ENDOGENOUS DEPRESSION IN GENERAL PRACTICE

BY

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In six years of practice before the war I diagnosed only one case of endogenous depression, and that after the patient had committed suicide. After psychiatric experience in the Army I have found the condition comparatively common in general practice. In six months no fewer than 20 cases have come under my care, pointing to the prevalence of the complaint. Not many family doctors have the opportunity for postgraduate study of psychiatry, and the result must be that a great many cases go undiagnosed. Only a small proportion of the cases, usually the most serious, come before a psychiatrist, as the fear of mental-hospital stigma keeps the patient away from specialist help until either the case is certifiable or time itself has effected a cure.

This paper is a preliminary report to draw attention to the endogenous depression which is far more common than is generally realized. The term "endogenous" is used in preference to the term "psychotic" as the latter implies insanity, and few of the patients found in general practice could be certified as insane. Of the 20 cases in this paper only three were considered bad enough for electro-convulsive therapy (E.C.T.). All three stubbornly refused to go to a mental hospital for treatment. Two have recovered without it, but the third is showing no signs of improvement.

One seldom hears of a patient with cancer committing suicide. On the other hand, suicidal ideas are common among the depressives. The desire to end things is some measure of the patient's suffering. Depression is probably the most unpleasant illness anyone can contract. With such deadly diseases as cancer or tuberculosis there is always some hope, real or built on euphoria; but to the depressed patient, whose condition is far from hopeless, there is no hope and no future.

The mental hospital cases with a general retardation of the psychological and motor systems are fairly easy to diagnose; but for each classical case there are a score of mild depressives who eke out a miserable existence in their homes, keeping their troubles to themselves or receiving the only treatment a family doctor can offer, which is often inadequate. Others are

wrongly diagnosed as neurotics, hypochondriacs, and other chronic forms of invalidism. An accurate diagnosis is important, as there is always the danger of suicide. The patient is often reluctant to talk about his feelings and is easily put off by unsympathetic handling. He is only too ready to attribute blame to himself. Thus to be scorned as a neurotic or simply told to "pull himself together" is both cruel and unfair. Frequently his relations have tried these "back-slapping" methods, implying that he is either soft or weak-willed. No patient in practice deserves more sympathy. Good rapport, if it can be established between the patient and his doctor, is one of the most valuable weapons with which to treat the disease. Once adequate rapport has been created, such difficult subjects as suicide, the nature of the illness, and the possibility of mental hospital treatment can all be discussed with pleasing candour. The patient may show surprise when such subjects are broached, but he is rarely upset by them, because in his heart he has already weighed up such possibilities. "I have thought of suicide, but I should never have admitted it if you had not asked me," is the typical reply to such a question.

Symptoms

The disease is largely symptomatic and it can simulate almost any functional or organic illness. There is an almost infinite variety of types. The following symptoms are the most important, and each will be considered in detail. (a) depression; (b) suicidal ideas; (c) changes in the sleep rhythm; (d) changes in habit and outlook; (e) obsessions and phobias.

Depression

In the type of case one deals with in general practice this is rarely profound, and one cannot always see it written on the patient's face. Close relations usually notice some difference. The patient as a rule complains of one or more somatic symptoms and admits of depression only when questioned directly. The varieties of early symptoms are shown in the accompanying Table.

The patient will usually admit that he is depressed and that his outlook on life has changed. His sense of humour is different from what it was and he rarely laughs. Life has become a burden and every molehill looks like a mountain. Problems and responsibilities he would once have taken in his stride now make him hesitate and hold back. He has lost confidence in himself and his ability. When asked if he or his

Table Showing Varieties of Early Symptoms

Case No.	Sex	Age	Previous Attacks	First Symptom	Sleep	Suicidal Urge	Habit Changes	Work	Length of Illness	Result
142	M	25	None	Patient had malaria	Normal	Present	Asocial	Put off work	3½ months	Recovered
143	F	47	"	Insomnia	Early waking and bad dreams	None	"	Carried on in a fish-shop	5 "	"
144*	M	60	Recurr each spring	Depression	Early waking	"	"	A chronic invalid	2 "	"
145	F	27	None	"	General insomnia	"	None of note	Kept at work	5 weeks	
146	F	46	One previous attack	Patient had cut flexor tendon	Difficulty in falling asleep; sleep broken	"	Seeks company; fears to be alone	Off work	10 months	I.S.Q.
147	F	43	None	Fainting	General insomnia	"	Has stopped playing piano	Kept on at house-work	8 "	Improving
148	F	60	"	Pain in chest	"	Present	Weeping bouts	"	3 years	Recovered
149*	M	38	"	Indigestion	Difficulty in dropping off	Marked at times	Asocial	Off work	8 months	"
151	F	51	"	Wind in stomach	Broken sleep and dreams	Present	Weeping bouts	Kept on at house-work	2 years	I.S.Q.
152	M	45	"	"	Early waking	None	Asocial	Work modified	3 months	Recovered
157	F	53	"	Depression	Broken sleep	Present	None of note	Kept on with house-work	3 "	I.S.Q.
160	F	49	"	Indigestion	Nightmares	None	Could not write letters	"	2½ years	Recovered
161*	F	48	"	Bad taste in mouth	Broken sleep	Present	Lost interest in her hens	"	8 months	Improving
166	M	43	"	Fatigue	Early waking	"	Lost interest in hobbies	Off work	7 "	Recovered
167	F	42	"	Depression	Broken sleep; wakes early	"	None of note	Kept on with house-work	2 "	Improving
170	F	40	In 1939 was in mental hospital	Fatigue	Broken sleep	None	Became irritable	Off work	1 year	Recovered
172	F	44	None	Dizzy bouts	Early waking	"	Weeping bouts	Work modified	4 months	Improving
176	F	48	"	Vaginal discharge	Broken sleep	Present	"	Carried on with work	1 month	I.S.Q.
178	M	37	"	Cough	Difficulty in falling to sleep	None	Gave up rabbit breeding	"	8 months	Recovered
180	M	47	"	"	Cannot sleep for cough	Present	None of note	"	10 "	I.S.Q.

* Case described more fully in text.

environment has changed he will usually admit that the change lies in himself. He is a different man from what he used to be. He has difficulty in concentrating and in thinking things out. He has to drive himself to do his work. Even his hobbies have lost all attraction. Actual retardation may be difficult to demonstrate, but the sevens test is sometimes useful. The patient is asked to subtract 7 from 100, and then 7 from 93 and so on, until he has reached the lowest possible digit, which is 2 if his calculations are correct. The usual time for a brain-worker is about 30 seconds. The test can be repeated at intervals, and an improvement in the time is some indication of progress.

To the depressive the future looks very gloomy, if not hopeless, and reassurance is not readily accepted. Delusions, such as poverty or that something dreadful is going to happen either to the patient or to one of his near relations, are not uncommon. The patient is prone to get lost in his thoughts. He may sit for ten minutes before doing a job. One patient, at her worst, could not account for a whole day, but none of her relations had noticed any gross peculiarity during that time. Vertigo or fainting is a common symptom among women.

Suicidal Ideas

This subject must be approached with tact. One does not want to upset the patient or to put ideas into his head. If he admits depression one can inquire if he feels bad enough to wish he was out of it. Most of these patients admit that they have had such wishes. One can then ask if they had had any ideas about suicide. Some will agree, and others who may show surprise will say they have never reached such a pitch of depression.

Sleep Rhythm

Few depressives get off without some upset in their normal sleep habits. The classical story is that they get off to sleep fairly easily, but that the least noise awakens them and their sleep has gone. Others wake up in the early hours and cannot get off again. It is during these early hours that they feel worst and suicide is most likely to occur. As the morning wears on they improve and by nightfall feel positively normal, only to waken early the next morning to start the same dismal rhythm again. Some few depressives enjoy good sleep. Others are afflicted with bad dreams and wake exhausted in the morning. Others have difficulty in dropping off to sleep; but such suggests an anxiety state. With some, no two nights are the same. If there is no upset in the sleep rhythm one must seriously question the diagnosis of endogenous depression.

Change in Habit and Outlook

This is often very striking. One patient mentioned that she had always been musical, but since her illness had started she could not bring herself to play the piano. An amateur comedian found himself unable to hold his audience, and so gave up his work in the concert team. One patient gave up drinking when depressed. Others go to the opposite extreme.

Case 110.—In August, 1945, this patient was admitted to a neuropsychiatric centre agitated and visually hallucinated. His tongue was red and atrophic, and knee-jerks were absent. There was a history of heavy drinking to complete the picture of delirium tremens. On intravenous nicotinic acid and aneurin he made a rapid recovery, being mentally normal in four days. His family and past history was almost completely negative. He had begun drinking heavily in the February because he could not sleep. Even a heavy dose of brandy could not keep him asleep after 4 a.m. His commanding officer and his wife were closely questioned as to the patient's habits. His wife admitted that since the February he had changed. He had lost all interest in his home and children, never doing the odd jobs about the place to which he was accustomed. He ate and slept badly. The depression appeared to have cleared up with his delirium tremens. Both the patient and his wife affirmed that he was back to normal before he was discharged in October, 1945.

It is well worth while bearing melancholia in mind when a man, previously known to be sober, suddenly starts drinking to excess for no apparent reason.

The social man may find himself shunning society. Others fear to be alone, and seek company, but feel out of it when they get there, as they have nothing to say and are so different from what they used to be.

Case 149.—This man, aged 38, first came to see me in February, 1946. He complained of stomach-ache occurring at intervals, an occasional headache, and a listless feeling. Physical examination failed to reveal any abnormality. His knee-jerks were sluggish, but it was felt that his symptoms were those of an anxiety state. During preliminary psychotherapy he admitted a morbid fear of tuberculosis, a disease which had killed his brother. He was reported to the local tuberculosis officer, who had him x-rayed; but no evidence of the disease was found. As he did not report back it was assumed he had been reassured, but towards the end of April his wife communicated with the surgery. She was very worried about him, as "he was a changed man." He was depressed and unhappy, and had dropped all his social activities. He was interviewed again, and it was found that he was very low, feeling that life had lost all its charm for him. Only the thought of his wife and family prevented him from taking his life. He was worried because, while he had earned good money during the war, he had saved nothing and the family ran the risk of poverty. His sleep was poor unless he took sedatives. By the middle of May he was worse, and had a bad suicidal urge. He was taken home one night in a state of depression, and stated that but for the presence of friends he would have finished it. He was persuaded to see a psychiatrist, who suggested he needed hospital treatment at once. The patient consented, but only because he knew if he did not agree he would never get away from the psychiatrist! This man, who had been a local comedian and very sociable, became solitary and schizoid. Fortunately, soon after his visit to the psychiatrist he began to improve, and by the middle of July was back at work again.

Case 161.—This woman, aged 48, said she had been ill for about a year. She complained of a nasty taste in her mouth and tight feelings round her neck. These symptoms were always most severe in the mornings. She suffered from insomnia and was given to bouts of weeping. She was prone to lose herself for ten minutes or so at a time. She had "nasty thoughts"; these usually implied impending death to herself. When her son announced his engagement she had felt happy because she knew he would not have a mother much longer. She had wished she was dead, but when first seen that feeling had passed. She always felt better in company, which she sought, but was embarrassed when people said she was not the jolly soul she used to be.

Obsessions and Phobias

These may indicate an underlying depression. *Case 149* had a phobia about tuberculosis. Other patients reveal absurd consternation about some trivial mole or wart. Early in 1946 one of the local inhabitants hanged himself because of a tapeworm which had worried him for a few months. In the Army the V.D. obsession was particularly common.

Case 27.—This man, aged 34, had an obsession about V.D. For over a year, while employed in the Middle East, he had seen every available urogenital surgeon and venereologist. He had twice submitted to cystoscopy. Before returning home he reported once more to yet another camp M.O., who took pity on the patient and threatened him with "You don't want to be sent to a psychiatrist, do you?" He ended up at a neuropsychiatric centre, and was given psychotherapy as an obsessional case. He became much worse and made a strong negative transference with his therapist. When seen in March, 1945, there was no obvious cause for any anxiety. He talked too frankly about his sex life, which as Ross (1937) suggested was a pointer towards a psychosis. He had marked feelings of unworthiness, and was always comparing himself unfavourably with others. He was depressed and had suicidal ideas. He slept badly. He was given six E.C.T. treatments and rapidly lost his obsession for V.D. When seen seven months later he was back at work and apparently fully recovered.

Some innocent organ may be blamed for the patient's feelings of ill-health. A man may demand the removal of his testicles, or a woman who has had a prolapse for years suddenly begins to blame it for all her symptoms and is prepared to undergo any operation to have the offending organ removed. Such operations are obviously futile and do not touch the real problem.

On the physical side there is usually no evidence of organic disease. A moderate degree of hypertension is not uncommon. The knee-jerks, which as a rule are brisk in an anxiety state, tend to be sluggish (see *Case 149*). Many depressives are overlaid with a fair degree of anxiety, so that the sign is not of much significance. Depression can of course be coincident with an organic disease, which may make the diagnosis much more difficult.

Case 144.—This man, aged 62, was an invalid from chronic emphysema. He had to spend most of his time sitting in a chair,

as the least exertion made him breathless. He was usually cheerful and philosophical about his complaint, but in March, 1946, he became very depressed. He kept to his own room and was solitary. He felt he was finished, and wished he was dead. He had no suicidal urge. His sleep rhythm was changed and he started waking at 3 or 4 a.m. His relations had noticed the change in him. He was given luminal at night and benzedrine in the mornings. In six weeks the depression passed and he resumed his place in the family circle, feeling "his old self again."

Diagnosis

Any organic or functional disease can be simulated by the psychotic depression, but the most difficult differentiation is in the field of the psychoneurotic illnesses.

Anxiety State

The differentiation here is most important, because the deeper therapy which is applied to the neuroses is definitely contraindicated in the endogenous depression. Case 27 shows how deep therapy can aggravate the condition.

There are two main aids in the differential diagnosis. An anxiety state can be traced back to its origin in frustration or feelings of guilt. The endogenous depression comes "out of the blue." Secondly, the "feel" of the cases is different. A bereavement will make the normal individual depressed, but his poise should have returned to normal in two weeks. The neurotic may prolong the depressive state over weeks or months. The condition is then known as a reactive depression. It is, in fact, a depression brought on by circumstances, and, like all neuroses, is an exaggeration of normal. Furthermore, a reactive depression is motivated and serves a useful purpose. The motive lies below the level of consciousness, and the purpose may be to get sympathy from the remainder of the family. Bereavement may set in motion an endogenous depression. It might be a factor, but could not be the sole cause of the illness. Much more frequently this disease comes "out of the blue." Wringing her hands, the patient exclaims: "And I should be so happy. I have such a nice home and husband, and I am so proud of my family." The illness is not engendered by circumstances and is not motivated like an anxiety state.

The second important point in the diagnosis is the "feel" of the case. It is quite different from any other illness, and the ability to feel out cases comes from the experience of handling them. The typical depressive oozes with depression—so much so that the physician himself feels depressed. This does not often happen in the mild cases described in this paper. The kind of rapport one establishes helps in the differentiation. The neurotic who is going to respond shows an intellectual interest in his treatment. The depressive allows talk to flow over him, and only appears to be interested in going over his feelings. He is never tired of telling his story over and over again. Thus with the depressive the psychotherapy is more stereotyped and easier than with the neurotic. It consists of repeated encouragement, and while the repetition may not appear to convince the patient it does not bore him. In the anxiety state there may be a hidden fear of mental illness. The patient would be very upset if this were suggested by the therapist. The depressive accepts, without resentment, the suggestion that his illness is mental, although he will dig his heels in hard at the mention of a mental hospital. In his heart he knows the way he is heading. He is grateful for the diagnosis, perhaps because he is glad to find someone who understands and can sympathize: he is so often misunderstood.

Prognosis

The one bright spot in this gloomy illness is that the prognosis is comparatively good, especially in cases of involutional melancholia. The length of the illness varies from a matter of a few weeks to months or even years. Henderson and Gillespie (1944) suggest that when relatives press for an opinion it is best to state that the attack may last for a period of 3 to 6 months. Many cases are well in much less time, but others run a longer course—maybe of years. With E.C.T. dramatic recovery is likely to occur in anything from 50 to 70% of cases of involutional states, according to Sargant and Slater (1944). Henderson, Tod, and Daly (1943) in a review of E.C.T. suggest 46% recovery in other types of depression. High-dosage insulin sometimes works where E.C.T. has failed, especially in the

depressive case with schizoid characteristics. The recovery figures do not appear startling when compared with the results in the appendicectomy operation, but they are very much better than those of older methods of treatment, and in successful cases the patient is relieved of weeks or months of suffering. With patients it is wise to take a very optimistic view of treatment, but one should give the relatives a more accurate statement as to the prognosis.

Treatment

The first step in the treatment of these cases is to establish a firm rapport. The illness may be a long one, and such a rapport may well carry the patient through the bad patches when everything else seems hopeless. So far as general practice goes, the treatment is threefold—psychotherapeutic, symptomatic, and occupational.

Psychotherapy

In his book *The Common Neuroses*, Ross (1937) devotes an excellent chapter to the treatment of the mild depressive. The therapy consists largely of reassurance, and the same ground may be gone over again and again without the patient becoming bored by repetition. He should be told that his symptoms are due to an illness which is not uncommon, and which is well understood by the therapist. "I am not really ill" is a common apology offered by a patient, and it comes as a relief to know that his feelings are the expression of an illness and not due to his own peculiarity and failings. Surprise and satisfaction are often expressed when the therapist, in his patter, is able to describe some of the patient's symptoms more clearly than the patient himself. The patient realizes that here at least is someone who understands, someone to whom he can talk without being laughed at or told to "pull himself together." The only consolation is that, if he can hang on, the illness will pass over. He must be reassured that, in spite of any feelings to the contrary, the illness is self-limiting. One cannot remove a delusion by argument, but this analogy sometimes gets home: The patient is told that his "dashboard instruments" are recording falsely, and he needs to be guided by those of his doctor and his relations until accuracy is restored. He must be told to measure his progress, not by days, but by weeks or months. Even when he is climbing out of a depression he must be warned against setbacks, which frequently occur. These may be accompanied by a strong suicidal urge. Nothing is more disappointing than to lose a patient who seems to be well on the road to recovery.

Symptomatic Treatment

Every effort should be made to promote sleep. In some cases 1–3 gr. (65–195 mg.) of phenobarbitone is adequate, but usually 7½ gr. (0.5 g.) of medinal is more effective. The latter is taken dissolved in water and flavoured with sugar and fruit juice. Benzedrine sulphate is sometimes useful in dispelling the early morning depression, and creating "pep" and energy in the patient. One or two 5-mg. tablets are usually given on waking. Another may be necessary by noon. To avoid creating insomnia at night none are administered later. Aspirin compounds may be given to relieve headaches and alkaline powders to allay dyspeptic symptoms. Stilboestrol is useful to abate menopausal symptoms, but does not in itself relieve the depression. There is no need to withhold any drug which promises to relieve discomfort merely because the pain is psychogenic, but it is more important to promote reassurance and understanding than to give any form of medicine.

Occupational Therapy

This is most important. The patient is often quite unable to do any responsible work, but to make him idle by merely putting him off work is to invite trouble. Time drags horribly with a depressive, and anything which helps him to while away an hour is useful. He should be encouraged to do things with his hands, and to be sociable with his friends. He should be discouraged from lying idly on his bed or going for walks by himself with only his own wretched thoughts for company. Perhaps more important than the negative aspect of whiling away his time is the positive side of achievement. The patient feels useless and impotent, and it is often an encouraging surprise to him to find he can do even small jobs.

Specialist Treatment

E.C.T., insulin shock, and in certain cases leucotomy require specialist attention. Few forms of treatment in the whole of medicine are more dramatic or more gratifying than E.C.T. in the depressive, especially the involuntal type; and here comes the rub. Very few cases found in general practice are certifiable. The patient does not resent the mental implication of the diagnosis, but he resents strongly any idea of being sent to a mental hospital for treatment. The bait of going in as a voluntary patient, of having a special ward, is quite ineffective. If the patient is suicidal the position is most embarrassing for the doctor. To send a patient in against his will would break a useful rapport. It is maintained by some psychiatrists that E.C.T. given to a resistant patient is less effective than to one who voluntarily submits.

The G.P. is looking after a large community. If every depressive were certified and sent to a mental hospital for treatment not only would his practice diminish but he would vitiate his own work. Few neurotics and depressives would have courage to confide in a man who was liable to lock them up. In any case, in America E.C.T. is given to out-patients, and the majority of mild depressives could well be treated in that way.

It is high time that every general hospital had a neuro-psychiatric wing where neurotics, depressives, and amenable psychotics could be treated without the stigma of the mental hospital to add to their misery. Such a cover has already been given to patients suffering from venereal disease, but it is denied to depressives, who are more deserving of such help. If all possible cases were treated as out-patients that would save valuable hospital beds. Calling a lunatic asylum a mental hospital is a theoretical improvement, but it has not in any way allayed the public dread of such an institution. Furthermore, any "nerve hospital," no matter what euphemism labels it, is doomed to similar unpopularity. Only by incorporating the centre into a big hospital will the stigma be avoided.

During the war psychiatry has made great strides, especially in the Armed Forces. Psychiatric facilities are urgently needed by the civilian population. It is estimated that one-third of all the cases seen in general practice are functional. Psychiatric specialist facilities are meagre in the extreme. Under the present system the vast majority of mild depressives, who are far from "insane," will have to get along as best they can with the inadequate treatment which the G.P. can offer. There will be a disproportionate number of suicides, which with a better system would be avoided.

Summary

Attention is drawn to the prevalence of the endogenous depression in general practice. It is a diagnosis which is often missed.

The main symptoms, the diagnosis, and the domiciliary treatment of the condition are outlined.

The difficulty of procuring special treatment is pointed out.

An appeal is made for better psychiatric facilities in general hospitals, so that amenable patients can avoid the stigma of mental hospital treatment.

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Sir JOHN CONYBEARE'S *Textbook of Medicine* by various authors first appeared in January, 1929, and by April, 1945, had gone into seven editions and four reprintings. Now it has reached an eighth edition (E. and S. Livingstone; 30s.), and the editor's skill in managing his team is no less evident than before. Most of the sections have needed only minor touching up. F. E. Lipscomb has largely rewritten the articles on malaria, blackwater fever, bacillary dysentery, and typhus, and that on effects of heat has been rewritten and transferred to the section on tropical diseases. In the section on the endocrine system there is a new article on the menopause, and many changes have been made in those on thyrotoxicosis and diseases of the pituitary gland. Now that penicillin is more and more available, and there is a large literature about its use, the editor has added a section on the subject. There is also an appendix on aviation medicine by R. H. Winfield. This textbook has won a firm place in the esteem of students and practitioners, and the new edition will maintain its well-deserved popularity.

SO-CALLED TRIPLE-SYMPTOM COMPLEX
OF BEHCET

BY

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In 1937 H. Behcet described what he believed to be a hitherto unrecognized morbid entity in which grave eye disease occurs in association with peculiar ulcers of the mouth and external genitals. Later he published other articles (Behcet, 1938, 1939, 1940). The clinical picture naturally is dominated by the eye lesions, which range from conjunctivitis and corneal ulceration to hypopyon uveitis, and may lead to total blindness. The eye involvement may precede, coincide with, or follow the oral and genital manifestations. Both eyes may be affected simultaneously, but more usually only one eye is involved for a while; after a variable interval the other eye shows similar changes. The ulcers of the mouth and genitals are small and discrete, either aphtha-like or nodular and necrotic, resembling periaadenitis mucosa necrotica recurrens (Sutton). Other skin lesions may also occur, such as erythema nodosum or an acneform eruption. The disease, which appears to affect men twice as often as women and to occur predominantly in the third decade of life, is essentially a relapsing one over a period of years, the symptoms at the three main sites recurring simultaneously or successively. Behcet believed the syndrome to be due to a filtrable virus.

A similar combination of symptoms had been reported earlier—for instance, by Whitwell (1934) and Nishimura (1935). Whitwell concluded that there is a relatively unexplored syndrome of ulcers in the mouth accompanied by "embolic" lesions elsewhere; the syndrome may be partial—that is, mouth lesions alone—but at any time the skin and/or the vulva may be involved; eye lesions may also occur, as in one of the cases he cited. Nishimura's case was one of acute ulcer of the vulva, with aphthoid changes of the oral mucosa and acute iritis.

Since Behcet's articles a number of other cases of the same complex have been reported (Weekers and Reginster, 1939; Bechgaard, 1940; Cavara, 1940; Franceschetti and Valerio, 1940; Mach *et al.*, 1941; and Ephraim, 1944). The last-named author questioned whether *ulcus neuroticus oris et vulvae* (Loblewitz), *periaadenitis mucosa necrotica recurrens* (Sutton), and *aphthosis* (Neumann) do not all belong to the same group. A case recorded by T. Jensen (1941) may be quoted as an example of the syndrome.

The patient was a man aged 22. The disorder began with aphthous ulcerations of the mouth at the age of 9; the ulcerations healed spontaneously in a few weeks, then recurred. Ocular symptoms appeared at 12, lasted four or five days at first and then about three weeks, and recurred at intervals of one month. Vision decreased after each attack. Iritis, iritis and choroiditis, total atrophy of the left and partial atrophy of the right optic nerve, and hypopyon were successively diagnosed. Six years later small painful ulcerations developed from time to time on the scrotum and penis. The patient gave a positive response to intradermal tests with tuberculin, Frei antigen, and dmelcos vaccine. Non-specific reaction was therefore suspected and confirmed by positive response to 0.1 ml. of a physiological salt solution. Superficial puncture of previously sterilized skin caused the appearance of a pustule the size of a pinhead and surrounded by a red somewhat infiltrated zone having a diameter of 5 mm. The pustule disappeared in four to five days, leaving some epidermal scarring. Behcet inclusion bodies were not found in the secretion of the regular ulcerations.

A case recorded by Berlin (1944) is of especial interest because, in addition to the classical eye, mouth, and genital lesions, the central nervous system was involved. Berlin's patient, whose eye disease began three and a half years after the oral and genital signs, eventually developed headache, giddiness, and fits, which culminated in coma and death. At necropsy small multiple foci of inflammation and softening were found in the brain.

The subject has been fully reviewed recently by Curth (1946) and Katzenellenbogen (1946). Curth describes the first American case of the disease. The patient was a young man with typical recurrent hypopyon which led to the enucleation