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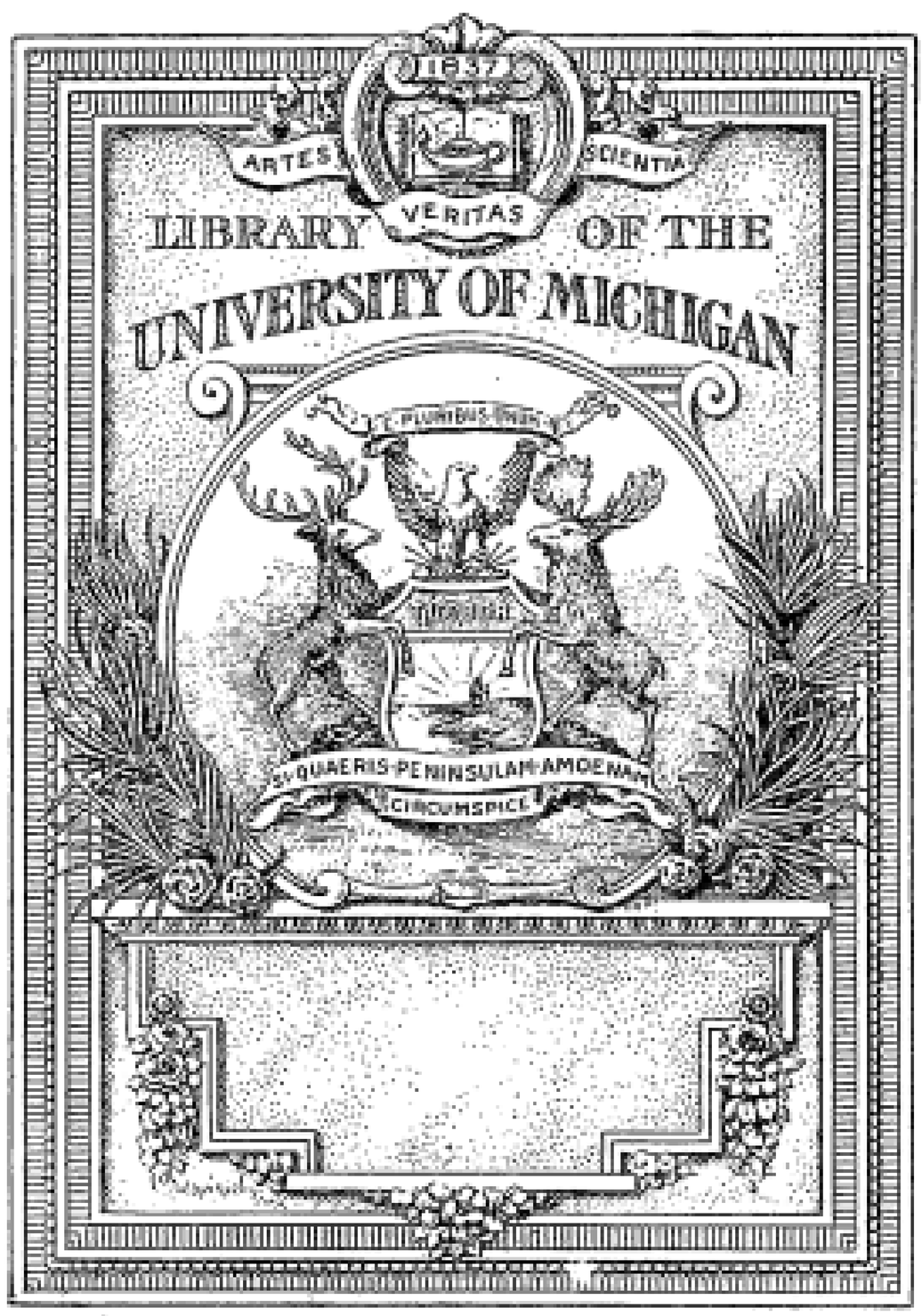

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THE

ALIENIST AND NEUROLOGIST

A QUARTERLY JOURNAL

—OF—

SCIENTIFIC, CLINICAL AND FORENSIC

Psychiatry and Neurology.

Intended especially to subserve the wants of the General Practitioner of Medicine.

"Quantam ego quidem video motus morbosi fere omnes a motibus in systemate nervorum ita pendent, ut morbi fere omnes quodammodo Nervosi dici queant."—*Cullen's Nosology: Book II., p.* 181—*Edinburgh Ed.* 1780.

VOLUME IV.

—EDITED BY—

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And an associate corps of collaborators.

ST. LOUIS, MO.:

EV. E. CARRERAS, STEAM PRINTER, PUBLISHER AND BINDER.

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THE
ALIENIST & NEUROLOGIST.

Vol. IV. JANUARY, 1883. No. 1.

ORIGINAL CONTRIBUTIONS AND PREFERRED TRANSLATIONS.

Bilateral Secondary Descending Sclerosis and Atrophy, mainly of Pons Varolii and Medulla Oblongata; Slight Diffuse Myelitis.

By WM. JULIUS MICKLE, M. D., M. R. C. P.,

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UNILATERAL secondary descending fasciculated sclerosis of the pyramidal tracts is, not infrequent, consecutively to certain cerebral lesions. It courses downwards through the basis of the crus cerebri through the pons and medulla oblongata, and mainly accompanies the decussation of the pyramidal columns of the latter into the post-lateral columns of the opposite side of the cord, but usually also, to a slight extent, takes on a direct distribution in the median segment of the anterior column of the same side. It supervenes in certain cases of hemiplegia, and its chief clinical manifestations are a rigid contracture, distortion and marked paralysis of the limbs of the affected side, to which also an exaggeration of the tendon-reflexes may in some cases be added.

This condition is almost invariably unilateral, the primary encephalic lesions capable of originating it being almost always unilateral. Bilateral it may be, if it is consecutive to certain considerable destructive lesions of

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the pons, or oblong medulla, or spinal cord. Bilateral, also, the sclerosis usually is in a very different affection —namely, *primary* lateral spinal sclerosis.

But even the secondary form of cerebral origin may also, though rarely, be bilateral; and in what follows reference is made solely to cases in which bilateral and similarly situated cerebral lesions have given origin to double descending atrophy and sclerosis equally developed, or nearly so, on the two sides, and symmetrically situate in the crura cerebri, pons Varolii, medulla oblongata and spinal cord. And of these, attention will be limited to the examples in which the pons and medulla oblongata mainly suffer, and in which the spinal changes are comparatively moderate and diffuse.

These cases, no doubt, are rare; for it seldom happens that bilateral local cerebral lesions are of sufficient extent, and so situated, as to cause well-marked, symmetrical, and nearly equal, secondary sclerosis descending on each side. Ere this can occur certain strands of fibres passing from the pyramids of the oblong medulla through the crura cerebri and internal capsule—or their upward continuations, apparently must suffer symmetrically from decisive lesion.

Where this bilateral form of the atrophy and sclerosis chiefly and severely affects the pons Varolii and medulla oblongata, but also the cord in some degree (although here the change is more diffuse), it appears, judging by the case related below, that a group of symptoms arises which is distinct from the symptom-group attending primary or idiopathic lateral sclerosis of the cord, as described by Dr. W. H. Erb and others, and also from the symptoms attending ordinary paraplegia, as well as from those found in locomotor ataxy.

Although, during the earlier periods, at least, the clinical differences between the two affections are marked, yet in its ultimate course the tendency here perhaps would be for the locomotor and other symptoms to become those found in primary lateral spinal sclerosis.

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But this is not certain, inasmuch as symptoms like these latter may occur without the said sclerosis, and the sclerosis without some of the symptoms in question.

It is worthy of note, too, that in the case to be related the lesion itself was rather an atrophy, with shrinking and disappearance of the affected nerve-elements, and some induration which tended to diffuse itself, than an ordinary gray degeneration and strictly systematic encephalitis or myelitis. Also, that certain cranial nerves had undergone atrophy and induration, apparently as the result of a chronic descending neuritis. Also, that the atrophy and sclerosis descending from the internal capsule mainly affected the pons Varolii and medulla oblongata; the lateral columns of the cord not suffering in any extreme degree, and the posterior sharing in the undue firmness; while the only alteration in color of the cord was the somewhat increased pallor and whiteness of the several columns. Clinically, the affection of the lateral and posterior columns would tend to partially neutralize each other.

SYMPTOMS.—To describe the symptoms in detail:

Earlier periods. The gait is slow, unsteady, somewhat shuffling, and has a rather jerking, springy appearance. The heels are in some measure brought down first, although not in the highly marked manner usual in locomotor ataxy. At each step, also, the lower limb is planted in a heavy and clumsy manner, and with a quaking and shakiness simultaneously due to quivering, jerking, flexion and extension movements at the knee-joint, as if it was loose. There is now no marked tactile anæsthesia or analgesia of the legs. The reaction to tickling impressions on the soles of the feet is somewhat lessened. The patient does not sway or fall on closing the eyes, and, indeed, he can walk blindfolded. There is an occasional hesitation in speech, and even quasi-stammering, especially when speech is commenced.

Later on, the gait is shaky and unsafe; the toes are somewhat turned out, the heels brought down, and the

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feet planted jerkily and convulsively. As the patient walks (but not when he is at rest), the arms are at times held stiffly, and a little from the sides of the trunk, and the fingers rigidly extended, separated and bent back at the first phalangeal joint. And at this period, on standing with feet together and closing the eyes, the patient sways and inclines to fall, and soon violent tremblings and shakings of the whole frame come on.

And later still, in walking at times the legs are bent forward, but the trunk bent backward. In its more marked degrees this produces a strange distortion of the frame either in standing or in walking; the legs and knees being bent forward, and the latter brought nearer to the ground, the thighs and trunk being bent much backward, the head a little forward, and the posture being that of one about to fall backwards upon the scapulæ; as, indeed, the patient would sometimes fall if not prevented. In walking the heels are still planted first, and the toes are more or less turned out; nevertheless, the latter at times scrape the floor slightly. The steps are still shaky, and after taking each one the limb is convulsively shaken backward and forward at the knee-joint.

After standing awhile, the body becomes tremulous and shaky all over.

In the feet, tactile sensibility is now slightly impaired, but there is great failure in their sensibility to thermic impressions. Reflex action in them (as to pinching, touch, tickling,) is also lessened. Patellar tendon-reflex is present, even well-marked; no ankle-clonus is found.

In prehensile movement, the fingers are extended and separated widely and the act is slow, uncertain and accomplished after slow approaches.

Speech is now pausing, hesitating and spasmodic; *i. e.* there is an occasional long pause, a slowness to reply and a spasmodic speech-effort during the pause; after which comes a rapid, clear, fluent rush of words until interrupted by another quasi-stammering.

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The affection of locomotion fluctuates considerably. Intercurrent attacks occur in which there are increased motor helplessness, numbness and loss of power in lower limbs, with momentary loss of consciousness, vertigo and temporary ocular paralysis causing strabismus.

In the case below, the patient died with cerebral symptoms which came on at a time when walking was still accomplished.

Differential Diagnosis.

1. *From the gait and other symptoms of locomotor ataxy.*

The condition above described must be distinguished from locomoter ataxy:—

By the presence of well-marked patellar tendon-reflex.

By the failure of thermic sensibility in the legs and hands.

By the absence until very late, and then the slightness of any ordinary cutaneous anæsthesia of the feet and of any decided increase of impairment of equilibration, and of locomotion on closure of the eyes.

By the absence of lightning pains and of engirdling sensations.

By the differences between the special and more minute details of the act of walking itself, in the two affections.

2. *From the Spasmodic spinal paralysis and the spastic gait.*

The spastic characters were defective and points of difference, from spasmodic spinal paralysis, obvious. For there was not marked increase of the so-called tendon-reflexes; the toes were turned out, and the heels brought down in walking (instead of the patient getting on the toes); and in the later periods there was a backward leaning and tendency to fall backwards (instead of a forward leaning and a tendency to fall forwards.)

Then, again, on the positive side, the convulsive shaking and jerking at the knee-joint at each step; and on the negative, the absence of spontaneous spasms,

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ankle-clonus and of any permanent contracture, rigidity or distortion of the limbs, were all unlike the features of lateral spinal sclerosis.

REMARKS:—The changes in the calvaria and dura mater in the following case may have been due to a long-past syphilitic pachymeningitis and those in the basal ganglia and corpus callosum, to blocking of arteries affected with syphilitic disease. If so, the prolonged treatment by anti-syphilitic remedies had, for the most part, cleared up the syphilitic morbid processes, and their secondary results alone remained, namely, the wasting of certain nerves, the chronic meningeal changes and the local destructive lesions in the basal ganglia and other parts; while linked thereto, and one remove later, was a consecutive change, occupying the third place in a series of lesions successively dependent upon one another —namely, the descending atrophy and sclerosis of pons Varolii, medulla oblongata and upper part of cord.

The incipient induration of the cord, however, was rather diffused, being observed more or less in all its columns.

CASE.—M. M., Private, 79th regiment, single, æt. 35, service 17 years, partly in India and Ashantee. Admitted Feb. 1, 1876. First attack of mental disease and of four months duration. There was a history of syphilis and of some old injury to the head. He fell in a "fit" on parade, in Nov. 1874; this was followed by hemiplegia and by some affection of speech From these he recovered to a considerable degree, but complained of severe frontal pain; went on furlough, and was found to be insane. He became incoherent, was sometimes restless, noisy and violent and suffered from delusions and hallucinations having reference to personal annoyance, persecution and danger.

On admission: Height, 5 ft. 9 in.; weight, 137 lbs.; appearance, cachectic. The pulse was soft and small. The gait was now heavy and slow; the feet were slightly shuffled along the floor; the grasping power of

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the hands was lessened; the right limbs were the more paretic. A slight scar on the glans marked the site of a sore incurred in 1861–2, and one on the prepuce, that of a sore incurred several years later. In the groin was a bubo-scar; there had been several attacks of gonorrhea. Traces of former tibial periostitis were obvious. This, he said, had afflicted him about eleven years previously and also had been associated with severe frontal pain and cranial tenderness and swellings. For a long period also, there had been cranial pain and tenderness, they still existed both by day and night—the pain dull, heavy, remitting or disappearing for days together; the the tenderness mainly frontal and more marked on the right than on the left side of the head. On the lower face and trunk were cicatrices from acne and brownish stains on the skin of the back and arms. He said the forehead had been hurt during childhood, and the right side of the head in his fall in Nov., 1874, three or four months after which he had paralysis on the right side of the body, lasting four or five months and at that time was unable to speak; "the words were in his head, but he could not get them to come away,"

To return to the state on admission. The patient looked dazed and was easily depressed and fatigued, suffered from extreme impairment of memory and from auditory hallucinations. He also stated that people who had followed him from Ashantee, took away his meat and tobacco, caused the ceilings to flake over him and put gunpowder in his food.

Iodide of iron was ordered: also ammonia and quassia; and afterwards full doses of potassium iodide were added.

Subsequently, many of the delusions and hallucinations passed away, but mental impairment was still pronounced. Speech was deliberate, at times slightly hesitating, with elision or slurring, of syllables and a somewhat explosive utterance. No decided facial or lingual tremor or twitching was observed.

In Nov., 1876; vomiting, hepatic pain, tenderness and

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increased dullness-area; pain over cœcum, ascending colon and splenic flexure of colon. The patient also, was now unusually stupid and dazed, he looked pale, complained of vertigo, was emotional and wept. Cranial pain had ceased. These symptoms passed away but the gait became more impaired than before.

Dec. 1876. Walked in a somewhat jerky, springy manner, the heels also being in some measure brought down first and the right leg planted the more clumsily and shakily. About this period, and later, he was paroxysmally more confused, stupid and helpless and the articulation worse. At times, also, he appeared to have auditory and visual hallucinations and his conversation was often incoherent and fragmentary. At each step a quivering, unsteady flexion and extension movement occurred at the knee-joint, as if it was loose. The heels were somewhat brought down. Yet he could still do the "balance step." The grasping power of the hands was about equal.

In 1877, the gait became more like that of locomotor ataxy, but was distinguished therefrom by the facts that the patient did not sway or fall when the eyes were closed and the feet planted closely together, that he could even walk a little when blindfolded, that there was no apparent anæsthesia and no analgesia of the lower limbs, though their reflex action to tickling of the soles was lessened. The body also was bent backward in walking. The writing was more irregular and erratic than before. Speech was slow, deliberate and somewhat fragmentary and at times there was a confused mumbling. Thus he would begin to speak, would pause, seem about to make explosive utterance and at last articulate utterance would come with a sort of quiet rush; then came a sudden stoppage and finally a drawling and partially broken speech. On the hands, pinches and thermic impressions were appreciated well and thermic and tactile impressions on the feet; the reaction of the latter to tickling was only slight. Incontinence of urine began to be troublesome; the pupils still were sluggish and irregular in shape.

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July: Gait, delusions and hallucinations as at end of 1876.

Sept. 1877. A sudden attack of numbness and loss of power, particularly in the lower limbs, and momentary loss of consciousness, the speech being worse after it. Next day he could walk only unsafely, with the legs much shaken, the toes turned out, the heels brought down and the feet planted jerkily and convulsively, the right limb being rather the worse. On standing and closing the eyes, he now swayed and inclined to fall, and soon violent trembling and shaking of the whole frame came on. As he walked, the arms were held stiffly and a little from the sides, and the fingers were rigidly extended, separated and bent backwards at the first phalangeal joint. Slight left divergent strabismus was present but no ptosis, diploplia or mydriasis. Slight tactile anæsthesia of the feet was evinced and great failure of their sensibility to thermic impressions; reflex action to tickling, etc., was diminished in both, but rather less in the right foot, the one in which sensory failure was the greater. As regards impressions of temperature, he felt the same cold gold pencil case to be "warmer" when applied to the left foot as compared with the right one; and on neither could he distinguish between the same and a warm wooden pencil.

He improved and lost the strabismus. The long occasional pause in speech, the slowness to begin a reply and the preceding speech-effort remained. In grasping an object, the fingers were widely separated and extended, the act was slow, uncertain and accomplished after slow approaches. At each step after the foot was planted, were violent, spasmodic to and fro shakings of the limb, due to flexion and extension movements at the knee-joint. The patient stood unsteadily, swaying backwards, and forwards. Vertigo was complained of. In October, the former quasi-stammering condition of speech was exaggerated; also long words were sometimes slurred or mumbled and with speech were slight tremors of the upper lip and zygomatici. On December 14th, the manual

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grasping dexterity was improved; left pupil the larger, both sluggish. On the 27th, patient weaker; gait worse; swayed much when the eyes were closed. Blisters applied frequently over spine.

1878. At times the legs were bent forward, the trunk bending backwards as if about to fall supine, and even to actual falling, if not prevented. The gait varied from time to time, in degree of defect. Not now wet or dirty. Rambling incoherent ejaculations. Speech as in October, 1877. The skin became drier, duller, more sallow and parchment-like. Later on, he staggered, or stood unsafely, particularly if the eyes were closed. Spasm of muscles of the face and tongue. Caligraphy worse.

May, 1878. Improved. Gait now but little affected by eye-closure. (Blister spine).

Sept., 1878. Ejaculatory, irrelevant, incoherent, imprudent in his replies and remarks. Still stood and walked with legs and knees bent forward, and with thighs and trunk, from the knees upwards, bent backward, as if about to fall on the back of the head, but the head itself being bent slightly forwards; the patient walking with the heels planted first, and the toes, especially the right ones, turned out, the right toes at times scraping the floor. After taking each step the limb still was convulsively shaken backwards and forwards at the knee-joint. Tactile sensibility of the feet and hands was now fair, but their sensibility to thermic impressions was lessened; a cold key and a wooden pencil alike seemed "neither hot nor cold" to him. Patellar tendon-reflex was present in both legs, especially the right. There was no ankle-clonus. Grasp of right hand the weaker. After standing awhile the body became tremulous and shaky all over. Tongue very slightly tremulous, and protruded slightly to the left. Pupils equal, irregular in shape, sluggish, of medium size. Omit the iodides of potassium and iron, and take perchloride of iron and cod liver oil.

March, 1879. Ecthymatous patches over left first

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metacarpo-phalangeal joint; over fronts of thighs, especially of the left; and on the back and inner part of the right calf. Subsequently, boil on lower front part of left thigh, ulcer on dorsal root of right fourth toe.

13th.—Convulsion; enema chloral hydrate. 20th.—Convulsion, followed by slight right hemiplegia; drowsiness. 21st.—Short, shallow respiration, varying much in frequency, 16 to 48; tongue dry and brown; pulse 58; "pain in shoulders;" slight stertor; face flushed; urine free; sluggish, contracted pupils. Attempts to swallow produced violent cough, and he was fed by enemata. Replied fairly well. 22nd.—Same in day; at night 13 epileptiform convulsions (enemata chloral). 23d.—Modified Cheyne-Stokes' respiration; coma; contracted, immobile pupils; imperceptible pulse; face livid; skin rather cold, and of leaden hue generally; occasional twitches about face, especially about the left angle of the mouth. Later, the hands and arms became purplish, and the pauses in respiration became more marked. Death took place on March 24th, 1879.

ABSTRACT OF NECROPSY, 32 hours after death.

Calvaria, of slightly worm-eaten appearance internally, thin, part removed 12 3-4 ozs.

Dura-mater, rusty hue, and filmy formation, on its internal surface in the left temporal region, and slightly, also, in the right, and on the right orbital surface.

Cranial nerves, atrophy of the sixth pair, especially of the left; of the eighth and ninth pairs; of the second (optic) pair, which were small and hard; and doubtful slight atrophy of the portio-dura of the seventh.

Pons Varolii and medulla oblongata pale, atrophied, shrunken, and somewhat indurated on their anterior aspect. This was found on both sides; the anterior surface of the pons Varolii was irregularly sunken longitudinally, being retracted to fill up the place of longitudinal fibres now wasted or destroyed. The anterior pyramids of the medulla oblongata were shrunken; induration of its posterior columns was doubtful.

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Meninges, thickened, stripped off from the brain with undue facility, no adhesions to cortex, pale; their veins contained less blood than usual.

Arachnoid, unduly thickened and dense, its patchy opacity considerable in degree and of customary distribution, on the superior, external, and median aspects of the cerebral hemispheres.

Pia-mater, slightly œdematous, the œdema being distributed in its relative degrees in correspondence with the arachnoidal opacity.

Convolutions, of fair size; *cortex* of fair depth, rather soft, turning of a lilac hue on exposure to the air in the greater part of the extent of its upper aspect, elsewhere pale, as in the cortex of the base and insula, in both of which it is alike on the two sides. Yellowish softening, and brownish-black pigmentation, of gray cortex at left sulcus interparietalis, one-half inch behind the anterior limit of the postero-parietal lobule.

White medullary substance of brain, of fair consistence, *puncta cruenta* small.

Corpus callosum; yellowish softening of its *genu* and adjacent portion.

Lateral and fifth ventricles enlarged, their ependyma as well as that of *the third* and particularly of the *fourth ventricles*, much granulated and of a sanded appearance and feel.

Corpora striata. On the ventricular surface of the left corpus striatum were two patches of softening and atrophy, shrunken, yellowish, each of the surface-area of a sixpence bit; one occupying the anterior tip, the other immediately external to and behind the first and separated from it by a narrow ridge of tissue and extending transversely from the external borders of the candate nucleus to within 1-8 of an inch of the internal. In the right corpus striatum was a softened and atrophied patch, almost symmetrical with the second of those just described in the left. The nervous tissue beneath each of them, to the depth of nearly half an inch, was reduced to turbid, yellowish,

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detritus; and the tissues surrounding the irregular cavities thus formed were also invaded and modified in texture.

Optic thalami, general shrinking, pallor, and defective consistence; but no localized softening except a small patch in the depth of the right thalamus.

Gray commissure not visible. [Nothing special as to cerebral arteries at base.]

Cerebellum pale, its arachnoid opaque.

Spinal cord, pale, unduly firm in all its columns, but perhaps more so in the lateral columns; a somewhat diffuse leuco-myelitis, more marked laterally.

Weights. Right cerebral hemisphere, 21 1-2 ounces; left, 22 1-2 ounces; cerebellum, 5 1-2 ounces; pons and med. obl., 1 ounce; spinal cord and meninges, 1 1-2 ounces; blood and fluid from brain, 7 fl. ounces.

It need only be added that there were congestion and œdema of *lungs* and hypostatic pneumonia and at the right apex, traces of former arrested phthisis. L., 42 1-2 ounces; R., 22 ounces.

Liver, a capsular cicatricial patch as if from old gumma, 58 1-2 ounces.

Spleen, 10 1-2 ounces, firm, of flesh color, old perisplenitic adhesions and cartilaginoid local thickening of capsule, which elsewhere was pigmented brown and yellow.

Kidneys, healthy.—L., 5 ounces; R., 5 1-4 ounces.

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Myxœdema or Pachydermic Cachexia.*

A Critical Review by Dr. G. Seppilli.

UNDER the name *myxœdema or cachexia pachydermica*, there has been described a morbid state, which has long been confounded with other affections of the organism, and particularly with *polysarcia*. Although it does not belong to the domain of the diseases special to the nervous system, we regard it as not outside our province to give to the readers of the *Rivista* some information as to its nature, as it is characterized, besides the singular aspect of the external configuration of the body and the alterations in the skin, by sensory, motor and psychic disturbances; and furthermore, as several observances of the disease have been made in individuals received into asylums for the insane.

The first to draw attention to it was Dr. Wm. Gull, in a memoir presented in October, 1873, to the Clinical Society of London, in which he related the observations made on five women, in whom he had noted, as characteristic, a general œdema, very consistent and extended in the skin and the subcutaneous connective, which deformed the whole body, but in an especial manner the face and the extremities, and was attended by a grade of intelligence very analagous to that of cretinism; he therefore designated this new morbid state *cretinoid œdema*.

A few years later, in 1878, Dr. Ord reported some personal observances, with phenomena perfectly similar to those stated by Gull in his cases, and he further described pretty fully the anatoma-pathological results of an autopsy which he, for the first, had the opportunity of making in such cases. Ord, having regard to the nature of the

* Translated by Joseph Workman, M. D., Toronto, Canada, from the *Rivista Sperimentale di Freniatria, etc.*

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œdema, quite special, which, as we shall presently describe it, is observed in the course of the affection, substituted for the name given to it by Gull, that of *myxœdema.*

In the meantime Charcot had, in his practice, noted some singular facts, which he proposed to bring under attention, under the designation of *pachydermic cachexia*, before he became aware of the observations of Ord, which exactly agreed with his own.

Up to the present time the number of cases found in medical literature has been more than forty. These cases are so analagous in both their symptoms and course, as to enable us to delineate the general physiognomy and the principal characteristics of the disease with sufficient completeness.

In observing the patients we are, first of all, struck with the general deformity of body, which, at the first view leads to the belief that they are affected with Bright's disease. The face is swollen, broad, and of an ashy pale color, with which the rosy tint of the breasts is in marked contrast. The eyelids are tumefied and semi-transparent and are widened with difficulty; the distance between the eyes seems to be increased, the nose is gross, broad and flattened at the base, and the nostrils are dilated; the lips are tumid, drooping and bluish; the mouth is enlarged transversely, and but little movable. All these traits give a characteristic imprint to the physiognomy, deprive it of all expression, and make it appear as if covered with a mask. The limbs, too, are notably increased in volume, consistence and weight; they resemble real cylindrical columns, and seem to be all formed of a piece; the hands and feet become so tumefied and deformed as to resemble the extremities of a pachydermous animal; their movements are accomplished with slowness and a certain difficulty. Gull compares the singular form assumed by them to that of a spade. The abdominal walls are also tumid and resisting. The skin is pale and thick; it presents folds corresponding to the various regions of the body (the forehead,

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neck, etc); it is dry to the touch, rough and resisting, as if it had been bathed with some strong alkaline solution; on the palm of the hands and the soles of the feet, it acquires the consistence of leather, and gross large scales of epidermis cover it. The secretion of sweat and sebacious matter is suppressed, the hairs become scarce and fragile, sometimes the nails fall off deformed, or break and become detached.

The œdematous aspect of the whole cutaneous envelope is analagous to that of anasarca, from which, however, it differs in substance through the anatomical condition that determines it, and the almost stony hardness which the skin assumes, in consequence of which it does not pit under pressure of the finger, nor maintain the imprint, as observed in true œdema.

Besides the skin, the mucous tissues also participate in the morbid process. A tumefaction, more or less considerable, of the mucose of the gums, the tongue and the velum pendulum is met with, which in some cases extends to the larynx, in consequence of which the voice acquires a special tone, and becomes hoarse. Sometimes thickening of the rectal mucose is observed, from which defecation is obstructed; the vaginal and uterine mucose also is thickened. The dyspepsia observed in some cases renders it probable that the mucose of the stomach also shares in the general infiltration of the external and internal investment of the body, as Dr. Ord believed he had established in an autopsy made by him.

The nervous system is the seat of various disturbances. All the mental processes are usually manifested with considerable slowness, the association of ideas is defective and difficult; memory is imperfect and diminished, the will is feeble; in short, a true cerebral torpor is present. Sometimes, however, psychical activity remains intact. This was observed by Dr. Morvan in fifteen cases, and he has furnished the richest exemplification of the disease.

In some cases, on the other hand, there was observed

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a state of maniacal excitement with delirious ideas, or of melancholia with illusions and hallucinations. Hammond relates the case of a woman affected with myxœdema, who had frequent hallucinations of sight and hearing, and insisted that vitriol was put into her milk and food by certain Frenchmen, in order to make her suffer. Inglis reports two cases: one of a man who, three months before presenting myxœdema, had fallen into a state of lypemania with suicidal tendency; the other, of a woman of thirty years, the mother of eight children, who, for two years past, had given signs of mental enfeeblement, and was attacked by a true maniacal access.

The case recently published by Blaise is very interesting—that of a woman who, at the age of twenty-seven years, began to present a progressive thickening of the skin, which was associated with alterations of the special senses. She found her food, however well prepared, tasting and smelling nastily, she accused the persons about her of speaking evil of her, insulting her and making obscene proposals to her; it seemed to her that her body exhaled a repugnant odor, and that her head was changed into that of a dog. The sensorial alterations and her ideas of persecution lasted through several months, and then progressively disappeared. It is noteworthy that the improvement in the mental state of this patient, advanced *pari passu* with the diminution of the infiltration which had been formed in the skin and the mucose.

The torpor of cerebral activity is exhibited beyond the psychic domain, also in the functions of motion and sensation. The movements of the body are tardy, ambulation is unsteady, slow and difficult; the most simple acts, such as dressing, raising a light weight, or even raising food to the mouth, are accomplished with effort, which seems to stand in relation with defect of energy of cerebral excitement, rather than with muscular enfeeblement. In. the first case of Inglis, above cited, there existed a diminution of the Faradic contractility of the muscles where œdema was most marked.

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The movements requisite for language take up so much time in accomplishment, that the words follow each other with a surprising tardiness; the voice is monotonous, hoarse, and, in consequence of the œdema which infilters the mucose of the larynx and the isthmus fancium, it takes on a nasal tone. At the moment when the patient has to speak, says Dr. Ord, he commences to close the mouth, then he depresses the lower lip, makes a movement of deglutition, and executes an inspiration, opening the mouth widely, and at the same time he drives the air with noise through the nostrils. According to Ord, this movement of deglutition has for its object the retraction of the velum palatinum.

The general sensibility is usually obtuse; sensorial impressions are but little and slowly perceived; sometimes the special senses are also debilitated.

Among the subjective symptoms most frequent, we may mention cephalæa, which may be intense, a tendency to sleep, sometimes irresistible, and a sensation of cold. The temperature is almost always below the normal, but sometimes one degree above it. The extremities are very cold. Haddon examined the mean temperature in five cases, and in only one did he find it a little above normal, 37.3 C. (99.14 Fahr). The lowest temperatures noted by him, oscillated between 35.5 and 25 C. (?) 95.9 and 77 Fahr. The last marking was met with a few minutes before death. In a case of Hammond's a lowering of temperature was noted, which never exceeded 35.5 (95.9). In another, described by Bourneville and D'Olier, the rectal temperature, taken morning and evening through eight consecutive days, was invariably 37.2 in the evening—(98.96).

As regards the organs of vegetative life, it has been observed that in the majority of cases the heart presented no abnormality; in only a few cases the second sound was accentuated. Respiration is generally difficult, and is accompanied with a sense of dyspnœa. The digestive functions are disturbed; dyspepsia and constipation

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are almost always constant; sometimes sialorrhœa is observed. Menstruation is difficult and irregular; usually amenorrhea is present. The urine does not contain albumen, unless in the last periods of the disease, in which there may supervene an alteration in the kidneys analagous to the vulgar interstitial nephritis. Unless this complication is realized, the urine does not become albuminous. Haddon observed in the urine a notable diminution of urea, and Hammond an excess of urates.

From the preceding description it is seen that the deformity of the body, and more particularly that of the face and limbs, consequent on the tumefaction of the skin, the torpor of cerebral activity, manifested as well in the psychic functions as in those of motion and sensation, the diminution of temperature, the absence of albumen in the urine, are the morbid phenomena most salient and characteristic of the special affection which has been called *myxœdema* or *pachydermic cachexia*.

The causes of this disease are yet unknown to us. It was, for some time, believed that women only were subject to it, but it has since been seen that men also may present it. Nevertheless, it appears that the disease is most readily developed in women; from our collected observations we conclude that its frequency in the two sexes stands in the proportion of five women to one man. Some of the women had been married and had children before the signs of the disease presented. Adult age is the most predisposed to this affection; it was observed almost always in persons between thirty-five and sixty; very rarely before thirty years of age. Only two cases have been known in which the symptoms appeared in infancy. These occurred in two children of four years, one of whom, reported by Goodhart, was affected with cretinism, and the other by Charpentier, with idiocy. Some writers adduce as causes, affliction, emotions, the climactaric period, prolonged fatigues; but in our opinion these have little value. It appears that syphilis, excesses in drinking and eating, climate, have no influence in the genesis of the disease.

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Myxœdema has a very slow but progressive course; it lasts for many years. It is difficult to fix the time or manner of its commencement, because the majority of the patients have come for examination by physicians when the affection had progressed some time, and they could not give precise information as to its origin. It seems that in some cases it had commenced rather suddenly, as in the observation of Prof. Charcot, reported by Thaon, in which the œdema manifested itself cotemporarily in all the four extremities. In one patient of Ord, the first signs of the disease were chills which were followed by general debility, pains along the back and tumefaction of the skin. Death occurs after some visceral complications and especially lesions of the kidneys. It has been recorded in only two or three of the cases described.

What is the nature of the phenomena we have detailed? To what anatomical lesions do they correspond? Dr. Gull, who was the first to engage in the study, restricted himself to a very neat description of the morbid phenomena observed by him, leaving to others the task of determining the nature of the disease. He made choice of the designation cretinoid œdema, with the sole view of representing the exterior aspect of the patients, which much resembles that of cretins. Ord had opportunity to make the autopsy of a female patient. By some clinical and histological researches, he established that the general cutaneous and sub-cutaneous infiltration, which in a characteristic manner deforms all the body, is not due to a collection either of fat or of serum, but to a special substance of gelatinous aspect, which gives to all the tissues the characters of mucous tissue; the sudorific glands are manifestly atrophied; the nerve extremities in the skin appear to be enveloped in a transparent substance; the adventitious tunic of the arteries is three or four times thicker than normal. Besides the lesions of the skin, œdema of the vocal cords and of the gastric mucose observed, atheroma of the aorta and of the cerebral

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arteries, hypertrophy of the muscular interstitial connective, especially in the heart, from collection of mucine, with diminution of the muscular elements were also noted. In the liver also the intercellular substance was increased in volume, because of which the hepatic cells appeared very distant from each other and in part atrophied. The alveoli of the thyroid gland were compressed and in a large measure destroyed by neoform interstitial substance. The kidneys were notably thickened, and finely granulous on the surface, with obliteration of the glomerules.

On the basis of these data, Ord sought to explain all the morbid phenomena of the disease, making them uniquely to depend on the presence of mucous tissue, and for this reason he designated the disease myxœdema. According to him, not only the deformity of the body and the principal visceral disturbances and especially those of the digestive functions, but also all the morbid sensuous motor and psychic phenomena are due to the infiltration of mucine into the connective of the skin, the muscles and the mucose. He believes that the mucous substance which is collected in abundant quantity among the meshes of the subcutaneous connective, finding itself in contact with the nerve terminations, forms around these a species of isolating envelope, by reason of which the nerves respond to the action of peripheral stimuli only feebly and imperfectly and hence become incapable to arouse, conveniently, as in normal conditions, the activity of the nerve centers. These remain in a state of inertia, which affords us the explanation of the slowness of movements, and of the tardy and monotonous articulation of speech and the enfeeblement of all the mental processes. In a word, the brain, coming under want of its habitual stimuli, falls into a state of stupor and becomes habituated to tardiness of reply, as happens to a limb whose function is enfeebled when it remains unexercised.

But this theory of Ord, which subordinates all the symptoms of the disease to the accumulation of mucous tissue on the periphery of the body, has appeared to

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several other observers, and to ourselves also, as not to be accepted in an absolute manner. The idea of trying to explain in all cases, the cerebral torpor by diminished functional activity of the peripheral nerves of sense, and consequently a less reaction to stimuli, is inexact and absolutely contrary to what experience teaches. Some morbid states are known, in which, although general sensibility is notably diminished, cerebral activity is by no means torpid. Proof of this is given by certain hysterics who are insensible to any stimulus applied on any part of the body, in whom the mental processes are yet manifested with uncommon promptitude, activity and energy: certain insane persons, quite insensible to dolorific and thermic stimuli, show in the midst of their mental disorder, very evident signs that their minds still live and act. In lepers, despite their general anæsthesia, the cerebral faculties remain active through many years.

The interpretation of Ord might have a certain value had it been first shown that in all cases of myxœdema, the infiltration of the skin and the cellular tissues had preceded for a long time the appearance of cerebral phenomena. But in none of the cases was this chronological sequence of symptoms verified; in some, indeed, the inverse order was observed. In the case cited by Blaise, the cutaneous infiltration and the sensory and psychic disturbances were presented cotemporarily and disappeared so, from which we might hold them as the effect of the same morbid condition.

Goodhart was among the first to combat the interpretation of Ord, noting the fact that no affection of the skin, such as myœdema, is capable, *per se*, of disturbing the mental faculties, when once the brain has acquired its complete development. This influence, he adds, may be admitted only in infancy, in which the nervous centers have not yet been fully developed.

It seems to us much more probable that the cerebral torpor may be the cause of diminished cutaneous sensibility, rather than the effect of it; it would then seem to

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be not a subordinate morbid symptom, but would form rather a cardinal symptom of the disease. Thaon shows himself inclined to ascribe to the state of the brain the greater part of the morbid phenomena of myxœdema. Goodhard thinks that in the nervous centers, modifications analagous to those observed in the connective of the other organs take place; but this opinion is opposed to the fact, that the researches of Dr. Ord on the central organs of the nervous system gave negative results.

Dr. Hadden has advanced another hypothesis on the nature of myxœdema, which is, that it is a primitive affection of the vaso-motor system, on which depend the physical and mental torpor, the subnormal temperature, the diminution of the quantity of urea, &c. But this hypothesis is untenable, for it is not known that either a paralysis or a spasm of long duration of the vaso-motor fibres can give origin to morbid phenomena similar to those of myxœdema. (Ord)

Thaon makes the observation, that in this affection all the organism takes part; the decadence is general, the blood is impoverished, the functions are languid. Such a state, then, represents a true cachexia.

It is therefore evident, that it is not granted to us to establish, with precision, anything on the nature of the disease. In order to arrive at conclusions of some value, further observations are required, which may serve to exhibit better, the clinical course of the disease, and the anatomo-pathological alterations, about which we know but little.

Almost all the observers are found in accord in holding that the morbid state described, constitutes a nosological species quite distinct. It may be differentiated from the *morbus Brightii* by the following characters: absolute absence of albumen in the urine and of uremic phenomena in the course of the affection (excepting however in the last stages), solid consistent œdema which does not pit under digital pressure, as in the case of serous œdema, persistent cerebral torpor. Dr. Mahomed, however, believes that myxœdema is not an autonomous

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morbid affection, but a symptom of the chronic disease of Bright, without albuminuria.

The analogy of morbid phenomena, (tumefaction of the skin, tardy articulation, cerebral inertia) which is observed between the myxœdema of adults and cretinism, might lead, according to Ord, to the belief that cretinism commences in a simple general myxœdema, in consequence of which the stimuli of sensation necessary to favor the development, and to excite the functions of the nerve centers, are interrupted in their action; the absence of external sensations deprives the brain of one of its principle means of education.

In this hypothesis of Ord, on the genesis of cretinism, an exaggerated importance is given to the lesions of the skin. In cretinism we have a slow poisoning of the blood by a special miasmatic principle, which, associated with other circumstances, as hereditary defect of race-crossing, bad hygiene, &c., impresses on the general economy, modifications more or less profound, impedes the development of the organs, and above all, of the cerebro-spinal system.

In a case of myxœdema described by Bourneville and D'Olier, observed in a certain idiot of nineteen years, the solid œdema of the skin, the deformity of the limbs and face appeared tardily. The authors, therefore, in this case considered the appearance of the myxœdema as a complication of the pre-existing state—the cretinisms—which would weaken the hypothesis of Ord.

It may now not be denied that a certain similitude exists between myxœdema and cretinism, in the external configuration of the body, the inertia of the cerebro-spinal centers and the special characters of the skin observed in the two cases. Dr. Gull, who had already noted it, defined the special morbid state observed in his cases, as a cretinoid state developed in adults. It is known, however, that whilst hypertrophy of the thyroid body is met with frequently in cretins, it is generally wanting in persons affected with pachydermic cachexia.

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Up to the present day but little is known as to the treatment of this disease; milk diet, sulphur baths, residence in a dry temperate climate may promote improvement. It is worthy of note that hygienic means prove much more efficacious than medicine used internally. These are, in general, badly tolerated in consequence of the gastric disturbances so frequently observed, and perhaps, also, because of the obstacle which the infiltration of the skin presents to the functions of excretion, through which the accumulation of medicinal substances within the organism is favored.

We shall close by calling the attention of our physicians to this as yet little known and little studied disease, hoping that the description we have given, by profiting from the observations hitherto published, may serve as an incitement to the initiation among us also of appropriate researches, and to the bringing into notice of those cases which any may have had opportunity to observe.

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Experience of an Opium Eater During the Withdrawal of the Drug.

BEING THE CONFESSION OF A PATIENT WHILE UNDERGOING TREATMENT FOR THE CURE OF THE HABIT, AT A DISTANCE FROM HIS PHYSICIAN.

Recorded by C. H. HUGHES, M. D., St. Louis.

SINCE DeQuincy and Coleridge published to the world their experience with the drug that enslaved them, medical literature has been but little enlightened by the self-recorded testimony of such as have yielded to the neuropathic thralldom of opium. Since the highly sensational records of these *literati* first appeared in print, an occasional auto-biography has been printed like those that may be found written down in "The Opium Habit," a book published a few years ago by the Harper Bros.; the contributions of Calkins, Kane and others also contain histories of cases. But it is rare to encounter among one's patients, a person with enough persistent courage and fidelity and determination of purpose to honestly and successfully aid in the management of his own case, while living at a distance from his physician and having to rely upon his own volition in the trying emergencies always associated with the perfect emergence, even in the best managed cases, from the slavery of opium. The patient whose self-recorded history in great part appears in the letters that follow, was one of this kind—a man of rare courage and exceptional fidelity to truth for an opium eater, respecting his enslaving habit, as he who publishes these records of the true inwardness of the feelings and effects of the victim manfully struggling and determined to be free, can attest, having had him a sufficient length of time under his own eye and roof, after the victory, to know that he was in truth "redeemed,

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regenerated and disenthralled." The writer of this record has had sufficient experience with the victims of chronic meconism to know how cautiously their words are in general to be taken, when they pertain to their vice and its abandonment. The letters are given without the dotting of an "*i*" or the crossing of a "*t*;" *verbatim et literatim.*

When the patient on one occasion found himself fearful that no self-resistence aided by what medicines he had, would alone save him from relapse, he came speedily by rail, a distance of several hundred miles, to his physician, remaining until his pangs were relieved by additional medication. This he did in accordance with his promise that if he at any time feared he could not hold out, he was not to resort to morphine, but to come at once to us for help. This was his last and triumphal effort. An increase in the amount of his cannabis indica, quinine and camphor during the day, some timely galvanism and chloral and the bromides at night, for three days, turned the scale. The minimum daily quantity of morphine taken by this patient was ten grains before he began to break off the habit.

October 20th, 1875.

DEAR DOCTOR.—I have almost begun to think we are going rather fast. Last night was fearful; slept considerable, but very poor sleep; and worse dreams; and this A. M., feel like I had been stewed. Have not energy enough to move if I was not compelled to move to rest my aching bones. Can't keep myself in one position more than a second; every inch of bone has ached continually since eleven o'clock yesterday. I think I turned over 185,000,000,000 times last night; didn't count 'em however, and may have got it two or three too many; have tolerable appetite at times; but when I do eat, the food stops just as soon as possible and torments me for two or three hours; can't get it to go on down; sometimes I feel hungry and sit down to eat, but as soon as I commence the appetite leaves and my stomach says no more. If I continue to go down as fast as I have so far, it will be but few days until I can't get out

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of bed. I have taken the medicine according to direction as near as possible, and think I have taken very little if any, more or less than one tablespoonful daily. You did not say at what time of day, or how I should take the black looking drops from small bottle, those that I am to increase two drops daily; thus far I have taken them in morning, by dropping into the spoon with the solution—is this correct?

Yours truly,

R. S. McM———

October 21st, 1875.

DEAR DOCTOR.—I wrote to you yesterday that I was then feeling rather badly and thought perhaps we were going a little too fast, but, by ten o'clock yesterday, I was feeling better and slept better last night than usual, and to-day do not feel so weak as yesterday, and now rather hope I am good for it. But, from about three o'clock A. M., I slept but little on account of soreness in chest and across kidneys; suppose it is liver; have been subject to spells of same kind for many years; they usually hang on two or three weeks at a time unless I take something; but I have very seldom taken medicine for it; usually let it wear off. Have been troubled rather worse than common for two or three days, so much that I have to breathe very short, as a long full inspiration *seems* to tear the *lining* out of my chest, and at the above mentioned time, it is impossible to move the body without pain. But, after I get up and move around awhile, the soreness leaves me. I concluded I would adopt a new plan to-day, namely: In morning take only about half a dose of the solution, and at noon, little or none, and at night take more so as to get better rest. Can get along much better in day time than in night, for during the day, if I conclude I can't sit still any longer, I can get up, but in night it is not pleasant to do so. However, if it does not meet with your approval, of course I will discontinue it and follow directions.

Yours truly,

R. S. McM———

October 23d, 1875.

DEAR DOCTOR.—Nothing new. Think I feel fully as well as when I last wrote, and rather think the idea of taking light doses of solution, morning and noon and more at night is a good one, at least it seems to work

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well. Yesterday morning I took, as near as I could guess, about forty drops, and at noon the half of that, and at night about three-fourths of a tablespoonful, and rested very well; however, I got pretty shaky late in afternoon, but think I can make it go.

Yours truly,

R. S. McM———

October 25th, 1875.

DEAR DOCTOR.—Yours of 21st. received. At present, I have not a shadow of a doubt but I shall get through in good shape, with considerable of the old frame, which I can weather-board and fix up so as to look almost as good as new. I flatter myself that I am getting along first-rate. I rest better and feel better. For the past three or four nights have slept pretty well, feeling as well as one could expect. I understand that unless I can't get along with the solution [acidulated solution of quinine] and black drops [tincture of cannabis indica], I am to get the other prescriptions filled. But, if I can get along without them, I had better do so; unless I am mistaken I think I can make it with those alone, at least for a while.

I emptied the bottle of tonic which I had put up while in St. Louis, into the bottle of substitute last night, and as I take from solution, add the substitute. The pills you mentioned in your last, I will do without as long as possible, with your permission, for I really don't believe I could get one down.

Yours truly,

R. S. McM———

October 27th, 1875.

DEAR DOCTOR.—Yours of 21st. received. Am still getting along finely; have not had the hypnotic prescription filled and have some idea that I will not want it, at least for some time. I understand that I am not to take any more of either the solution or neurotic than is necessary to keep me on my pins; thus far I have taken only two doses daily of latter, twenty to twenty-two drops each. Am I right to take just as little as I can?

I chew but little tobacco, but smoke a great deal. I find the more I smoke, the better I feel. But as tobacco does not taste right, I chew but little. Would it not be a good plan to take solution and neurotic both, or

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rather either, only when necessary? I think I take both sometimes when not really needed. Yours truly,

R. S. McM———

October 30th, 1875.

DEAR DOCTOR.—Yours of the 28th, received this A. M. I am still feeling first-rate; however, night before last I had a terrible old head-ache; I had been at office all day; head ached a little, but not bad until about 5 o'clock; went home and by time I got there, was fearfully sick; thought head would burst; bathed it with the evaporation lotion [aeth. sulph.] and laid down; head eased off in a couple of hours; felt weak next morning, but am all O K this A. M.; have the utmost confidence in result of your treatment, and am satisfied will take less than half the drugs and medicines you expected. Since 3 o'clock, Thursday, to the present, 10 A. M. Saturday, I have taken two tablespoonfuls of solution and sixty drops of neurotic only, [cannabis indica, camphor and ammonium bromide] and expect to reduce the neurotic to twenty drops to-day, and if that works all right will still further reduce amount to-morrow.

Will keep you fully posted and will try no experiments without your knowledge; but I am just fool enough to firmly believe that if I was there with you now, I could drop the entire lot, and by walking around and having plenty of amusements could get along without any medicine of any kind; and I also think by the time I get the bottle of substitute [quinine solution] all emptied into solution bottle, that I will be O K, and never loose a day from office. I have felt better for last two weeks than I have a long time; but, of course imagination helps some. I have not the least shadow of a doubt as to result. The thing is settled; I will make it O K.

Yours, etc.,

R. S. McM———

November 3d, 1875.

DEAR DOCTOR.—Again I write to say, all goes well, am getting along finely; feel first-rate; sleep very well and work every day at my desk; think I feel fully as well if not better than when I wrote last, with the exception of nausea at meal time. Have good appetite and go to table hungry, but by time I get one-fourth enough, begin to feel slight nausea; sometimes it leaves me on

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quitting table and sometimes have to vomit, especially in morning—on several occasions within a week have had to leave breakfast table to vomit; otherwise, I feel as well as usual; that is, I feel as well as before commencing the *remedy*, and am not certain but better. At any rate I feel five hundred per cent. better than I expected to at this time.

I think I am too much constipated; my bowels move only every other day. Would have written yesterday, but have been so very busy I could not get time.

Yours truly,

R. S. McM———

P. S.—So far have had no occasion to use anything but the solution and neurotic. Have not had hypnotic prescription put up, and hope will not need it.

R. S. McM———

November 23d, 1875.

DEAR DOCTOR.—I still live; stomach getting so weak can hardly eat, especially breakfast. Took a look at sand box* this morning to see how it was holding out; can't find bottom, guess have good supply yet; but if I get down much lower its going to take a good deal to run me—bowels pretty loose, back pretty weak and energy all gone. Have to scribble over four quires fools-cap before I can get nerves steady enough to write legibly; however, I still rest well at night. Last night slept first-rate, but when I got up could hardly stand; eat no breakfast. Have taken nothing yet but solution and neurotic; don't intend to until forced or at least necessity demands it.

From what I have read and heard of such cases, I flatter myself that I am getting along better than the majority of cases, if not better than any heretofore. If my stomach could stand food so I could get a little strength, I think I could stand anything else. But it is this abominable weakness that beats me. Occasionally I have an appetite and eat a pretty good meal, but it hurts my stomach so fearfully for hours after, that I don't dare to eat more than just enough to keep me on my pins. But still, I am thankful its no worse; and have not yet had a doubt as to the result. Yours, etc.,

R. S. McM———

*Medicine.

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December 2d, 1875.

DEAR DOCTOR.—Yesterday morning I got up with severe head-ache, which so increased, that by ten o'clock had to go to bed; pain appeared seated in back of head and neck and extended for [from] I [eye] to eye, sometimes left and then right; it was intense; the evaporating lotion had no effect whatever only to apparently increase the pain; never suffered such pain before; *almost* wanted to die. About five o'clock P. M., my wife sent for a physician; he gave hydrate of chloral, and left about twenty quinine powders and a box cathartic pills; chloral was to be given every fifteen minutes until relief, but it did no good; I would take it until I got about so full and then throw it up; all the time the pain continuing. About ten o'clock P. M., I decided that something must be done or I would have spasms; sent to drug store and got two grains sulphate morphia; took one-fourth grain and in twenty minutes, one-eighth grain. About 10:45 o'clock, pain began to subside; suppose it was the morphia, but could not feel it in blood. Before taking the morphia, however, I could hardly feel any pulse; it was very low, but *sharp* and *quick*; could feel it only in temples; my wife said she could feel it at wrist, but I could *not*. You need not be surprised to see me at St. Louis most any morning, for, unless I feel better to-morrow, I shall skip out. Yours, etc.,

R. S. McM———

December 4th, 1875.

DEAR DOCTOR.—I guess I am feeling better this A. M.; kept up all day yesterday and day before, and think am gaining strength since the terrible old spell I had on Wednesday. Shall postpone visit to St. Louis for present, unless I get worse again. Have written for passes so if it becomes necessary to skip out, can do it. Think will work at office to-day; did but little yesterday, and nothing day before. Yours truly,

R. S. McM———

December 8th, 1875.

DEAR DOCTOR.—Am still on my pegs and have been doing very well; got through with pretty good day's work yesterday, and will do same to-day. Rest pretty well at nights, and have given up going down to St. Louis for the present; want to put it off as long as

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possible. I have a little head-ache to-day, but otherwise feel pretty well, considering.

Yours truly,

R. S. McM———

December 13th, 1875.

DEAR DOCTOR.—Am still on my feet and getting along as well as could be expected if not better; have my ups and downs, more of latter than former; but have plenty sand [pluck] left; shall not get discouraged unless I get down so can't help myself; and I still have faith that I will yet weather it through without [getting] down. But oh! Cæsar, what work it is to do anything. It takes almost all the sand I have to stick to desk sometimes, but I do it; but if I was to go to bed, I could easily believe I was sick.

Yours truly,

R. S. McM———

December 22d, 1875.

DEAR DOCTOR.—Am still able to move around, but rather slow. Think I will go to St. Louis last of this week; probably call on you Saturday morning; am not positive, but hope to be able to get away on Friday; would have written you oftener lately, but have felt so little like such work that I have neglected it; in fact have neglected everything in shape of work that possibly could; hoping to see you soon.

I remain, yours, etc.,

R. S. Mc M———

[Came to city December 24th, and stayed four days.]

January 24th, 1876.

DEAR DOCTOR.—Must beg your pardon for putting off writing to you so long; but, for a week after my return I was feeling so lazy and bad that I never attempted to write a letter to any one; and then I took a train and have been running on road since and have no convenient place to write, and consequently, have neglected it. I am now entirely out of woods and can crow; am feeling first-rate, only don't like this cough which sticks to me. I took a severe cold coming home and have been barking a great deal since. Went to drug store when first came home and got bottle of cough syrup; but three doses were enough; slept too nice and sound that night;

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spoke to physician next day for prescription for cough syrup without opium; he gave it to me and I think am getting along in pretty good shape. After I run a train 219 miles and take up 150 to 350 tickets, I can go to bed and sleep sound, five and a-half to six hours.

Your Friend, R. S. McM———

———

Memoranda of directions made at the time this patient came under treatment.—Mr. R. S. McM—— is chief clerk in passenger department of the ——— Iowa R. R. He has taken as much as two drachms of morphiæ sulphas weekly. He now takes the contents of a one-drachm vial every week, or eight grains daily in three equal portions. He began the habit for neuralgia and an obstinate headache. The medicine was prescribed by a physician. His general physical health is good. Complexion somewhat sallow; but he says this is natural. Began treatment by reducing amount to four grains, and gradually reducing that at the rate of $\frac{2}{15}$ of a grain reduction daily. Gave the following prescription, with accompanying directions:

℞ Morph. Sulph. - - - ʒ ij.
Aq. Menth. Pip. - - - ℥ xv.
M. *Sig. The Solution.*

———

℞ Quin. Sulph. - - - ʒ ij.
Pulv. Ipecac - - - - gr. v.
Aqua Distill. - - - ℥ x.
Elix. Tarax Co. - - - ℥ v.
Acid. Sulph. dilut. q. s. ft. sol.
Sig. The Substitute.

———

℞ Tr. Cannabis Indica - - ℥ iij.
Sig. The Neurotic.

DIRECTIONS:—Take from the solution four tablespoonfuls daily in three equal doses. Replace each daily quantity from the solution bottle with a similar quantity from the substitute bottle. Take of the *neurotic* two drops the first day, increasing two drops daily up to 60 drops.

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Prescribed also a tonic of iron, quinine and strychnia (nux vomica) to be taken as needed, and a solution of chloral hydrate, as a hypnotic, in fifteen grain doses, at night time, when needed between sleep and keep nervous system thereby sufficiently recuperated for each succeeding day's labor and trial.

We do not now treat the opium habit precisely in this same way, preferring to diminish the number of doses daily, dropping off one at the beginning and counteracting the depressing effects of withdrawal by galvanism and tranquilizing neurotics, finally getting the patient to rely on the one dose and gradually reducing that.

Whatever question there may be as to the propriety of the withdrawal of the opium in certain of these cases, especially in old persons long inured to the drug, in whom marked psychical changes have appeared either before or since the formation of the habit, when slight reduction in the daily quantity consumed is attempted, there can be no question as to the justification of the "weaning process" in the young or middle-aged and vigorous, still engaged in the active duties of life, and possessing sufficient reserve vitality to justify reasonable recuperation, in reconstructive response to such therapeutic measures as we may find it necessary to employ, as we remove from the system the peculiar influence of this singular drug, which both weights the nervous energies as an incubus and supports them like a scaffold.

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The Management of Chronic Inebriates and Insane Drunkards.*

By Albert N. Blodgett, M. D., Boston, Mass.

In approaching a question of such magnitude as the present one, certain facts which have been proved by the experience of the past must be touched upon as a fundamental necessity to any intelligent discussion of the subject. Among these are the following:

It is a recognized fact that the peoples of to-day are different in many respects from their native ancestors, or from the peoples of those countries from which they may have emigrated. These gradual changes have long been observed, but in later years they have progressed with accelerated rapidity. This result is not confined to one language or continent, but is distributed in varying degrees of development throughout the whole civilized world. The changed condition is noticeable in many ways, principally, however, in features relating to the nervous system—that is, in those departments of the human organization controlled or specially influenced by the great central ganglia, the brain and spinal cord.

The most prominent evidences of such a change consist in an increased excitability, an abnormal activity of all the cerebral and nervous functions, a restlessness and nervousness, a precocity which is not the healthy development of normal powers, but is a strained and overwrought activity resulting from unnatural and disordered excitability. This condition, if developed suddenly in an individual, is considered indisputable evidence of disease, and is quite as properly reckoned a diseased action when its march is slow and insidious, so that its progress is unnoticed by the individual affected.

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*Read at the Annual Meeting of the Social Science Association at Saratoga, Sept. 6th, 1882, by Albert N. Blodgett, M. D.

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The expression of increased nervous excitability, is observed in nearly all the ordinary walks of life and in all conditions of people. Within the memory of most of us there have been such changes within the limit of personal observation to verify the truth of this assertion. The ground was well covered by the remark of a gentleman with whom I was recently conversing, who said, "I would prefer to live seventy years in thirty rather than to consume seventy years in living thirty."

The causes of the generally elevated tension in which we live are manifold, and reach into almost every avenue of life. They invade the most humble home and intrude into the drawing-rooms of our modern palaces. It is impossible to enumerate all, or nearly all, the influences which have united to produce such a baneful effect upon our population; but a few of the more potent causes may be briefly touched upon. Among these may be mentioned, as one now acting most powerfully in this country, the modern science of *politics*, by which I would not be understood as alluding to the science of true statesmanship, but the petty, miserable abortion of statesmanship—which is now everywhere disseminated throughout the land — in which personal ambition usurps the place of principle, and private advantage controls those acts which should be directed to the public good.

The abolition of *principle*, which is to the mind what the pole-star is to the mariner, is one of the most fatal accidents which can befall any individual. Its absence leaves the mind without a proper degree of rectitude, without that necessary steadfastness of purpose and consistency of method which are essential to healthy and vigorous mental activity. Weakness and debility of the mental functions must as surely follow its loss as physical infirmity succeeds the loss of any material condition of animal life.

The cumulative result of this defect is continually augmenting, like that of the opium habit or any other

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profound and growing influence operating upon the foundations of being in the individual.

The recent great mania for speculation, which has swept like a cyclone over this country, has been another powerful agent in disturbing the mental equilibrium of very many people in the past few years. The insatiable desire for wealth, the excitement attending the fluctuations of values, the anxiety regarding the favorite investment, the giddy exhilaration produced by sudden riches, and the despair at the shipwreck of the labors of a lifetime, all exert a most powerful influence in unsettling the mental balance of many individuals, thus exposing them more easily to the effects of accidental influences, by which their debilitated mental and moral natures may now become more or less profoundly disturbed.

The rapid dissemination of intelligence from one part of the world to another, thus bringing the events of distant locations to our earnest attention, with the added elements of exaggeration and sentiment, with almost the same force as those affecting our personal relations, must act as a constant excitant or spur to the emotional and sympathetic parts of human nature, and operate to strain these qualities of the mind to an unusual and harmful degree. In fact, one of the most dangerous forms of mental disease at this time is the so-called "emotional insanity," produced, or at least developed and perpetuated, by great and prolonged excitement of these mental faculties. The "inspiration theory," with its frequent deeds of horror, comes under this class of mental disease, of which we have had several most piteous examples.

Another potent factor in the increased mental vulnerability of our recent population is the changes in the private and domestic life of the people. There is an increased tendency towards aggregation in large communities, and all large cities are overcrowded. The natural result is that much of the home life, if indeed not all, with its quiet restraint and peaceful influences, is lost upon those natures which most need them. The young

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of both sexes are thus thrown into the whirlpool of modern town life, and deprived of the most necessary means of protection from its contamination.

Is it to be wondered at if irretrievable damage is done the mental and moral natures of inexperienced or susceptible individuals, which, like a slight deviation from a straight line, becomes further and further removed from its proper course?

When we add to all these the harmful practices associated with club life, now unfortunately becoming so popular among all classes, which pander to all the foregoing evils but counteract none of them, and supplement all these with late hours and their associated dissipations, the lack of friendly advice, the perils of gaming and the other social dangers, we surely have ample cause for the weakened and debilitated moral sense, and the overstrained and excited emotional nature of a large and increasing proportion of our young and middle-aged people.

If, now, these unfortunate individuals become the slaves to passion or appetite, in any specific form, their bondage will be more oppressive from the lack of a powerful will to resist and a firm principle to guide; and the danger from encroachments of other vices will be augmented, owing to diminished power of self-control, due to degeneration or abolition of standard mental qualities.

At this point, one of the prime evils of our present system of living becomes evident, in connection with the facts mentioned a moment ago. Human nature cannot indefinitely support the increased strain to which a continually enlarging number of individuals are exposed. *Natural food and natural rest will not provide for unnatural and superhuman exertion.* There is a limit to all healthy energy. Beyond this limit, labor is accomplished only at the expense of vitality. In this extremity, which is exactly the condition in which a large number of our people find themselves, the use of artificial stimulants is

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necessary, in order to follow an irrational and insane ambition. The constant mental toil, the unceasing anxiety, the sleepless nights and overburdened days, gradually produce a degree of exhaustion, in which the individual is forced to one of two measures—either to relax the strain under which the system is laboring or to endeavor to support the failing energies by the use of some form of artificial stimulus. There is little need to add that the latter is the measure usually adopted at the present time. . . . There is a sensation of exhaustion which imperatively demands the aid of a stimulant, and is temporarily relieved by its employment. The individual is led to think that the remedy has been found, and continues to use an agent which has afforded such marked benefit.

It is easy to conceive that any article which thus becomes necessary to the performance of daily labor may gradually acquire such power over the individual that the force of habit, combined with the physiological action of the substance, may at length render all efforts at its abandonment entirely futile. . . .

The cumulative effect of prolonged over-stimulation is twofold; first, the action upon the nervous system, as a spur, by which an extra amount of energy may be temporarily evolved, with a gradual encroachment on the normal powers of the organism, until no extra energy *can be awakened* except from the effect of stimulation; and, second, a change in the physiological and organic relations of the structural elements composing the nobler functional organs, with gradual degeneration of the higher mental and moral qualities, so that the foundations of character are undermined and the powers of reason are perverted, while the emotions and sympathies are excited to increased activity, and the unfortunate individual becomes a slave to sudden and irresistible impulses, the consequences of which may be disastrous to himself or others.

Probably, many unsuspected cases which claim our attention in their care and treatment are the direct results of

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an attempt to prevent exhaustion of the vital powers by the use of artificial stimulants. One of the most careful writers of our day says that "cerebral exhaustion, however caused, more often leads to irresistible drink-craving than is generally supposed;" and Dr. Meyers states that "there is no form of nervous exhaustion more severe in its character than that which is induced by the abuse of stimulants."

The organic effect of prolonged over-stimulation upon the brain may be of two varieties: first, to dry up, so to speak, and to a certain extent solidify the tissues, with the symptoms of a greater or lesser deviation from mental soundness, sometimes amounting to mania; often followed, second, by softening of the cerebral structure, accompanied by a gradual blunting of many, if not all, the mental faculties, at times resulting in actual imbecility.

Dr. Sankey, in his lectures, traces the close parallel between the gradual degeneration of brain and degradation of mind in the drunkard and the insane person, and shows that these processes exactly correspond in some cases, and that the cerebral changes are almost identical. . . It is safe to say that no person can employ alcoholic stimulants for any length of time continuously without impairing the integrity of some, or all, the great organs of life, and vitiating their functions. With this result once induced, the necessity is felt for continued use of the harmful agent; and the weakened mental faculties are powerless to oppose the demands of an abnormal and depraved appetite. Thus, the bad habit is fostered and perpetuated, and the *chronic inebriate* stands before us. The uncontrollable appetite, diminished mental vigor and complete subjection to the obnoxious substance, are the essential factors which constitute the chronic toper, whose progress is now invariably from bad to worse. Dr. Bucknill considers this condition to be a form of emotional or moral insanity. He says: "The prominent nature of this propensity is its *irresistibility*."

The second class which claims our attention at this time is that other element of society which is subject to alcoholic

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influence, and which presents a series of phenomena utterly different from those we have previously considered These unfortunate persons are generally (so far as my observation has enabled me to judge) those who are originally in some way constitutionally defective, or are, to a greater or lesser degree perhaps, congenitally "weak-minded," or, in the words of Dr. Fisher, "those who inherit an unstable, nervous constitution from drunken, neurotic or insane ancestors," They are oftener found among the more illiterate ranks of society, or, if they belong to an elevated walk in life, they are inferior to their position, and are generally regarded as deficient in some essential qualities. This group of persons does not generally become addicted to the use of alcoholic stimulants from an original necessity for them, but from inherited vicious propensities, pandered morbid appetites, and depraved mental constitution. In them, the results which obtain in the chronic inebriate are less frequently observed, organic changes in the various animal structures are more rare, and the principal deleterious effect is to be noticed in the department of the higher cerebral functions.

The nervous system in these unfortunate individuals seems to be so constituted that the effect of any powerful stimulant is developed at once, and particularly in these structures. A person who has taken but a very moderate amount of a common stimulant may present no outward sign of intoxication; the step may be firm, the face not flushed, the pulse but slightly accelerated; but the mental organization of the individual may be completely overturned. There is often not the violent aspect of mental derangement which accompanies delirium tremens, but a complete suspension of normal cerebration. The general tendency of this state is one of personal exaltation, of unlimited resources, of gigantic enterprise, of assured success in most extraordinary undertakings. Although not generally inclined to be violent, there is complete disregard of the proprieties of the person or property of others, which, coupled with the fact that any effort at restraint is at once resented,

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is often the occasion of the development of a state of fury in which life is often imperilled and sometimes sacrificed.

In this state of maniacal rage there is no consistent selection of means, nor any consideration of the results which may ensue, but the unrestrained passion of the moment leads the individual to the most violent demonstrations as the result of interference with the delusions which temporarily possess the mind of the insane drunkard. Dr. Fisher, who has devoted much thought to this subject, says: "Under the influence partly of an uncontrollable impulse and partly of intoxication, they will perform truly insane acts. Closer investigation of their mental state will usually disclose the fact that they are liable to periodical recurrences of causeless exaltation and bursts of self-confidence on trifling occasions."

A case is now in my mind in which an amount of alcohol, not usually followed by any appreciable result other than a slight exhilaration, is in this patient the cause of uncontrollable rage, during which his room-mate, who is his dearest friend, becomes the object of the most malignant fury, and is in momentary danger of death from any convenient means. This impulse to violence towards others alternates with a powerful inclination to jump from the window, which is the only expression of any suicidal tendency in this patient. Some days are required for the re-establishment of his disturbed mental equilibrium, though the bodily functions are at no time seriously deranged. The effect of stimulation in this and similar cases seems to be primarily and chiefly exerted upon the nervous system, and is particularly developed in the cerebral lobes, where its action is expressed by disordered mental action as the disturbed function of these organs.

With each repetition of so dangerous an interference with these important structures, the tendency to diseased action is increased, so that the aberration of the intellect is each time more prolonged, and its character perhaps changed. The diseased condition may be produced by a lesser amount of the stimulant, and the impression upon the whole

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organism may become more pronounced, until at length reason may be permanently impaired, and the patient become the object of continuous apprehension or perpetual restraint, as a protection to himself or his surroundings or both.

Dr. Blandford regards persons of inherited or acquired weak mental constitution who are impelled to periodical drinking, by which indulgence the mental impairment is increased and perpetuated, as *insane*, thus expressing exactly the condition we have endeavored to describe.

From the foregoing, it becomes at once evident that the victim of drink may become a charge to society in either of the ways described. As such, he should not be regarded in the light of a voluntary offender or a hardened criminal, but as a sick and diseased individual, who is in need of humane and considerate treatment, and who is perhaps susceptible to recovery from his disordered condition and to restoration and cure of his infirmity. The cause of his present condition, whether intemperate indulgence of vicious propensities or any other reason, is not now a subject for consideration. The *mental and physical requirements of the patient* are to be chiefly regarded. Dr. Bodington, at a recent meeting of the British Medical Association, says, "For my part, I look upon all habitual drunkenness as a disease, and I would boldly call it dipsomania." And the American Association for the Cure of Inebriates takes the broad ground that "intemperance is a disease."

Here, our greatest need in the proper care of these unfortunates becomes strikingly manifest. We have continuously in our midst a class of patients of deficient will-power, or nervous force, or principle, as we may choose to call it, who become the subjects of public care, and are daily becoming such in increasing numbers.

Their existence as a class has been recognized, and their needs partially expressed. But I believe I am right when I say that in all our broad land there is not an institution or an establishment properly adapted to their reception or remedial or curative treatment, or for their care, if

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incurable. I have yet to learn of the resort so arranged as to be applicable to their needs, or so conducted as to be of practical service to this element in our society, which the public must care for.

From the nature of things, it is generally among the poorer people that these patients are met with, and therefore among those least able to properly care for them, and least likely to appreciate the fact that they are really sick, and deserving treatment rationally addressed to their condition.

The fact that they are frequently, and indeed generally brought to our notice through the commission of some act which calls for the intervention of the civil law, should not blind our eyes to the equally evident fact that accountability and moral responsibility may be more or less deficient or entirely wanting in the subject of the misdemeanor, and that he is inversely in just this degree incapable of the commission of a crime or amenable to its penalties.

The only provision which has thus far been made for the treatment of these unfortunate creatures is of two varieties: first, those conducted by private enterprise as a means of accumulating money or from charitable motives, and those controlled by the municipal or State government.

The first of these is defective in many ways. There is, as a prime objection, the fact that in these resorts the patient is a *boarder*, and as such is retained only so long as the means for keeping him there can be provided; and, upon the absence of the pecuniary element, he is dismissed without regard to his physical condition. While in these retreats he is only a voluntary inmate, he is not constrained to remain until his condition is relieved, but often, and perhaps always, the restraint proves so irksome that the patient leaves the institution before he is in fit condition to do so, and consequently derives little or no benefit from his residence in it.

Dr. Fisher says: "If able to pay and willing to go, such a patient might be kept for a short time in the Washingtonian

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Home or some similar establishment on the voluntary plan. But this kind of temporary detention only restores and strengthens the confirmed inebriate for renewed indulgence. . . . The disease has a deep root in the nervous constitution of the individual, which cannot be eradicated in this way." These institutions are also often administered upon certain dogmatic religious or hygienic ideas, which may essentially impair their usefulness as curative asylums.

The only institutions recognized by the State or municipal government for the reception of this class of patients are of two kinds: first, the various prison institutions for the confinement of felons, thieves, murderers, etc., into whose companionship the mentally and physically weakened victim of alcohol is introduced, and which can objectively and subjectively act only as an aggravation to his infirmity, and from whose walls he emerges, cursed with the moral stigma of its indelible associations.

The second and only other resort to which a patient may be referred by judicial authority is the mad-house, with all its horrors, of which words can often convey no adequate conception. I quote again the words of Dr. T. W. Fisher, when speaking of Massachusetts: "There is no provision anywhere for the treatment of delirium tremens but in the almshouse at Deer Island or Tewksbury. Cases of mania from drink, if likely to prove of short duration, are sent to the former place for observation, subsequently to be transferred to an asylum, if the insane condition seems to warrant it." To the lunatic asylum, the insane drunkard may be committed with the same degree of rigor as to the prison; and too often his case is fully as much a matter of routine in one place as in the other. The overcrowded condition of our public insane asylums, the lack of careful discrimination which I fear often prevails, with absolutely inadequate facilities or official staff for the humane and kindly treatment of so many sufferers, effectually prevents this resort from being of service to our subjects.

The confinement with maniacs, the constant association

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by day and by night with those in whom the power of reason is perverted, and whose every act and word is the expression of a diseased mind, is a cruelty and an inhumanity toward the weak and helpless. We have, and shall continue to have among us, a certain definite class of invalids, who are, and will continue to be, a burden to the public, and must be cared for at the public expense. It is certainly no proper argument that, because they must be supported at the public charge, they may as well be maintained in prisons and asylums as anywhere else. We must not forget that we owe to these unfortunates a degree of humanity in their treatment which should endeavor not only to relieve their present distress, but to restore them, if possible, to the full exercise of their previous faculties. That is to say, the treatment of these individuals should have for its ultimate object, *the cure of the disease.* This beneficent result is surely not to be attained by incarceration in a prison with the most hardened and desperate characters of our heterogeneous communities, nor is it to be hoped for behind the bolts and bars of our great and crowded insane asylums. Dr. Fisher expresses the same idea in these words: "Insane drunkards would be undesirable inmates of our insane hospitals if there was no difficulty in retaining them. They need little medical treatment, but require prolonged restraint, varied employments and moral discipline. The private retreats for inebriates and insane drunkards are, so far as my experience goes, quite powerless to accomplish any result, further than is in harmony with the will of the patient, and are, on the whole, of doubtful benefit for this class of cases."

As an instance of the working of two of the above-mentioned institutions, I would cite the following cases, which occurred within my own personal knowledge. A gentleman, who had long been a hotel proprietor, met with sudden reverses and suffered considerable pecuniary loss. Always of active temperament and usually of sober habits, his present mental distress was very acute, and

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he became addicted to drink. I have never seen this man in the least degree affected in speech, gait, or other physical manner, nor to a casual observer would he excite attention as being intoxicated. Yet, in this state, he is a dangerous man, and his family have often suffered violence at his hands; and with each succeeding debauch there is a decided change in his mental condition, which is gradually approaching a state of homicidal mania.

On more than one occasion, this patient has been placed in a private institution for inebriates, which has a very imposing name and a wide-spread fame, in the hope that he might be reformed, and again become a useful member of society. Each time, however, after a residence of a few days in the institution, this patient has called for his clothes, and has left the retreat to again indulge in his diseased propensities.

For such subjects as can be influenced by purely moral persuasions, these institutions may be of service, as those patients do not require restraint; but for the uncontrollable manifestations which accompany the action of alcohol upon many persons, such resorts are total failures. They have not the judicial authority to aid their work, they are powerless to restrain the turbulent subject, and are quite useless as a means of reformation or cure in any excepting mild cases.

An example of the opposite form of treatment also recently occurred within my observation. The patient was brought before the court and was adjudged an insane drunkard, and as such was judicially committed to one of the State Insane Asylums. After a time, he was released on a motion from the court, and thus describes his experience while under treatment: "The doors were barred and kept continually locked. There was no privacy, hardly the opportunity for the exercise of decency in personal toilet. Even during the day, the forced restraint was distressing, but at night it became much more so. The shouts and yells of excited patients in neighboring wards were painfully audible and disturbed sleep. The

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other occupants of this room were one patient who was constantly endeavoring to take his own life, one who feared that some one was seeking to kill him, on who was confined on account of homicidal tendencies, and one who was constantly striving to kill the others. The ward went by the cheerful name of the 'suicides' room.'"

The patient remarked that, "even if a person were sane, on being confined here, he might easily become insane from such surroundings,"—an opinion in which I am inclined to concur.

Another disadvantage attending the present management of insane drunkards is the uncertain length of time during which the patient is retained for treatment. Upon this point, I cannot do better than quote from the valuable monograph of Dr. Fisher, who says: "Great as is the task of getting an insane drunkard committed to an insane hospital, the difficulty of *keeping* him is still greater. This arises from the transient character of the prominent symptoms, which are only brought out under the paralyzing influence of alcohol. As one writer has said, the dipsomaniac is only sane while in the hospital. Although in his extremity, under arrest for disturbance of the peace and perhaps suffering mentally and physically from the immediate effects of drink, he acquiesces in his commitment, in a surprisingly short time he is on his feet, under perfect control, looking around for a lawyer to help him swear that his confused recollection of the the circumstances of his commitment is the true version. *No hospital can hold him a moment against his legal protest,* and he is discharged as a matter of course."

In view of the existing facts in relation to the management of chronic inebriates and insane drunkards, I think we are safe in asserting that no wise, humane and practical plan has yet been inaugurated for this object, which shall insure the protection of society at large, and work no injustice to the individual. It is comparatively easy to see the defects of existing methods, but it is by no means easy to suggest a remedy. We may, however, perhaps learn

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something concerning the direction in which our effort may be most profitably exerted, with the hope that in the fulness of time the desired result may be obtained.

What conditions, then, would be most favorable for the restoration or cure of an individual wrecked by drink and a burden to society? This is the question which in one form or another must really underlie any earnest and sincere endeavor for the practical relief of this unfortunate class of people. . . . For its solution upon any plan, one thing must evidently be premised as an essential condition, which is, *that there shall be a suitable disposition of authority which shall place these people within the control of some restraining force.* Without this indispensable provision, no effort for their benefit can be successful. With such power guarded by wise restrictions, it might be possible so to influence the life of the drunkard that his diseased tendencies and abnormal inclinations might be eradicated, and mental and physical health be restored to him.

It we consider what elements of treatment would most conduce to recovery from the state in which we find these patients, we shall not fail to recognize the great importance of two conditions, namely: a judicious amount of physical toil, which will induce a certain degree of bodily fatigue, with a consequent inclination to natural repose; and a life as much as possible in the open air; a diet composed of strong, nutritious food, but of plain, non-stimulating character, regularity of habits, and provision for abundance of undisturbed sleep.

By the present methods of dealing with the two classes of patients of which we are speaking, neither of these essential conditions are secured. The associations which now accompany their treatment are of the most unfortunate character, and cannot but be detrimental to the well-being of any person exposed to their influence. A mind congenitally defective, or unsettled by overwork or over stimulation, or a character depraved by the long continued indulgence of vicious tendencies and pernicious appetites, will certainly not be benefited by the companionship of

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those with whom one is necessarily brought into contact in a prison or a mad-house. The treatment to which these patients are at present subjected cannot be properly called curative. It cannot possibly operate to relieve them to any such degree as it might do, if these features could be eliminated.

How this may best be accomplished, and how those persons addicted to the habitual use of intoxicants, and those rendered insane by the same means, may be most advantageously treated both for their own good and for the good of society, I regard as among the most serious problems of our day. I doubt if our people are ready at this time to seriously consider it with that degree of candor and disinterestedness which the subject demands; nor will they do so, until a purer and more healthy spirit pervades our governing power, and a more rationally humane and truly charitable disposition is evinced by the people.

The suggestions which I have to make may not be the wisest or most desirable; but they are the best I can advance at this time, and are presented not as a basis for any present action, but for the sake of eliciting discussion and inviting more practicable suggestions from the members of this distinguished society.

The fact must be constantly borne in mind that these individuals, whatever their former condition or ability, generally degenerate physically, morally and financially, unti they become dependent upon private charity or require the official care of the State or municipality. Now, if the public can assume control of these unprofitable members of its body and institute a judicious treatment of their infirmities, treatment based upon careful and considerate study of their diseased condition and needs, these patients will not only be better cared for than they now are, but they will experience the added benefit that the result of such treatment will tend toward their radical cure. Such a plan would premise that the municipal authority should be in some way enabled to include within its limits those persons, not yet criminals perhaps, but intellectually weak and depraved,

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and possibly unconscious transgressors against laws they do not comprehend. The protection of society from the violent acts of drunkards, sane and insane, is a matter of vast importance, when we consider the frequency of such occurrences. The public is shocked at each new victim of insane violence, and shudders at the unending procession of suicides, but is strangely insensitive to the existence of *potential* homicides and suicides, who meet us at every turn. If these people could be properly cared for, their indulgence in intoxicants restrained, good and sufficient food be given them instead, and they may be made to employ their bodily powers in some muscular activity, graduated to suit the requirements of each individual case, with enforced regularity in regard to repose, I am sure that a short time would be amply sufficient to turn the tide in many cases from disease to health, and from the progressive degradation of the insane drunkard to the light and liberty of a free, sane and competent man.

How this desirable result may be best achieved in America at this time, under our present system, or rather lack of system, I am not prepared to say. One thing, I think, is true beyond question. None of the so-called "Inebriates' Homes," "retreats," or asylums, as at present conducted, have proved to be of much service in the real treatment of habitual drunkards and particularly of insane drunkards. It is not in their nature to accomplish this result, as they are entirely without authority to exercise judicious and needed restraint in those cases in which it is absolutely required. They are essentially little more than temperance boarding-houses, where inebriates can remain by paying a certain sum of money and conforming to the regulations of the institution. Probably, the majority of those patients who are benefited by a residence in these establishments would be quite as well able to reform under favorable conditions without residence in any asylum.

But it is not this class of cases alone which we are called upon to consider. It is also the poor and the

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helpless whose circumstances do not allow them to enjoy the luxury of prolonged abode in these retreats, and who have not the moral strength to forsake their vicious habits. These also require attention and care. For their treatment, the exercise of judicial restraint is absolutely necessary. They must be *assisted* to overcome a diseased tendency, for the control of which they do not possess the necessary strength. Here is where all present institutions are found wanting. The inmate cannot be legally detained within their care one hour beyond his own desire. He can thus at any time defeat all such efforts for his reformation. Dr. Fisher remarks that "an insane drunkard with homicidal propensities is more independent of legal restraint than any other person in the community."

The manner in which a legal supervision is to be exercised so as to secure the humane and curative treatment of the mental and physical condition in the various classes of drunkards in our midst, it is not the province of this paper to discuss. If the views herein advocated receive the approbation of this society, some plan for their practical application will not long be lacking. A few hints from practical experience may, however, not be without interest in this direction. Some years ago, while making a foot tour through a portion of Germany, I passed through a section of country of considerable extent which had been a barren, cheerless waste, but which was in some parts at that time occupied by extensive plantations of regularly set and cultivated spruce or other evergreen trees in varying stages of growth. Upon making inquiries, I was told that, in several neighboring municipalities, the penalty for the less serious violations of law was transportation to this wild region, and a forced detention there until a certain number of trees had been properly planted or other forestry labor performed, when the offender was at liberty to return to his former home. I was told that drunkenness and its minor accompaniments were among the more frequent causes of this temporary banishment and enforced labor.

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I was forcibly struck at the time by the much better circumstances for the moral and physical reconstruction of the subjects of alcohol there than in our own country, where they are often confined in hot, overcrowded, unwholesome rooms, at unhealthy occupations, in company with those much worse than they are, who must exert a harmful influence upon them.

In another part of Europe, I was told that the greater part of the prepared stone for the building and repairing of the magnificent post-roads in that part of the country is the result of labor sentences as the penalty for minor transgressions against the civil law. Certainly no one can doubt that occupation in the open air, of purely muscular character, and not so laborious as to occasion too great a degree of fatigue, with proper restraint and supervision, would be the very best means for counteracting the effects of over-stimulation in our inebriate population.

We have, in all large cities, certain commissions or departments of the municipal service which are so limited and circumscribed as to make it possible to exercise complete supervision. Such is the care of the city stables, in which one overseer could easily observe the movements of a number of employes. The paving and sewer departments usually control large enclosed areas, in which considerable numbers of men might be employed. The care of the public parks, and the labor in landscape gardening, now so commonly seen in every town of even moderate pretensions, might be performed by these wards of the public, who would thus accomplish two important ends: 1. Their own improvement and final recovery in a much larger proportion of cases than under our present treatment of drunkards. 2. They would, as a class, become self-supporting, instead of becoming and remaining the subjects of public maintenance. In many other ways, which will readily suggest themselves to any thinking person, these individuals might be employed, and carefully guarded from temptation until nature might effect a cure, and so reclaim her own.

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Some may consider these suggestions as too visionary and too ideal ever to become a reality. They may not be practicable at this time; but they certainly are possibilities, as has been demonstrated by the experience of the Lintorf Asylums for Inebriates, near Duesseldorf, in Prussia. Here, a system similar in its general character to the one I have outlined has been in operation, if I am not mistaken, since 1851, and is productive of very gratifying results. The life of the inmates is carefully regulated, and strict compliance with the rules of the establishment is required. A large majority of the inmates remain for a period longer than six months, and are treated by means of good food, medical care, labor, kindness and sympathy, recognizing in inebriety a disease more than a vice, and treating it as such.

The reports state the proportion of cures to have been from twenty-seven per cent. to thirty per cent. of all cases, a figure far beyond anything yet approached in our country.

The objection may be raised to the views advance in this paper, that they are inexpedient, or, in other words, that the man or woman who is degraded to such a degree as to indulge in intoxicating drinks has thereby merited the full measure of disgrace and suffering accompanying the punishment for their acts while drunk, or their treatment if sick. In reply to such objection, it can only be said that in a former age, the same spirit was evinced by the world toward many other physical and mental disorders with which frail humanity is afflicted; but I think the time is fully come when any such unjust and unsubstantial reasoning should be superseded by a mode of treatment more nearly in accordance with the advanced knowledge of a more enlightened century. And, in addition to this is the important fact that, in the majority of cases, the individual afflicted is really no more reponsible for his condition than is the victim of syphilis, the slave of opium, the subject of epilepsy or intermittent fever or many other misfortunes which might be mentioned.

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It would certainly now be regarded as inhuman to allow patients with leprosy to die uncared for in the fields, and it is no longer considered necessary to burn inoffensive lunatics. It is fully as great a cruelty to confine persons, really the subjects of mental disease, in the same place with the vile and desperate element which one finds in our crowded prisons and houses of correction. It is inhumanity beyond expression to subject the insane drunkard, perhaps only temporarily diseased and quite susceptible of cure, to the daily and nightly companionship and uninterrupted association with furious maniacs, epileptics, suicides, maudlin babblers and imbeciles. Experience demonstrates that the fatal influence of only occasional exposure to such diseased surroundings often shows itself in mental derangement of those who have been connected with the care of the insane, and I am informed that a surprising number of the physicians and nurses connected with our asylums and other institutions of a similar character, either become subjects for their protection and care, on account of positive mental derangement, or are maintained by their friends in domestic seclusion rather than in a public institution. Thus, mental disorder sometimes seems to be acquired by the healthy individual from occasional contact with the subjects of disease; and, if this be true, how much more liable to the same danger an individual must be whose nervous system is already temporarily shattered by over-stimulation, whose intellectual powers are already unsteady, if not positively deranged, and who requires treatment for weeks or months suited to the necessities of his condition, among the more essential elements of which are freedom from excitement, rest and peace of mind. I think the wonder is, that insane drunkards who are placed in asylums under the present system, ever escape permanent mental impairment from their unfavorable surroundings.

The practibility of this or any similar plan of treatment will always depend upon two principal factors; first, the ability of the public to realize that it is as easy to

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support an insane drunkard in some asylum arranged for his particular care, as it is to support him in an institution designed for the legitimate needs of another and a different portion of the public burden, in which the indispensable conditions for his appropriate treatment and care do not and cannot exist, and from the restraints of which he can at present always effect a legal escape at a time when he is in immediate danger of a relapse upon any exposure, with a certainty of rendering each subsequent period of treatment less hopeful than before. One such case, the record of which is preserved by a friend and colleague, has been committed to the house of correction four times, and has been an inmate of the lunaitc hospital *seventeen* separate times, from the recurrence of a diseased condition, which, by appropriate treatment, might perhaps have been easily and permanently cured in its earlier stages, instead of becoming a chronic state, which is truly a "second nature," and often justifies the remark that "the insane drunkard is only sane while in the hospital."

Second. The other factor which must be present to render this or any similar method of treatment possible, is that alluded to a moment ago, a dispensation of authority in such a manner that this large and increasing class of our community may be reached by its provisions, and benefited by its practical application.

It may be claimed that the views here advanced, are concerned not with the cause of drunkenness, but only with its effects, and that any attempt to benefit drunkards should be directed to the prevention of the evil rather than to its cure, when the evil is already wrought. This criticism is very true, but it must not be forgotten that the subject of the prevention of drunkenness is still one of the purely speculative questions of the day, in the solution of which, absolutely, no essential advance has been made, notwithstanding the fact that the ingenuity of a generation of philanthrophy has been devoted to its study; but the products of the evil are continually around us, and are constantly demanding some practical relief at our hands.

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Cerebral Syphilis Manifested by Isolated Involvement of the Trigeminal Nerve; Persistent Conjunctivitis and Facial Anæsthesia.

By Allan McLane Hamilton, M. D.

THE following case presents many interesting features in relation to diagnosis, in the fact that ocular symptoms appeared at first which were mistaken and considered to be only of slight importance. Their persistence and subsequent association with evidences of serious cerebral disease gave them, however, greater weight. Not the least suggestive feature of the case was the involvement of the vasomotor nerves of the skin of the face, and mucous membrane of the mouth and nose.

C. F., a business man, thirty-seven years old, consulted me in January, 1882. He had suffered for several weeks from a severe conjunctivitis of the right eye which defied all ordinary treatment. It was found that there had been no injury to the eye, that it contained no foreign body; that there was no corneal ulceration or other trouble visible, and no abnormal appearance was presented except a lively injection of the conjunctiva, with profuse lachrymation. The patient complained of pain and photophobia.

I ascertained that he had had a chancre twelve years ago with bubo, but no history could be obtained of secondary symptoms that might be made use of. His hair was luxuriant, and there were no marks of former eruptions. He had had mucous patches however, and has recently had nocturnal headaches and shin-pains. His present trouble began, as he said, like an ordinary influenza; he had faceache, and his sense of smell was blunted just as it had been before, whenever he had a severe cold in the head. His right eye became inflamed

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and it "always felt as if there was something in it." As has been stated, however, nothing was found, except a small ecchymotic spot near the outer canthus, which was of spontaneous origin.

The right side of the face was more or less anæsthetic and analgesic areas supplied by the superior branches especially, were most so, and sensibility of the lower part of the face was not so much affected as above the eye. The right side of the mouth was involved as was the nasal mucous membrane. Irritation of the right nostril and removal of hair produced no discomfort. The buccal mucous membrane was roughened and the gums were tender and puffed.

There was no notable loss of the sense of taste. He could always detect acid, sweet, salt and bitter substances, though in the beginning imperfectly, and always best at the back of the tongue and on the left side. At one time the physical character of food was perceived and little else in the affected side. I applied Neumann's galvanic test to the tongue, two fine insulated wires with exposed ends, and connected with fourteen cells, Leclanche elements being used, and it was found that the electric taste was most acute at the back of the tongue.

The anæsthesia was preceded by neuralgic pains which affected the upper branches especially. He has now *anæsthesia dolorosa* occasionally, and when the Faradic electrode is passed over certain points in the cheek, it produces deep pain. Hearing is unimpaired. There appears to be a diminution of reflex excitability.

The motor branches are seemingly affected but slightly. The jaw action is good. There is slight elevation of the arch of the palate upon the affected side. A slight drooping of the lower part of the right side of the face exists, however, which may depend upon the loss of several teeth upon this side or perhaps to a weakening of the masseter.

One of the most interesting changes is witnessed in the altered vascularity. If the finger is brushed ever so

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lightly over the skin of the right cheek, or when the points of the æsthesiometer are removed, a bright red *tache* is left.

This phenomenon can readily be produced and lasts for some little time. The left side of the face may be stroked or rubbed without any such effect. The affection of the vasomotor fibres in the trigeminus probably accounts for this, as well as for the condition of the buccal mucous membrane, and the ophthalmic symptoms.

Since the commencement of treatment his hair has rapidly changed in color, and there really seems to be a preponderanee of white hair upon the affected side. His condition during the past nine months has been modified somewhat by treatment, which is of a specific character and consists of iodide of potash in large doses and inunctions of oleate of mercury. The effects of taste and smell have been improved and his eye does not look as badly as it did, nor is it so hyperæmic as it was several months ago. The anæsthesia of the maxillary branches of the nerve is less, but it is evident that the cerebral lesion is involving other regions, for the tongue points to the affected side.

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The Curability of Insanity; New Observations.

By Pliny Earle, M. D., Northampton, Mass.

SUPERINTENDENT OF THE NORTHAMPTON LUNATIC HOSPITAL.

ONE of the consequences of the publication of the articles on the Curability of Insanity, in the annual reports of the Northampton Lunatic Hospital, for the years 1876, 1877 and 1878, was the conviction, in the minds of of the members of the State Board of Health, Lunacy and Charity, of Massachusetts, that the long persued method of reporting the statistics of the hospitals of the insane was so imperfect, in some respects, as to deceive rather than to enlighten the mind of the reader.

Desiring to test, so far as possible, by new statistics, the main question in regard to curability, as well as to place the institutions of the State upon the right road toward the attainment of truth, that Board, in 1879, procured the preparation of an almost entirely new series of tables, and recommended their adoption in place of those formerly used. The proposition was immediately acceded to, not alone at the four State Hospitals, but at the McLean Asylum and the City Asylum of Boston.

The reports of two official years since that time have been published, and those of the third, which has just expired, will doubtless be in print before the 1st of January, 1883. We have already, then, in Massachusetts, the results of a three years' experience under the new order of things which was introduced by the adoption of the tables mentioned. That period is sufficiently long to furnish material from which, as premises, conclusions entitled to a very considerable degree of confidence may

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be drawn. Drs. Park, Brown and Goldsmith, of the three hospitals at Worcester, Taunton and Danvers respectively, have very courteously furnished me, in advance of publication, with the statistics of those institutions for the year recently elapsed. I propose to pass in review this new material from the four State establishments, and endeavor to ascertain its teachings.

It should be stated that the figures of the statistics relate to *persons* and not to *cases*, the same person not having been counted twice within either year, whatever might have been the number of his admissions. It is possible that, in a few instances, the same person was admitted in more than one of the years; but, if any such there were, the number is not sufficient to materially affect the results.

1. Admissions of Persons in Three Official Years.

HOSPITALS.	1879-80.	1880-81.	1881-82.	Totals.
Worcester, - - - - -	222	237	304	763
Taunton, - - - - -	184	267	237	688
Northampton, - - - -	115	120	119	354
Danvers, - - - - -	571	488	507	1,566
Totals, - - - -	1,092	1,112	1,167	3,371

The principal value of this table is in its exhibition of the progressive increase in the number of *persons* admitted to the hospitals. In the two years intervening between the first and the last report, that increase was seventy-five (75)—twenty (20) in the first year and fifty-five (55) in the second. This ratio of increase, if continued, would double the number of persons admitted as patients in 29.79, or, in round numbers, in thirty years. The population of the State is not increasing so rapidly as that, and consequently, so far as these figures are to be relied upon, the proportion of the insane committed to hospitals, as compared to the number of inhabitants of the State, is on the increase.

At Worcester there was a regularly progressive increase

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in the numbers admitted. At Danvers and Taunton, where fluctuations in this respect were the greatest, the admissions were largely governed by outside influences, not natural but arbitrary. The patients from Boston were sent sometimes chiefly to one of them, sometimes to the other, as circumstances determined.

2. Admissions and Recoveries of Persons in Three Years.

HOSPITALS.	Persons Admitted.	Persons discharged Recovered.	Per cent of Recoveries on Admission.
Worcester,	763	148	19.40—
Taunton,	688	148	21.51+
Northampton,	354	76	21.47
Total of three Hospitals,	1,805	372	20.61
Danvers,	1,566	378	24.15
Whole number,	3,371	750	22.25

The hospital at Danvers has so recently been opened that it is exceptional, in some respects, as compared with the other three. I have consequently so arranged the table that those three can be considered separately.

The proclamation,—"The best authorities assert that 75 to 90 per cent. of recent cases of insanity are curable," with which, or with something equivalent, each half-fledged tyro in mental diseases formerly soared into the regions of imaginative psychology, either in his annual report, as a recently installed superintendent, or in some article upon the subject, as a pamphleteer or a writer for periodicals, is familiar to those who have read the Northampton reports, even though they may not have met it in its original places. Like the "voice of the turtle," in Palestine, in the spring-time of seasons long gone by, that proclamation was, until within the lest three or four years, often "heard in our land;" but now, like the song of Childe Harold, it "hath ceased," or, at best "has died into an echo," like his theme. Yet to him whose faith was challenged by its reiterated assertion, and whose hope was stimulated thereby into an expectation that all cases might soon be treated in their early stages, the

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table here presented cannot fail to be sadly and sorrowfully interesting.

It matters little what is asserted *can* be done so long as it is *not* done. To the philanthropist, the humanitarian, the political economist, the tax-payer, even the mere citizen, the important question is, not what is the proportion of the insane that has been alleged, on very flimsy grounds, to be susceptible of recovery, under certain given but often impossible circumstances, but what proportion *do* recover and return to their homes as useful members of society?

By the table just introduced, it is shown that in the the course of the three official years ending with Sept. 30, 1882, three thousand, three hundred and seventy-one (3,371) *persons* were admitted into the four State hospitals, and seven hundred and fifty (750) *persons* were discharged from them as recovered. The recoveries were 22.25 per cent. of the admissions. Hence, *not one-half, not even one quarter*, but only *a fraction more than one-fifth* as many *persons* recovered as were admitted. In the oldest three of the hospitals, the most recently erected of which has been in operation twenty-four years, the proportion of recoveries was still smaller, being 20.61 per cent., or almost precisely one-fifth, as compared with the persons admitted.

It is not a little interesting to observe the very near approach to equality of these proportions in the oldest three of the hospitals.

At Danvers, the ratio of recovery was larger. This is sufficiently explained by the fact that, at the beginning of the period of three years, that hospital had been in operation less than eighteen months. It was not full, and it was the resort for nearly all of the recent cases of insanity from Boston and the four other cities in its vicinity.

For the purpose of further illustration, I here introduce a table showing the ratio of persons recovered to persons admitted, at each institution, in each of the three years respectively.

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3. *Percentage of Persons Recovered in each Year.*

HOSPITAL.	1879-80.	1880-81.	1881-82.	For Three Years.
Worcester, - - - - -	18 46	21 94	18.09	19.40—
Taunton, - - - - -	26.62	21.34	17.72	21.51+
Northampton, - - - -	24 34	16.66	23.83	21.47—
At the three Hospitals, - -	22.65	20.67	18.94	20.61—
Danvers, - - - - -	28.89	25.41	17.55	24.15—
At the four Hospitals - -	25 95	22 75	18.34	22.25—

Perhaps the most noteworthy information derived from this table is, that at the hospitals, as a whole, there was a progressive diminution of the annual proportion of recoveries from the beginning to the end of the period, as shown by the figures 25.95, 22.75, and 18.34. This regular but quite sufficiently rapid falling off in the proportion of persons recovered may be merely incidental and temporary, but nevertheless it is not encouraging. The graded reduction of recoveries took place at the oldest three hospitals, but to a less extent. In the hospitals, as a whole, it was equal to 7.61 per cent. of the persons admitted; in the three oldest hospitals it was only 3.71 per cent., or a fraction less than one-half as much. The greatest diminution, equal to 11.34 per cent. of the persons admitted, was at the Danvers Hospital. The cause of this is readily understood. As the institution became filled to crowding, the current of recent cases which had been flowing to it was, to a certain extent, diverted from its course, and directed toward the other hospitals.

The largest percentage of annual recoveries at any of the oldest three hospitals, in the course of the period was 26.62, at Taunton, in 1879-80; and the smallest, 16.66, at Northampton, in 1880-81.

It is a delicate matter thus to bring the several institutions into the closest juxtaposition, for the puspose of a comparison of the results of their work. Were it not that I have great confidence in all and each of them, it would not be attempted. I regard these Massachusetts hospitals as among the best of their kind, not in the

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United States alone, but in the world; and I most conscientiously believe that they are now under a medical management so good, and so nearly equal, that any insane person who would recover at any one of them would likewise recover at either of the other three.

We now approach a part of the statistics before us, perhaps the most important as well as the most interesting of all, in consequence of their bearing upon the question of the absolute curability of mental disorders. The extreme liability to relapse of a large proportion of the cases recovered from insanity, is now very generally known. In some instances the relapse and the recovery occur so frequently that some physicians maintain that there is *no* recovery; but that the disease, during the apparently rational intervals of the patient, is merely in a state of suspense. But, in these cases, it is the almost universal practice at the hospitals, if they are discharged at the subsidence of each returning paroxysm, to discharge them as recovered. As heretofore shown, the recoveries are thus sometimes largely increased beyond the number of persons. In view of these cases, I have often been reminded of the notorious old toper who one day greatly surprised an acquaintance by telling him that he had "left off drinking," and when the assertion was doubted, reaffirmed its truth, declaring, as undeniable proof of the fact, that he had "left off three times" that morning.

The subjoined table shows the number of persons discharged recovered, and the number of persons readmitted, who had at some former time been discharged as recovered.

4. *Readmission of Persons formerly Discharged Recovered.*

HOSPITAL.	Persons Discharged Recovered.	Readmission of Persons formerly Discharged Recovered.	Proportion of Readmitted to Discharged.
Worcester, - - -	148	65	1 in 2.28
Taunton, - - -	148	70	1 in 2.11
Northampton, - - -	76	43	1 in 1.76
Totals of the three Hospitals,	372	178	1 in 2.09
Danvers, - - -	378	66	1 in 5.72
Totals of the four Hospitals	750	244	1 in 3.07

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In the return to their homes of seven hundred and fifty (750) persons recovered fron their insanity, the hospitals accomplished a great good. This work of beneficence was, however, as is shown by the table, in one sense partially counterbalanced by the readmission of two hundred and forty-four (244) persons who had been previously discharged as recovered. The percentage of the readmissions on the discharges is 32.53. In other words, very nearly one-third as many formerly recovered persons were taken back from the community, as were given to it by the hospitals. At the three oldest hospitals the proportion was still larger, the number of formerly recovered persons readmitted being very nearly one-half as great as that of recovered persons discharged. At the Worcester Hospital it was a fraction more than two-fifths; at the Taunton Hospital, nearly one-half; and at the Northampton Hospital, more than one-half, or nearly three-fifths.

At the Danvers Hospital three hundred and seventy-eight (378) persons were discharged as recovered, and only sixty-six (66) formerly recovered persons readmitted. The proportion of the returned recovered to the discharged recovered was as 1 to 5.72, or a little more than one-sixth. This, like the heretofore mentioned exceptional results at that institution, is a consequence of its newness. As before mentioned, at the beginning of the three years it had been in operation less than a year and a half, and hence there had not been time for a relapse of any of its recoveries other than in those persons whose disease recurs at short intervals. As will be seen by the table next to be introduced, the numbers of the readmitted recovered, in each of the three successive years, was 18, 17, and 31, respectively, nearly one-half of them being in the last year of the period. As the hospital grows older, this, as well as the other results in its medical history, will approximate more and more nearly those of the three other and more early established institutions.

Before leaving this special topic, it should be remarked that although the Danvers Hospital readmitted but

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comparatively few of the persons whom it had discharged as recovered, yet it is highly probable that it admitted a no inconsiderable number who had previously been discharged as recovered from the other three institutions. The early reports give no direct information upon the subject, but within four and a half months from the day the hospital was opened, no less than *forty-three* (43) patients suffering from a *second attack* were received. It is probable that the larger part of these had recovered from the first attack at other institutions. The same may be said of the seventy-three (73) patients with second admitted in the official year 1878-9, which began at the close of that period of four and a half months. Of these one hundred and sixteen (116) patients, who knows how many had recovered once each, at either Worcester, Taunton, or Northampton? The number can be ascertained only by an examination of records.

In the first two years of the three years' period to which these statistics refer, the Danvers Hospital admitted one hundred and one (101) patients who had been inmates of the other three hospitals mentioned, but we are not informed of the condition, in regard to recovery, in which they had been discharged from those hospitals.

5. *Annual Readmissions of Persons formerly Discharged Recovered.*

HOSPITALS.	1879-80.	1880-81.	1881-82.	Totals.
Worcester,	25	17	23	65
Taunton,	19	29	22	70
Northampton,	22	10	11	43
Total of three Hospitals,	66	56	56	178
Danvers,	18	17	31	66
Totals of the four Hospitals,	84	73	87	244

Some of the most important information imparted by this table has already been mentioned. By an examination of the figures in detail it would appear that the number of formerly recovered persons annually readmitted is accidental, or incidental. It follows no law. There is

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neither a regularly progressive increase nor a regularly progressive decrease. The whole number is admitted in the first year is smaller by two than that of the last year; but at the oldest three hospitals the number in the first year exceeded by ten that of either of the other years.

So much in regard to the persons who had previously been discharged recovered, but who had returned to the hospitals. It will now be shown that some of those persons had been discharged recovered more than once. This will be done by giving the number of times that all of them (244) had been so discharged.

6. *Ratio of Recoveries to Persons Recovered.*

HOSPITALS.	Readmissions of Persons formerly discharged Recovered.	Number of times they had been discharged Recovered.	Excess of Recoveries over Persons	Average Recoveries to each Person.
Worcester, - - -	65	160	95	2.46
Taunton, - - -	70	122	52	1.74
Northampton, - -	43	66	23	1.53
At the three Hospitals, -	178	348	170	1.95
Danvers, - - -	66	67	1	1.01
At the four Hospitals -	244	415	171	1.70

Hence it will be perceived that the two hundred and forty-four (244) recovered persons readmitted had been discharged recovered four hundred and fifteen (415) times. The excess of *recoveries* over *persons* is one hundred and seventy-one (171). At the oldest three hospitals the *proportionate* excess is much larger. Their one hundred and seventy-eight (178) formerly recovered persons readmitted had been discharged recovered three hundred and forty-eight (348) times. The excess of *recoveries* over *persons* is one hundred and seventy (170). The number of *recoveries* lacks but eight (8) of being twice as great as that of *persons*. At the Worcester Hospital, much the oldest of the four establishments, sixty-five (65) recovered persons readmitted had been discharged recovered one hundred and sixty (160) times. The excess of *recoveries* over

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persons was ninety-five (95); and the number of *recoveries* nearly twice and a half as great as that of *persons*. At the Danvers Hospital the number of *recoveries* exceeds that of *persons* by only one (1). For reasons already given this result will be understood.

There is one supposable source of error in these statistics of repeated recoveries, and that is the possibility that a person who had been discharged recovered more than once, may have so been discharged in more than one of the three official years. If, for example, a person who had previously recovered three times were discharged recovered in the first year, making his *fourth* recovery, and being afterwards again admitted and discharged recovered in either of the other two years, he would be reported twice in the period, once as having had *three* former recoveries, and again as having had *four*. This would make the number of his recoveries, as represented in the table, *seven*, whereas it had been but *four*. If the table contains such errors, they probably do not increase the totals of repeated recoveries to a greater extent than they are diminished by the admission of persons at Danvers who had previously recovered at the other three hospitals.

This rather minute and detailed analysis of the statistics of recoveries at the Massachusetts State hospitals, is, from my point of view, more than justified by the circumstances under which it is made. The truth of the seven conclusions which were legitimate deductions from the data which, in 1876, I was able to glean from the results of observations and experience under an imperfect method of recording such statistics at the hospitals, was widely doubted. This doubt was no especial cause for wonder, since, in some instances, those deductions differ very greatly from what, even in the minds of well-informed persons, had hitherto been regarded as the truth. To a very considerable extent the doubt has been removed by the articles upon the subject which have appeared in the reports of the Northampton Hospital since the date just mentioned, but it may still exist in some places.

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In Massachusetts a method of record and tabulation expressly designed for the purpose of bringing out, from the practical experience of its hospitals, the data which would prove or disprove the truth of those conclusions, has been in operation for some years. It was clearly proper that I should avail myself of the fruits of this crucial test, as I here have done. What are the results? The answers can best be made to appear by the reproduction in brief of several of the conclusions.

Conclusion 1.—The reported recoveries are increased to an important extent by repeated recoveries of the same persons.

This is proved by Table 6, where it is shown that at the three oldest hospitals one hundred and seventy-eight (178) *persons* were discharged recovered three hundred and forty-eight (348) times.

Conclusion 2.—The recoveries of *persons* are much less numerous than the recoveries of *patients* or *cases.*

This conclusion is, as a proposition, the converse of the first. Hence, it is proved by the converse of the same statistics. At the three oldest hospitals the number of recoveries of *persons* was one hundred and seventy-eight (178); but the number of recoveries of *patients* or *cases* was three hundred and forty-eight (348), or very nearly twice as great as that of *persons*.

Conclusion 3.—From the number of reported recoveries of *cases*, or *patients*, it is generally impossible to ascertain the number of *persons* who recovered.

This may also be proved by the same (6) table. Under the old method of reporting in this state, as well as elsewhere, the three hundred and forty-eight (348) *recoveries* at the three hospitals would have been published, without giving any clew to the number of *persons* in whom those recoveries took place. By the new method that number is given, and it is found, in this instance, to be one hundred and seventy-eight (178).

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Conclusions 4 and 5 are, by their very nature, not susceptible of proof or disproof by these statistics.

Conclusion 6.—The (formerly) assumed curability of insanity has been practically disproved by more extensive experience.

By cumulative evidence in Table 2, that disproof is corroborated and strongly fortified. At the four hospitals, 3,371 *persons* were admitted, and only 750, or a trifle over one-fifth of them, were discharged recovered. This proportion — 22.25 per cent.— is much lower than was even dreamed of in 1876; and he who would then have ventured to assert that such could be the truth, would have been considered as either a Munchausen, an ignoramus, or a proper candidate for an asylum for imbeciles.

It will be perceived that this reduction of the ratio of recoveries is in part due to the rejection of the duplicate and multiple recoveries of the same person, thus giving to each person but one recovery. For all other than strictly technical or medical purposes, this is the information wanted.

Conclusion 7.—The proportion of recoveries at the hospitals has been constantly diminishing, during a period of from twenty to fifty years.

These statistics cannot prove anything anterior to 1876, when that conclusion was written. But by Table 3 it is demonstrated that, in the four Massachusetts hospitals, the dimunition, since 1879, has continued, the progressive reduction being represented by the consecutive annual percentages—25.95, 22.75 and 18.34. The proportion of recoveries in the year just elapsed is a little less than three-fourths as large as it was three years ago, in the official year 1879-80.

Very clearly, if insanity is to be diminished, it must be by prevention and not by cure.

With the forgoing exposition I might, perhaps, very appropriately close forever these published studies of the subject of the curability of insanity. If the arguments which have been used, and the illustrated proofs which

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have been adduced, in the course of a seven-years' discussion, have been insufficient to procure conviction of the truth of the conclusions published in 1876, it is not probable that anything will have power to convince. It was once intimated that there were minds which would not "be persuaded though one rose from the dead." Others like them there may be at the present time.

There is, however, one hitherto unused illustration furnished by the history of one of the American hospitals, that I cannot well forbear to present in the present connection. It corroborates the testimony of the experience at the Massachusetts hospitals during the last three years, and emphasizes the force of it.

The epidemic fever of opinion in favor of "good"—thereby meaning, as practically translated—"expensive" hospitals, which raged throughout the decennium from 1865 to 1875, or thereabouts, will be but too well remembered. It left, for Massachusetts, its own elephantine monument upon Hathorne Hill, in such fashion that it is not likely soon to be forgotten by the people of the Commonwealth, and, at the same time, similarly perpetuated its memory in other States. Of all the excessively costly curative institutions which were the products or outgrowths of that temporary craze, the Hudson River Hospital, at Poughkeepsie, New York, is, if I mistake not, the most remarkable for its costliness. Danvers is but a pigmy as compared with it. It was intended to be the institution of institutions, destined, so long as it might exist, to stand as a practical and therefore irrefutable proof that lavish expenditure upon hospital buildings can cure insanity.

That hospital was opened on the 20th of October, 1871, and its last published report covers the official year ending with the 30th of September, 1881. At the latter date it had been in operation ten years, minus twenty days.

In the course of that decennium it admitted sixteen hundred and seventy-one (1,671) patients, and discharged

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as *recovered* three hundred and fifty-three (353). The per centage of recoveries, as compared with the admissions, is 21.12, or a fraction more than one-fifth.

In view of this result at the Hudson River Hospital, one of the most prominent men engaged in the work connected with the charities of the State of New York, writes to me as follows:—"If any additional evidence of the correctness of your conclusions in regard to the curability of insanity is needed, it is furnished in the ten years' experience of this most expensive of institutions 'established persumably for cure.'"

The very near approach to identity in the results at Poughkeepsie and at the Massachusetts hospitals, may arrest the attention of the reader. The proportion of the recoveries was:

At the Hudson River Hospital,	- -	21.12 per cent.
At the four Massachusetts hospitals,	-	22.25 "
At the oldest three Massachusetts hospitals,		20.61 "

But there is a difference in the computation of these ratios which operates pretty largely in favor of the Massachusetts institutions. The statistics of Massachusetts relate only to *persons*; those of Poughkeepsie to *patients*, or *cases*. The Hudson River Hospital gets the advantage of all the repeated recoveries of the same person, which, like all other institutions of the kind, it must have had; whereas at the Massachusetts hospitals, these were al rejected.

Other appropriate topics, furnished by both the United States and Europe, might here be introduced, but I must pass them by, with two exceptions upon the other side of the Atlantic.

In my annual report, one year ago, there was a notice of the statistics of the Morningside Asylum, at Edinburgh, Scotland. It appears that, from a misunderstanding in regard to the patients who had suffered more than one attack, I was led to erroneous conclusions. It was stated that of the 347 patients admitted, 108 were readmitted after recovery from one or more former attacks. This

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was a mistake, of which the acknowledgement and the correction give me more pleasure than the assertion. The 108 should have been 63. But I will let Dr. Clouston make the full correction in his own language.

"The asylum discharged [in 1880] 165, but it had taken back, altogether, of persons who had been discharged, *recovered* and *unrecovered*, 80. Of this 80, 63 had recoved in former years, showing that *there is a considerable part of the inmates of asylums whose brain condition being unstable, they come in and go out frequently.* But out of the 267 first admissions there were 97 first *recoveries.*"

My most cordial thanks are due to the doctor. He acknowledges, in the language which I have italicized, that his own statistics show precisely what I have been attempting to prove for the last half-dozen years.

I am now indebted to the doctor for his very interesting report for the year 1881. In this the recoveries for the year are reported in a manner differing from that of the next preceding year, and by that difference the report becomes more lucid. The number of admissions, in the course of the year, was 339, of which 247 were for the first time, while 92 were readmissions. I here copy, in full, the table of recoveries:

Persons Recovered in 1881.

	Males.	Females.	Total.
A. Recovered for the first time, - -	45	48	93
(a) Readmitted, and again discharged recovered, - - - -	—	4	4
(b) Readmitted, but not again discharged recovered, - - -	6	3	9
B. Had made one or more recoveries in previous years, - - -	31	34	65
(a) Readmitted, and again discharged recovered, - - - -	—	—	—
(b) Readmitted, but not again discharged recovered, - -	7	4	11
Number of persons recovered, - - -	76	82	158
Number of cases of recovery, - - -	76	86	162

The whole number of *persons* who recovered within the year was 158: 93 of these recovered for the first time.

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