AN ADDRESS ON PUERPERAL INSANITY.

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Lincoln Branch.*

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GENTLEMEN,—My first duty and wish on taking the chair here to-day, is to thank you for the honour you have conferred upon me in electing me as your president for the ensuing year; I can assure you I am profoundly conscious of the compliment you have paid me.

As is the custom on these occasions, I have prepared an address to deliver to you. I have selected for this purpose a description of puerperal insanity; and I was guided to this selection by a belief that it was a subject where we should all be on common ground, and that a mutual benefit and interest would accrue from an interchange of experience concerning the disease and its bearings.

Formerly, the various mental disorders concomitant with and consequent upon the whole period of child-bearing and rearing were, more or less, mixed up, and described under the generic title of puerperal mania. These neuroses are now, however, properly classified as the insanity of pregnancy, puerperal insanity, and the insanity of lactation, and occur at the respective periods which their names indicate. They are three distinct clinical types of disease capable of diagnostic separation, a point which does not concern us now.

In this address, my remarks will be limited to puerperal insanity proper, by which I mean an insanity connected with the puerperal state, and occurring within a limit of six weeks after the date of the labour. By far the greater number of cases, however, commence during the first fortnight succeeding the labour.

Puerperal insanity is a better name than puerperal mania, as it comprehends all forms of mental symptoms, while puerperal mania would label the disease as one of excitement only. Excitement, as will be seen, is not always the obvious symptom.

The term mania, as indicating a disease, is in itself misleading. It should only, and in reality does, signify a train of symptoms in the sense that dropsy and jaundice do. Mania may be the outcome of many diseased states capable of further differentiation and elucidation. It is, however, a somewhat convenient term, and, if its true significance is borne in mind, it is useful for purposes of classification, and it cannot well be dispensed with.

The classification of the various forms of insanity connected with childbirth, and the nomenclature which I use, although, to a certain extent, admitted by the older writers, was first definitely set out by Dr. Batty Tuke in an admirable paper on this subject, published in the *Edinburgh Medical Journal* for 1865, and, since then, it has been generally adopted.

Before entering upon the description of puerperal insanity, there is a form of mental disorder which occurs during the progress of the labour which it will be well to notice in passing. It is an ephemeral excitement or delirium of an acute character, which usually subsides when the child is born. It is well to bear this in mind, as some importance, from a medico-legal point of view, may attach to this condition; for there can be little doubt that a patient labouring under it is not responsible for her acts. Dr. Playfair remarks, regarding this delirium, "that here chloroform will find one of its most valuable applications."

The onset of puerperal insanity is commonly rapid, and often abrupt. The premonitory symptoms are usually a listless depression, a sense of being ill at ease, a restless irritability and impatience of control. The patient neither eats nor sleeps well. She is unconcerned about her child, or actively hostile to it, and she is suspicious about her husband and relatives; her skin is clammy and pale, and her face is usually flushed; the eyes are restless and brilliant. She has some uterine tenderness, and the state of the lochial discharges abnormal; the pulse is quick and irritable, and the temperature tends to be high. This condition does not last long; an intense excitement supervenes,—an excitement characterised by great restlessness, loud and rapid talking, fleeting delusions, and vivid hallucinations. Constant conversations are carried on in a loud whisper with imaginary pres-

ences, interlarded with vehement denunciations of those present, whose identities are mistaken for fiends, devils, or monsters; volleys of abominable oaths and obscenities are discharged at them, and it is a characteristic of this disease that obscenities are almost always a marked feature in the ravings, and that there continues, even into the convalescence, a tendency to obscene and salacious conversation. The expressions of excitement are accompanied with much gesture, and generally with actual, though misguided, violence. All the manifestations of nervous action, mental and motor, are unpurpose-like, and void of coherence. In less acute cases, the general appearances are similar; or, as Dr. Batty Tuke puts it, "the same tone exists."

The bodily state is one of exhaustion little short of collapse. The lips and tongue get dry in an early stage of the disease. There is usually a marked antipathy to food. This antipathy to food is often the result of a delusion. It is thought to be poisoned, or to have been prepared by some filthy devil or fiend. On the other hand, it will be found to be owing to the general excitement and restlessness preventing the patient's attention being sufficiently arrested to get her to partake of nourishment. The bowels are confined, and the dejections offensive. The urine is small in quantity, turbid, and is stated to be frequently albuminous. The temperature, as a rule, is high, more especially so in cases where there are present inflammatory conditions of the passages, septic infection, or diseased states of other internal organs. The lochial discharges may be normal, but usually they are scanty, and more or less putrid. The milk-supply is small, and its quality is said to be poor. Tenderness on pressure, on the lower part of the abdomen, is by no means uncommon.

This state of matters usually continues for a period of from two to three weeks, sometimes longer. In favourable cases, the excitement then begins to subside, there are hopeful signs of mental coherence, the hallucinations are less vivid, sleep and appetite return, the general bodily state shows signs of improvement, and the patient gets stout. In unfavourable cases, the state of exhaustion and collapse continue, the insomnia does not yield, and the violent excitement becomes a state of delirium. Death may result from pure exhaustion, but, in fatal cases, it will be generally found that some form of uterine inflammation, septicæmia, or disease of the lungs, heart, or kidneys, were the most active factors in bringing about the fatal result.

Convalescence to mental health may be progressive and gradual, but, on the other hand, it is usually the case that the subsidence of the excitement is followed by a state of stupor or fatuity which endures for several weeks. The patient becomes dull, and never speaks voluntarily. She moves about in an aimless manner, replying to questions by repeating them like an echo, or by gazing vacantly at the interrogator. She has often, while in this state, fixed delusions, and they are vividly real to her. She is prone to indulge in masturbation now, as well as in the earlier periods of the disease, whether incited by local irritations or feelings arising centrally, it is not easy to determine; probably both causes are at work.

The bodily functions are in this stage in a good condition, sleep is readily obtained, the appetite is good, and the excretions are voided regularly.

Convalescence from this stupor is often abrupt. You may find the patient one day as usual, stupid and dull, but, on visiting her next day, she is bright, and more or less intelligent. Generally, however, the apparent fatuity passes away gradually, each morning finding the patient brighter and more intelligent than the one before. Complete mental health follows, but cannot be considered as established till the menstrual flow is normal.

In cases where the attack is less severe, the excitement is not so intense, and it is of shorter duration. The period of stupor is not so marked, or is absent, and convalescence is more rapid. The state of the bodily health is not of such serious import, the insomnia passes off easily, and the refusal of food is not so persistent.

In all cases of puerperal insanity, there is a tendency to suicidal impulses. Suicide is attempted in an aimless or purposeless manner, but the tendency on that account should not be disregarded, as such attempts have sometimes been successful.

Cases of puerperal insanity, in which mental depression is the most prominent symptom, are met with, but they are not so common as cases in which excitement predominates. The onset of these melancholic cases is more gradual, and generally, though not always, occurs in cases commencing towards the end of the puerperal period. The patient for some days appears out of health, and she does not continue to progress to convalescence after the labour, or appears to lose the ground she has gained. She is morbidly anxious about her husband and child, and she is fretful, and does not readily enter into conversation. As time goes on, she becomes profoundly melancholy, and has delusions of a desponding character. These delusions frequently

have a reference to her husband and child. She believes them ill or dead, and no proof to the contrary will convince her of the unreality of her fancies. The delusions have at times a so-called religious tendency, and point to a desponding hope of a future state. Suicide in such cases is more to be feared and guarded against, as the impulse to it is strong and of a stable character.

The face is pale and gloomy, and the eye listless. The skin and extremities are clammy and cold. The circulation is feeble, the pulse slow, and gives a feeling of emptiness. Sleep is not well obtained, and the appetite is bad. There is not, however, usually the same active objection to feeding, as in the maniacal cases. The bowels are confined, and the tongue is pale, white, and indented.

The melancholia is more obstinate under treatment than the mania observed in other cases. The general debility is more lasting, and the progress towards convalescence more gradual. I am led to think that this class of case will be more commonly found in women whose constitution has been weakened by a rapid succession of previous pregnancies.

There is another form but rarely seen. The patient, without much warning, becomes listless and fatuous, unattentive to her ordinary duties and to the calls of nature. She seems to take no notice of her surroundings. She sleeps if put to bed, takes food if it is given to her, but would starve if not attended to. This is a most intractable form, and if fairly established, usually progresses to complete and incurable dementia.

I have observed a few cases resembling, if not actually, cases of general paralysis of the insane, which seemed to take their origin from a childbirth, but of those which I have seen, the histories were not sufficiently available to form a proper opinion, and I merely mention this for the attention of future observers.

In reviewing the salient points of this disease, we notice in the maniacal cases a quick onset arising in the earlier periods of the puerperal state, a rapid development of excitement, an active excitement characterised by wild restlessness, incoherence, mistaken identities, obscene and immoral conversation, vivid hallucination, and obstinate insomnia. An active antipathy to food. A pale clammy skin, and generally a high temperature. An abnormal condition of the milk supply and of the lochial discharges; constipation and a dry tongue. A general condition of weakness and exhaustion, and we must not forget transitory impulses to commit suicide.

With regard to the temperature, there are some most interesting remarks in a series of Clinical Illustrations of Puerperal Insanity, published by Dr. Campbell Clark in Vol. 2 of the *Lancet*, for 1883. Dr. Clark draws attention to four types of temperature curves (a) "a moderate and uniform increase in uncomplicated cases," (b) "a periodicity of increase and decrease," (c) "a uniformly high evening temperature with well marked morning remission in phthisical cases," (d) "a persistent high temperature pursuing an erratic course," and he further adds "a significant addendum to the above statement is that cases of (c) and (d) types died."

The cases of melancholia are of a later origin, more gradual onset, and are marked by a depressed mental state and persistent delusions of a desponding character, a debilitated state of health, and a general condition of weakness rather than the exhausted condition observed in cases when excitement is most prominent.

The more uncommon type of dementia is marked by a progressive and gradual increase of mental weakness and a concurrent loss of health.

In connection with puerperal insanity in all its forms, it is observed that minor conditions of ill health are present; abscesses of the breasts, abscesses about the fingers and limbs, a tendency to rapid production of bedsores, and of course disorders consequent upon the recent parturition.

Uterine and pelvic complications must always be carefully looked for, and the state of the lungs, heart, and kidneys minutely observed. In this, as in all active morbid mental states, other disorders are apt to be overlooked, as the symptoms are sometimes masked by the too obvious nervous condition. The true state of affairs is only to be discovered by careful physical examination.

Among the causes which predispose a parturient woman to an attack of insanity, heredity plays an important part. It may be taken as an established rule that insanity of a parent or ancestor tends to produce in an individual a strong susceptibility to insanity, or allied nervous disorder—a pathological sensitiveness—a proneness to break down under exciting causes, which would not affect a person with a healthier pedigree. We may therefore clearly assume that hereditary predisposition is an important factor in the production of this disease. It is a more dangerous one also if the tendency has descended in the female line.

The first childbirth is more commonly followed by insanity than succeeding ones, more especially if it takes place late in life. A rapid succession of pregnancies, a prolonged suckling followed by another pregnancy have pernicious effects in this direction. The influence of a normal pregnancy on the blood is no doubt a factor, and if during the pregnancy there are nervous ailments, insanity is more likely to occur during the puerperal period. A previous attack of insanity, not necessarily puerperal, increases the probabilities as also do the presence of diseases of the heart, lungs, or kidneys. Puerperal eclampsia is a predisposing cause of some importance. Hæmorrhages, difficult and instrumental labours, the birth of twins, the sex of the child—male children being more dangerous—and even the use of anæsthetics during labour, are said to have caused the insanity, but most observers do not assign them a high place. Dr. Savage remarks that the drink craving, often present during pregnancy, if yielded to, may predispose to puerperal insanity.

There is a cause which may act as predisposing and exciting—namely, the influence upon the mother of the birth of an illegitimate child. The moral effect of the shame and degradation; the physical effects of less attention and care during pregnancy, parturition, and the puerperal state, are, no doubt, a combination of circumstances of powerful import.

Among the exciting causes, the effects of fright and anxiety, death of the child, or other distressing emotions, have been observed.

The strain of poverty and adverse circumstances, as well from their moral as from their physical effects, tending to improper care, improper or scanty nourishment, unsanitary surroundings, exposure and imprudence during the convalescence—all tend to produce the disorder. With regard to this point, however, I may remark that puerperal insanity is as common, if not more so, among the rich and well-to-do as among the poor.

We must also look upon injuries during parturition as predisposing to septicæmia, or to a complication of inflammatory conditions, as having considerable influence for harm in this direction upon parturient women.

Sir James Simpson, and, after him, Dr. Donkin, of Newcastle, suggest albuminuria as a frequent cause; but this has not met with general acceptance. It must not, on that account, be put aside; for a toxæmic condition, from this or any other cause, may excite puerperal insanity.

Dr. Gooch, in his interesting monograph on *Puerperal Mania*, states his opinion to be, that the cause of "puerperal mania" is "that peculiar state of the sexual system which occurs after delivery." In commenting upon this, in a subsequent chapter, Dr. Gooch's remarks are so striking that I quote them at length. "What I meant was this," he says: "the sexual system in women is a set of organs, which are in action only during half the natural life of the individual; and, even during this half, they are in action only at intervals. During these intervals of action, they diffuse an unusual excitement throughout the nervous system; witness the hysteric affections of puberty; the nervous susceptibility which occurs during every menstrual period; the nervous affections of breeding, and the nervous susceptibility of lying-in women. I do not mean that these appearances are to be observed in every instance of puberty, menstruation, and child-birth; but they occur sufficiently often to show that these states are liable to produce those conditions of the nervous system."

My own observations lead me to the belief that, in most, if not in all, cases of puerperal insanity, the causes will be found to be multiple.

Dr. Clouston, in his *Clinical Lectures on Mental Diseases*, sums up the etiology of the insanity in the following terse statement: "In regard to the cause of the disease, therefore, it is definite and clear—the accompaniments of childbirth produce it."

Having now described the disease, and recited its alleged causes, it may be interesting to examine in detail the statistics connected with it. It would seem an easy matter to assign the frequency of cases of puerperal insanity among parturient women, but I find it is not so. The published records on this point are few and vague. Obstetricians have placed on record the incidence of most, if not all, other puerperal disorders; but, as far as I have been able to discover, they are all but unanimously silent about puerperal insanity from this point of view.

During the years 1878 to 1882, the births of 3,537,580 children were registered in England and Wales. Allowing for plural births, the number 3,500,000 may be taken as fairly representing the parturient women in that period. In the reports of the Lunacy Commissioners for those four years, I find that 1,794 cases of insanity caused by childbirth and the puerperal state were admitted into the asylums of England and Wales. This would give a proportion of one case of insanity in 1,950 labours.

Dr. Reid, in a paper on Puerperal Mania in vol. i of the *Psychological Journal*, mentions that, in 8,338 labours, 21 were followed by insanity, or 1 in 397.

Mr. Rigden, of Canterbury, published, in vol. xxiii of the *Obstetrical Transactions*, a synopsis of 5,628 cases of labour, but did not refer to this point. I, however, wrote to Mr. Rigden, who promptly and courteously replied to me. In his letter he states that, among 6,000 cases of labour attended by himself, 5 cases of puerperal insanity occurred, or 1 in 1,200.

Out of the records of 11,940 cases of labour collected by myself from the registers of friends, and otherwise, I find 30 cases of puerperal insanity, or 1 in 398.

Calculating together the returns of Reid, Rigden, and my own, it would seem that one case of puerperal insanity occurs in each 469 labours. Comparing these figures with these, I based on the registered births and the admissions into asylums, it would seem that less than one-fourth of the patients suffering from puerperal insanity are sent to asylums. This calculation of mine on the registration returns is open to so much source of error that it is probably wrong. I state it for what it is worth.

Cases of puerperal insanity amount to 6 per cent. of the number of female lunatics admitted into English asylums, and to 3 per cent. of the total number of lunatics admitted. This proportion is a trifle higher in America, decidedly higher in the Colonies, but it is lower in Ireland.

When I purposed writing this paper, I addressed a series of questions to the medical superintendents of the English county and borough asylums, asking for certain detailed information about the cases of puerperal insanity admitted into their asylums during the four years 1878 to 1882. I received replies from many, and I here gratefully record the kind assistance of these gentlemen. I got thus important and authoritative facts about 620 cases. Dr. Campbell, of the Cumberland and Westmorland Asylum, gave me full details of 61 cases admitted into his asylum during a period of twelve years, carefully collected by his assistants, Drs. Macphail and Greenless. Most of these cases had been partly under my own treatment while serving in that asylum. Dr. Batty Tuke, in the papers already referred to, publishes details of 73 cases, and Dr. Clouston, in his *Manual*, of 60 cases. In 186 cases, 65 of them were cases following a first labour, or 84 per cent.; the rest occurring in multiparæ. In 169 cases, the insanity appeared within one week after the labour in 92 instances, or 54 per cent., and of the rest 36 had developed the insanity within two weeks, giving a proportion of 75 per cent. of the cases in which the disease commenced before a fortnight had elapsed after the date of the labour. Of 814 cases of puerperal insanity, 620 recovered, or 77.3 per cent.; 75.4 per cent. of the English asylum cases; 75.0 of Dr. Clouston's; 79.4 of Dr. Batty Tuke's; and 80.6 of Dr. Campbell's cases. Of these 814 cases, 74 died from all causes, giving a mortality-rate of 9 per cent. The causes of death were: in Dr. Batty Tuke's patients, of whom 8 died, 3 from phthisis, 2 from exhaustion, 1 from bronchitis, 1 from pelvic cellulitis, and 1 from peritonitis. Of Dr. Clouston's 5 fatal cases, 1 died of phthisis, 1 of septicæmia, 1 from maniacal exhaustion, and in 2 the cause is not recorded. Of the cases under Dr. Campbell's care, 3 died, 1 from phthisis, 1 from gastric ulcer seven years after admission into the asylum, and 1 committed suicide while absent on probation. Recurrent attacks are recorded in 152 out of the 814 cases, or 18.6 per cent.

The mothers of illegitimate children amounted to 95 of the total of 814, or 11.7 per cent. These figures show that the insanity is nearly three times more common among such than among married women. Hereditary predisposition to insanity was traced in 208 cases out of the 814, or 25.5 per cent. This proportion I believe to be understated.

The duration of the disease, as ascertained in the cases of 107 patients who recovered, is as follows: 34 per cent. recovered before three months, 73 per cent. before six months, and 87 per cent. before nine months had expired. Some of the remaining cases were under treatment for over two years before the recovery took place. In eight cases of melancholia which recovered, the average period of treatment was six months.

As regards mental symptoms in 239 cases, 185 were maniacal, 50 were melancholic, and 4 demented. Looking over these figures, then, we may conclude from them that we have, in puerperal insanity, a mental disease of common prevalence; that the symptoms are acute in a large majority of the cases; that more than two-thirds recover within a few months, and that the risk to life, judging from the asylum mortality-rates, is small. The results among the milder forms and among cases able to be treated at home are no doubt more satisfactory, but I am not in a position to give any reliable facts concerning them.

Puerperal insanity has considerable importance from a medico-legal point of view. Mothers in this state are frequently prompted to, and often accomplish, the destruction of their helpless offspring—prompted to the act sometimes by delusions, at others by sudden and uncontrollable impulses.

Suicidal attempts from similar causes are common, and acts of violence and destruction are a usual occurrence. In acute cases, with much excitement and incoherence, and in cases where mental depression is marked, the irresponsibility is obvious. Where it is not so, and where a criminal act has been committed by a puerperal woman, it should not, however, be too hastily concluded that at the time she was a responsible agent. It is also well to bear in mind that women are prone to make unfounded accusations of assault and immorality while labouring under puerperal insanity, and make them with much plausibility and circumstantial detail.

In an early stage of puerperal insanity, attacks may possibly be arrested by treatment, which should be on the lines of rest, support, and a somewhat derivative evacuation of the bowels. I have known a case, with considerable excitement, get well after a smart purge, a single dose of chloral, and good diet. If, however, the insanity has become fairly established, treatment and care are matters requiring time and trouble.

What to do with a case must depend, to a great extent, upon the circumstances and surroundings of the patient. If poor, and unable to afford the appliances for home treatment, the sooner such a patient is sent to the county or nearest available lunatic asylum, the better for her chances of recovery and life. Recent parturition should be no obstacle to her removal. I have known cases, where a fear that sending them away too soon after the labour would do harm, get so weakened from want of nourishment, and other proper treatment, that the removal to the asylum was all but too late. I have not, on the other hand, seen any injury of consequence follow a prompt removal of a patient in the first few days of the puerperal state.

If, however, the means and surroundings of a patient will permit of it, sending her to an asylum is neither necessary nor desirable.

The patient must be placed under the absolute control of a skilled nurse, who must, of course, act under the direction of the medical attendant. At first, the medical attendant should be prepared to see the patient several times a day, and be within call. The attendance and interference of friends and relatives, unless they happen to be people of sound sense, must be firmly dispensed with. One skilled nurse, in milder cases, assisted by an intelligent woman, will generally be found sufficient; but, in acutely maniacal cases, two nurses (one for day and one for night duty), assisted by two robust women, will be required.

A large, light, well ventilated, and properly warmed bedroom will be the best at first, and the patient should be kept confined to it. As circumstances require, other apartments can, of course, be available afterwards. The sanitary arrangements of the house should be good, and the use of antiseptics be encouraged. In the earlier stages, the patient is apt to be filthy in her habits; to prevent nuisance from this cause, all carpets should be taken up, and replaced by movable mats, where required for comfort. The bed should be roomy and not high—indeed, where the patient is very restless, a bed made up on the floor is the best. In cases where the clothes are torn up by the patient, a garment of strong stuff, lined with flannel, lacing up the back, will be found very serviceable. All superfluous furniture should at first be removed, as well as anything the patient might injure herself or other people with; for instance, a piece of long firewood will do to poke the fire with, and be a less lethal weapon than an iron poker. The patient must, on no account, be left by herself; and it is advisable that, at night, the windows should be shuttered.

The first consideration in the treatment, and one that must for the time overshadow all others, is to see that the patient gets sufficient food. The diet should be nourishing, digestible, and somewhat stimulating. Beef-tea, broths with the vegetables strained out of them, farinaceous food, and, above all, milk and its preparations. A reliance upon beef-tea by itself as a food is as much a delusion as any the patient labours under. It is an excellent stimulant, however, if good, and, with farinaceous foods, is nourishing. Eggs and milk as a custard, with some wine, are excellent. Alternate the kind of food, and administer it often. If the patient will not take it from one person, try someone else. If not from a woman, let a man offer it. I have often succeeded in getting such a patient to take a large basin of custard from my own hands when several nurses had failed to persuade her. It is by no means a bad plan to engage a patient's attention by chattering nonsense to her, while diligently spooning the food into her mouth. If the patient cannot be prevailed upon to take food naturally, it must be promptly administered artificially. The means of doing so do

not matter much, so long as she gets it. My own preference is to administer it through the stomach-pump, attached to a flexible India-rubber tube. The tube should be lubricated with glycerine. Food is easily administered in this way, and it is a sure method. Seldom are more than six feedings required for any patient, after which she will usually take food of her own accord. Through the pump, food should be given every four hours. Milk and eggs with wine, beef-tea thickened with corn-flour, but, in cases where the feeding has to be prolonged over three days, mutton minced fine enough to pass through the tube should be given once a day. Some malt-extract among them adds to the value of farinaceous foods; and, no doubt, in such cases, peptonised and pancreatised foods will be found valuable. Dr. Campbell Clark speaks well of enemata of defibrinated blood. Stimulants should be given freely, but with caution, and always along with food. If a patient vomits while the tube is being withdrawn, as she will often do the first once or twice, it cannot be helped; the feeding must be gone on with. Some of the food injected remains each time. The patient should be fed in a recumbent posture, and kept so for some little time after the operation is over. I have added ten grains of subnitrate of bismuth to each feeding with benefit for this vomiting; and, in extreme cases, I have found a subcutaneous injection of one-sixth of a grain of morphia half an hour before the feeding do good.

During the whole treatment, the diet must be generous. Let the patient have what she likes if wholesome, but, above all, plenty of it. The bowels should be carefully attended to, and kept open, for they tend to be confined. The state of the vaginal discharges and the urine require close attention. Bed-sores are apt to form rapidly in exhausted cases. Rubbing the skin over parts liable with an alcoholic solution of tannic acid to some extent prevents or retards their formation. If the breasts are tender and distended with milk, they should be rubbed with belladonna extract, dissolved in glycerine, or friction with castor-oil or salt, as Dr. Savage recommends, relieves them. Avoid the use of narcotics if you wish your patient to do well. In occasional cases, where there is great insomnia, a single dose of chloral given at night, along with some porter or some sherry, with a view of inducing sleep, may do no harm, and, if it seems to do good, use it sparingly, and with caution. If the patient can be got to take nourishment, sleep will come. Intercurrent bodily diseases should be looked for, and treated as they may require. Use the thermometer regularly. If the temperature goes over 99°, something is amiss, and must be discovered.

As the patient progresses towards convalescence, and the excitement begins to subside, outdoor exercise should be encouraged, on foot, if the strength will allow of it, driving if not. As early as possible, the patient should spend all the time her meals and the weather will permit of it in the open air. Some light manual employment while indoors, such as sewing or knitting, will be found useful in occupying her mind.

When the excitement has passed off, the patient should be allowed to see her friends, or even sooner if she asks for them. A visit from her husband may do her good, or, if apparently it does harm, the effect will not be lasting, and the visit need not be repeated for a time. If friends do see her, advise them not to fuss, or talk foolishly, but to address the patient as a rational being. During the stage of stupor that so often follows, the excitement, visits and converse with husband and relatives are often of great benefit. Tonics and hæmatonics are most useful during the convalescence; and, in women who are strong, morning shower baths are beneficial where there is lethargy or stupor. If the case goes badly from the first,—if complicated septicæmia or inflammatory conditions, or a high temperature persists,—these must be treated on general medical principles, with due attention to proper support.

The foregoing directions apply more particularly to acute cases, but milder cases, and ones where there is less excitement, must be treated upon the same lines. At first, rest, nourishment, and nursing, avoidance of narcotics and depressants, and vigilant observation for complications. Then exercise, employment, and gradually society, attention being given to the restoration of physical health. The treatment of cases where depression is the most prominent mental symptom differs but little. Less physical force is required to control the patient, but vigilance must be strictly enjoined, for here the suicidal propensity is strong and persistent. The need for nourishment is as pressing as in maniacal cases, and outdoor exercise is as beneficial. In all cases, as convalescence progresses, attention should be given to the state of the menses. No case can be considered as cured till the menstruation is regular; aloes and iron pills, ergot and warm hip-baths are indicated. I have found potassium permanganate given in pills most useful in this respect.

A patient who has recovered from puerperal insanity should not be

allowed to resume the society of her husband too soon. A pregnancy following quickly upon an attack of this insanity is fraught with considerable danger of a recurrence. If, however, she does become pregnant, she should be encouraged to look forward to her next confinement without apprehension, and the fears of her relations should be studiously concealed from her. When labour takes place, and is safely over, the convalescence should be carefully watched, and more than ordinary attention paid to the state of the milk, lochia, and the excretions. The patient should not be allowed to get low in strength, and, as far as possible, all emotional and disturbing elements kept away from her.

With these and like precautions, based upon intelligent medical experience, the danger of recurrence may be averted; but it must always be remembered that an attack of puerperal insanity not only predisposes a patient to a recurrence after the confinement immediately succeeding it, but also to a recurrence after all the subsequent ones.

Few diseases bring along with them such distress, anxiety, and sorrow as puerperal insanity does. It mars a time of rejoicing and joy in what, under other circumstances, would be a happy family circle, and, by its fell presence, changes bright hopes and congratulations into lamentations and woe.

AN ADDRESS

ON

MEDICAL EDUCATION, EXAMINATIONS, AND DEGREES.

*Delivered at the Annual Meeting of the Metropolitan Counties
Branch.*

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IN rising to perform, as best I may, the first if not the most important duty expected of me, as your newly-elected president, I must begin by thanking you, with all my heart, for the high honour you have to-day conferred upon me; an honour which I never sought, which I did not expect, and which is undeserved. I hope, however, in the near future, to make up for some of my past deficiencies, to earn a little of that kind confidence which has been accorded me by anticipation; and, if I may not rival my able, indefatigable and genial predecessor, at least to show my sense of his many great qualities and excellent services by making, during the coming year, his conduct in his high office the pattern for my own.

There is no rule or custom, so far as I know, which limits the choice of subjects for the Presidential address. I wish there were; for during the last few weeks I have been much perplexed by the difficulty of choosing; and have wasted no little time in the consideration of themes which I sooner or later discarded as unsuitable or inopportune. Had I been guided by personal inclination, I should have determined to devote the hour at my command to some study in clinical medicine. But, interesting as I hope such a lecture might have proved, I could not help acknowledging to myself that it would be better suited for one of the local meetings than for our annual gathering. I sought, therefore, among the questions which, during the last twelve months, have chiefly engaged the attention of the Council for one which I might venture to discuss; and it is needless to say that, look which way I would, one of them, predominant over all rivals, forced itself upon me—the question, namely, of how best to provide for students educated in London reasonable facilities for acquiring degrees in medicine. This has been largely discussed during the last year or two in our Council, at general meetings of the Branch, and in the medical journals; and it is at present under the serious consideration of the Royal Colleges of Physicians and Surgeons, to whose joint action most of us look hopefully for the solution of the difficulty. I, too, have had my say. It might well have been thought, therefore, that everything that could be usefully said upon the matter had already been said; and that, at any rate, it was hardly for me to prolong the discussion. I confess that those were my own feelings; and they so far prevailed with me that I should certainly have dismissed the subject from my thoughts, as I had done others, had I felt that I could only treat it from the point of view in which hitherto it has been chiefly regarded.