{8}$in., and $\frac{1}{8}$in. The highest runs transversely, with a slight inclination upwards on the right side at a level of $1\frac{3}{4}$in. above the external occipital protuberance; the other two run $1\frac{1}{4}$in. and 2in. below this. The two upper ones are deepest and best marked on the right side. Beyond rendering the furrows slightly more

* His profile resembles remarkably that of Antonia Grandoni, a microcephalic idiot portrayed in Dr. Ireland's book "Idiocy and Imbecility," p. 104, with the exceptions that his forehead slopes rather more and the scalp is furrowed. See also "Dict. of Psych.-Med." Art. "Microcephaly."

Case I. P.G.



Case II. J.M.

Two Cases of Abnormal Development of the Scalp.

prominent, the occipito-frontalis muscle has no action on them. Electricity gives negative results.

Mentally, P. G. has about the same amount of intelligence as a child who has just begun to speak. He is very observant of all that goes on round him. The voice is high pitched and babyish. The slightest trifle amuses him and makes him chuckle, crow, and swing himself to and fro in his chair with delight, and he calls to his friends to share his amusement. He has many childish ways, *e.g.*, hangs out his tongue when performing actions which to him are difficult, but he also has a way of letting it hang out as if it were more comfortable out than in. He puckers and contorts his face; is fond of babyish tricks, such as making noises with his mouth; is very imitative and often parrotlike; he repeats words and phrases (usually acquiring those least desirable) without knowing their meaning. Owing to his imitativeness, his tone of voice has altered considerably since his admission, and resembles in certain words that of his attendants or fellow patients. His articulation is badly performed; notably, he avoids all labials, *e.g.*, "henny" for "penny"; his vocabulary is limited to the names of a few familiar animals and a few simple adjectives and expletives and objects. Like a child also, he has words of his own construction to express objects or actions. He exhibits great motor restlessness, is always doing something, chattering, singing, pretending to read, playing with his toy fiddle, making remarks on what he sees; by way of amusement also, he has a habit of grinding his teeth. As a rule he is in the best of tempers and spirits, but now and again, on being teased, in a moment he gets very angry and tries to strike, or spits. Once, when in a rage, he threw a hatchet at some children (formerly he used to chop sticks). He has a notion of right and wrong. In habits he is clean and tidy, and able to indicate his wants. Since his admission he has shown educability and has considerably added to his vocabulary and general knowledge.

Case II.—J. M., aged 41 years, was admitted 12 years ago. His mother was insane, and a patient here for a short time. No other particulars known about him. This patient also is a genetous and paralytic idiot, but of a much more degraded type. He suffers from paralysis of the right arm and withering of the forearm and hand, with wrist drop; the right leg is weaker than the left, and drags slightly in walking; the feet are ill-formed, broad, and shortened antero-posteriorly. His cranial development is small, but not so visibly out of proportion to the features and rest of the body as in P. G.; cranium is round and bullet-shaped; features coarse and irregular; palate narrow and highly arched; teeth badly formed and rather crowded; lips thick, coarse, and everted, allowing the saliva to dribble out. He has a squint of the right eye due to a corneal opacity following an injury. He has a considerable stoop in the shoulders; if straight, would be about

5ft. 6in. in height. His weight is 10st. 9½lbs. Chest ill-formed, owing to stoop; circulation feeble. Motion is sluggish, gait clumsy and shuffling. Sense of touch is acute, but the other senses are dull. Superficial reflex action is exaggerated, especially on the right side; knee-jerks exaggerated on right side.

The hair is very thick generally, but is thinner over the crown of the head, where the scalp is less furrowed. The scalp is not so lax and mobile as in Case I., but still is abnormally so. The furrows, which in their situation and disposition resemble Case I. remarkably, run both antero-posteriorly and transversely; but they are more crooked and irregular, and their continuity is interrupted in places. The antero-posterior furrows are thirteen in number, six on each side, which are roughly symmetrical, and a short one on the left side. The two central antero-posterior furrows commence about the same site as in Case I., but are more equal in length, and extend forwards to near the forehead; they are more wavy in the outline and more shallow over the crown. On either side of these are the other furrows, varying in length from 4-8in., disposed much as in P. G's. case. The average depth of the furrows is somewhat less than in Case I. There are two transverse furrows in the occipital region, both best developed, and deeper on the right side. The upper commences in a curious depression, $\frac{3}{8}$in. deep, about 1½in. above the exterior occipital protuberance; it seems to penetrate through the bone partly. The furrow runs downwards to the left, its continuity being interrupted for about 1¼in.; on the right side it runs down for 2¼in. to within 3¼in. of the right mastoid process. The lower transverse furrow runs 1½in. below the upper for a length of 2⅝in., two-thirds of it being on the right side. This furrow is much shallower than the upper one. The occipito-frontalis muscle is extremely well developed, and is constantly in use, but has no action in either obliterating or deepening the folds. On tickling the skin of the neck behind, the two central pairs of furrows were seen distinctly to be drawn together and deepened. This movement was probably involuntary, for it has only been obtained twice and at considerable intervals; one cannot obtain it at will nor with electricity.

This patient mentally is quite idiotic, and has very little intelligence. He only knows his attendants; pays no attention to anyone or anything save his food, which he eats like an animal; is quite harmless, inoffensive, and stupid; but is irritable, and resents interference, especially from strangers. He speaks in a half-articulate mumbling manner; his vocabulary is practically limited to his own name and two foul words which he has picked up. When pleased and happy he bursts into guffaws of idiotic laughter; or he howls by way of agony. As in P. G., there is considerable motor restlessness, and he is never at rest save when asleep. He requires to have everything done for him save feed-

ing, and in habits is dirty; is addicted to masturbation. Although he has been here a long time, and many attempts have been made to educate him in habits, etc., he has not responded to the efforts made, and remains the helpless, degraded idiot he was on admission.

Cranial Measurements.	P. G.	J. M.
	inches.	inches.
Circumference	21½	21
From root of nose to occipital protuberance, over vertex ...	11 7/16	11⅜
do. do. do., on right side ...	10¾	10½
do. do. do., on left side ...	10½	10½
do. do. do., calliper ...	7 3/16	7 3/16
From ear to ear, over vertex	11	10½
do. do., calliper	5½	5 5/16

On the Possible Use of Sulphonal as a Means of Inducing Insane Patients who Refuse Food to Eat Voluntarily. By Dr. Brough, LL.B., L.R.C.P.Ed., etc., Assistant Physician, Argyle and Bute Asylum, Lochgilphead.

It is unnecessary to remind those to whom the practical care and management of the insane are entrusted how disagreeable and painful it is, not merely to the patient, but also to the operator, to be obliged to resort to forcible feeding, and any safe drug which will obviate to any extent this necessity will be welcomed.

As our experience in this asylum during the past six months has led us to believe that sulphonal may, at all events in some cases, have the desired effect, I have considered myself justified in communicating this paper, and by the kind permission of Dr. John Cameron, Medical Superintendent, I send notes of our cases.

During the period mentioned, only five of the 400 patients in this asylum have actually required to be fed forcibly, and in each of these cases the use of sulphonal has been followed by voluntary eating on the part of the patient. It is at present premature to say that the sulphonal was the *cause* of

the resumption of voluntary eating, and we can only point to the fact that after it had been administered each patient began to take food of his own accord, the sudden change of demeanour being very striking in the persistent and intractable cases referred to.

No markedly evil effects have been recorded as following the use of sulphonal for long periods, and even if some detriment may result from its long-continued administration nothing yet known suggests that this is likely to exceed the admitted evils of forcible feeding, especially when the liability to septic pneumonia is borne in mind.

This letter is written merely in the hope that those who have more extensive opportunities of observation will give the drug a fair trial in cases of this class.

It would not be proper to go into the cases at length, and so I merely send notes indicating their nature, and shall be happy to give more detailed information to anyone who may desire it.

Case I.—D. B., male, aged 38. Melancholia with strong suicidal tendencies. Patient, a very respectable man, who bore an excellent character, thinks that he has offended the Almighty beyond forgiveness, and has always given as a reason for refusing food that he is "a devil in wickedness, and that as such he has no right to eat, and that he only further offends and defies God by so doing." Patient was admitted in August, 1892. On 27th November he refused food, and had to be fed with the stomach pump. Forcible feeding twice a day had to be continued until 21st December. On the evening of 20th December, the patient having been sleepless and restless, 50 grs. sulphonal were given. On 21st he was quiet and somewhat sleepy, but towards evening he took some tea and toast voluntarily. On 22nd the effects of the sulphonal had apparently worn off. He refused to take breakfast, but at mid-day, after much persuasion, he was induced to take an egg, some meat, and toast. He refused positively to eat anything that evening, and on the following day forcible feeding had to be resumed, and was continued regularly until 31st December. On 30th, owing to sleeplessness and excitement, 40 grs. sulphonal had been given. On the morning of 31st he had to be fed by the pump, but he voluntarily took dinner and tea. The use of sulphonal was continued all through January, the patient continuing to take his food regularly of his own accord during the time. On the 31st January, however, the drug was discontinued, as the patient had become somewhat somnolent and lethargic. On 7th February forcible feeding had again to be resorted to, the patient refusing food and having been very irregular in his eating for two or three days, sometimes missing one meal altogether, and at other times taking an insufficient quantity. From this time forcible

feeding with the pump was continued regularly twice a day until 25th February. On 26th February, although the patient was not showing excitement and was not sleepless, it was considered desirable, in view of what we had seen in this and other cases, to try the effect of sulphonal on the refusal to eat, and accordingly 40 grs. were given at bed time, and 40 grs. more on the morning of 26th. Patient on that day ate his dinner of his own accord, and has continued to take his food voluntarily ever since; sulphonal, in doses varying from 30 to 40 grs., according to his state, being given every morning two hours before breakfast. This quantity of sulphonal does not cause sleep during the day.

Case II.—J. McA., male, aged 46; admitted October, 1891. Melancholia with marked suicidal tendencies. From the time of his admission this patient declined food, and had to be fed by the stomach pump almost continuously. He would, for instance, have to be fed forcibly for ten days or so, then he would take food voluntarily for a day or two, and then forcible feeding would have to be resumed again, and so on. The alleged cause of refusal to eat was that all food given him "contained filth." Patient, who was then being forcibly fed, was owing to excitement and sleeplessness given 40 grs. sulphonal on 25th January last, and a like dose on the morning of 26th January. On the evening of the latter day he took his tea voluntarily. Sulphonal was continued daily until 2nd February, and patient during that time and until 4th February continued to take his food regularly. On the last-named day he again refused to take food, and forcible feeding had to be resumed, and was continued until 12th February. On the morning of that day 40 grs. of sulphonal had been given, and in the evening he took his tea. Sulphonal, in doses of about 30 grains, has been given him daily ever since, and the patient has ever since continued to take his food voluntarily.

Case III.—C. McE., female, aged 50. Melancholia with very strong and most persistent suicidal tendencies. This patient had made several very determined attempts to destroy herself, and believes that she on one occasion succeeded in so doing, and that she is now in hell undergoing torment. As she was very restless and excited, sulphonal had been administered to her daily for some considerable time in doses varying from 15 to 26 grs. During the months December, January, February, and March the administration of the drug was stopped for a period of a few days on five different occasions, the patient having shown cataleptiform signs and some stupor. On each of these five occasions, after the drug had been stopped for a day or two, the patient refused her food, and forcible feeding with a spoon had to be resorted to, but as soon as the administration of the drug was resumed, she again, in a day or two, on each occasion, began to eat voluntarily, and continued to do so until the drug had been again stopped.

Case IV.—A. McL., male, aged 69. Melancholia. Always thinks that he is about to be tortured by someone, and also that

his soul will be eternally lost unless he can secure the "Book of Life," for which he is constantly searching. Doubtful whether suicidal. Refused food in February, and was forcibly fed with the stomach pump for two days. On the morning of the second day 50 grs. of sulphonal were given, and he took his tea in the evening. The sulphonal was continued for some days, and the patient continued to eat. On a subsequent occasion in March he became disinclined to take food, but by persuasion he was induced to take a small quantity. Sulphonal in 50 gr. doses was given as soon as the disinclination appeared, and this passed off on the following day, the patient voluntarily eating with apparently good appetite. The drug was continued for several days.

Case V.—N. S., male, aged 26. Melancholia with hallucinations of hearing. Hears voices telling him "to be good," and to "do penance by not eating." This patient had to be forcibly fed for three days in February and for two days in March. On each occasion sulphonal in 50 gr. doses was given, and on the day following its administration the patient resumed voluntary eating. The sulphonal in diminished doses was continued on each occasion for several days after the patient had commenced to eat.

The last two cases do not prove much, for the refusal to take food had not been long continued and persistent as in the other cases, and might have ceased apart from the use of the drug, but so far as they go they tend to confirm the other cases.

Two Cases of Pachymeningitis Hæmorrhagica Interna. By Hubert C. Bristowe, M.D.Lond., Second Assistant Medical Officer, Somerset and Bath County Asylum, Wells.

Through the kindness of Dr. Wade, I am permitted to publish two cases of pachymeningitis hæmorrhagica interna which recently died in the Somerset and Bath Asylum. The first case was of a fairly common type, whereas the second presented some very unusual appearances. Both seem worthy of record, and suggest the question—Were they due to hæmorrhage?

The patients were men past the prime of life, who suffered from the usual symptoms of general paralysis. The duration of the first case was about one year; that of the second four or five years. I regret that I saw neither case in its earlier stages, and also that in neither was a complete history to be obtained.

Case I.—T. J., æt. 44, married, labourer. Admitted December