The Bradshaw Lecture

ON

HYSTERIA IN SOME OF ITS ASPECTS.

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MR. PRESIDENT, FELLOWS, AND GENTLEMEN,—It is my first pleasant duty to thank you, Sir, for the honour you have done me in inviting me to give this, the Bradshaw Lecture. I only hope my theme is worthy of the occasion. It may be that I should have selected a subject more intimately related to recent advances in medicine, for in these days of accurate definition and of fruitful pathology my subject is out of fashion, since hysteria is wellnigh incapable of definition, and is without pathology or pathognomonic symptoms. Modern research and speculation, far from throwing clearer light on its problems, have rather tended to render them more obscure, and, instead of introducing greater harmony into our conceptions of the disease, have served to create more doubt and dissension.

Charcot's views on the nature and symptoms of hysteria have been rigorously criticized by various authorities during the last twenty years, and undoubtedly this criticism has been wholesome, for, as Babinski points out, the term "hysteria" was too loosely employed, and was made to include any disorder for which another name could not be found. Moreover, though his assertion that Charcot's stigmata are but the consequence either of autosuggestion or of unconscious suggestion on the part of the physician is too extreme, it has served a good purpose in calling attention to the importance of exercising care in the examination of suspected hysterical patients.

There is much that is bewildering in the many hypotheses of different teachers as to the nature of hysteria; but there is a considerable degree of uniformity in one direction, namely, the abnormal suggestibility of the hysterical, a mental peculiarity of practical moment in its bearing on the production or modification of symptoms, and on methods of treatment.

Happily it is not expedient that I should, in the limits to which I confine myself in this lecture, discuss the various hypotheses—physical, physiological, and psychical—that have been advanced to explain the nature of the disease. I imagine that Janet's theory of a restricted field of consciousness appeals to most, as it explains a number of hysterical symptoms, the anaesthesias, the restricted fields of vision and the amnesias, in a reasonable and convincing manner. The ingenious theory of Breuer and Freud, of the effect of latent mental trauma on the mind, claims respectful attention, but their contention that this subconscious shock is always of a sexual character is repellent and cannot be accepted without further investigation.

But the symptoms of the hysterical are not entirely psychical; there is in the great majority, as Sir James Paget pointed out, evidence of disturbance in the circulation. "I think," he says, "there is no constitution in which nervous mimicry is so commonly found as in patients who are said, perhaps truly, to have a bad circulation. Chiefly these are marked by being habitually cold-footed . . . but in some the feet, after being cold all day, flush in the evening, and in others become red, and even painfully hot. Such variation in the state of the blood vessels in a part seem to tell of nervous disorder overrunning from the cerebro-spinal into the vasomotor nervous system." Dr. Savill amplified Sir James Paget's views, and held that all the symptoms of hysteria pointed to instability of the reflex and other nervous centres, particularly of the neuro-vascular system. In support of his hypotheses he refers to the sudden pallor at the onset of hysterical syncope, to the chilliness amounting almost to a rigor in some other paroxysmal attacks, to the tendency to flushing. My experience leads me to support these views. Frequently, indeed, do the hysterical complain of flushing, tingling and burning sensations, perhaps of painful heat everywhere but in the feet, which remain

icily cold, or of an unconquerable tendency to blush on the slightest provocation. A psychical theory seems hardly capable of explaining these symptoms; moreover, it does not account for certain other more obvious and remarkable phenomena of a physical character occasionally related to hysteria—nutritional and trophic disorders similar to those at times met with in organic diseases of the nervous system. As examples of the trophic affections I have met with in hysterical patients I will briefly refer to two cases.

A young lady with a very neurotic family history at the age of 12 had hysterical chorea and some months later hysterical paralysis of one foot. At this period and subsequently she exhibited the typical stigmata of hysteria with spontaneous somnambulism. A little over two weeks later she lost all her toe-nails and most of her finger-nails. They were detached one by one painlessly, without any alteration in the appearance of the finger or of the nail about to be cast off. Just before a visit to me she had lost the nails of her little fingers. One night the nail of one finger came off, and next day the nail of the other. Although she had no nails on her toes, and the raw matrix was exposed, she walked well, and her mother said she was sure her daughter did not feel pain. The surface of the hands and feet were analgesic, and the left hemianalgesia and other stigmata persisted. Some months later she had an affection of the skin slightly vesicular in character in its early stages (according to her medical attendant, Dr. Matthews, of Waterloo, Liverpool), and appearing in crops on the back, chest, and limbs, fading in a few days and being succeeded by fresh crops, unattended by discomfort or constitutional disturbance. Moreover, at this period she became deaf. I found that it was impossible to make her understand by shouting, and loud noises behind her were unnoticed. This passed off and she became deaf to certain notes on the piano. She could hear middle F, but not the neighbouring F sharp or G.

A girl aged 12, at the end of a term at school, suffered from hysterical paraplegia, and rapidly recovered under rest and massage, but six weeks afterwards the paralysis returned, and she was again put to bed. On the morning of the day after she was found with much of her hair out, or coming out. She went to bed with a good head of hair, and lost most of it in a few hours. There had been no febrile disturbance and nothing apparently was wrong with the scalp.

These nutritional disorders have been noticed by so many independent observers in association with hysteria that I think there can be but little doubt they are occasionally due to it. Gilles de la Tourette, and Pîtres, and Galcom recognize the sudden loss of the nails and hair as an occasional rare and hysterical phenomenon.

Féré¹ noted a curious trophic trouble of the hair in an hysterical patient. During the premonitory period of a crisis the hair was in no way abnormal, but after the fit all the hairs were split at their extremities; this condition occurred after every attack.

For Babinski the condition required to make a symptom an hysterical one is that it be reproducible by suggestion and be capable of removal by persuasion; all other accidents, even the slightest manifestations due to vasomotor disturbance, are to be regarded as the fruits of fraud. Now the physical accidents in these cases could not be produced or removed by suggestion, and I am confident were not created by trickery. The nature of the more curious nutritional disorders—the spontaneous shedding of the nails and hair—exclude such a possibility, neither could the idea of deception be entertained with regard to the affection of the skin in the first case. She was very young, happy in her surroundings, fond of school and games; she made light of her illness, and resented the fussy sympathy of her mother. I have met with two other cases of eruption in hysteria, both erythematous; in one the skin in the neighbourhood of the eruption was anaesthetic, and in the other the rash appeared immediately after an hysterical fit. In one of several cases of hysterical oedema an obstinate monoplegia was attended with marked muscular atrophy, but the patient after a while made a good recovery.

I will now briefly refer to Charcot's stigmata and the precautions I have exercised in examining after his method patients suspected of being hysterical; afterwards I shall

consider hysteria as I have met with it in association with other diseases.

I have always avoided putting any questions to such patients which could possibly influence them or their replies. I have found that much is to be gained by securing closure of the eyes, not only because it ensures temporary blindness to subsequent procedures, but also because some information may be gained from the behaviour of the closed eyelids, as in the great majority of the hysterical—probably over 80 per cent.—although there may be no tremor of the hands, there is more or less tremor of the closed eyelids, a vibration readily felt by a finger laid lightly over them. I have next tested the common sensibility of the skin by gently pricking. I have found that, as a rule, the expression of the patient is a sufficient guide in this direction. One side of the forehead may be pricked without causing any sign of discomfort, while the same operation on the other side is attended by flinching. Similar caution is exercised in investigating the sensibility of other parts, whether of the surface or mucous membranes. If no expression of pain follows pricking of either side, it may be necessary to put some such questions as: "What do you feel?" or "What am I doing?" and similar inquiries may have to be made in conducting the more delicate examination by cotton-wool or brush. The behaviour of the patient is usually sufficient to indicate to what extent there is sensibility of the conjunctiva, or how far the faradic current causes discomfort.

I can only briefly refer to the visual stigmata. Restriction of the visual field and dyschromatopsia are undoubtedly of great value. In one or two patients the fields of vision have been so reduced that the subject of the disorder complained of blindness. I exhibit charts of the visual fields of two patients, both of whom stated that they had lost the sight of one eye.

In hysterical dyschromatopsia I have occasionally found that, contrary to the rule, the field for blue has been more extensive than for red, as in the chart exhibited. I also show another perimetric chart of interest. In this it will be seen that the visual field of one eye is much narrowed and of the other nearly normal, while its fields for colour are remarkably reduced. Monocular diplopia was present in many of my cases, and I have more frequently met with macropsia than micropsia; the former has sometimes been very marked; one hysterical lad to whom I showed a sixpenny bit pronounced it a five-shilling piece. I need not dwell on the fact that Charcot's stigmata may be wanting in the hysterical accidents of children, or that they are sometimes but few in number in older persons, and found only after careful search. Frequently, indeed, the only evidence of defective sensibility of the skin to be brought to light is a little analgesia of one side of the forehead, or of the back of a forearm. With this, however, there will probably be restriction of the visual fields, and though the loss of sensibility be slight the restriction will be the greater on the side where the sensation is impaired, and thus the correctness of the observation is confirmed and the veracity of the patient established.

In testing the olfactory sense I have occasionally found that an hysterical subject could inhale strong ammonia through a nostril without manifesting discomfort, an indication that the common sensation of the lining membrane of the nose was impaired.

In some instances the mental state of a patient, the psychical stigmata, furnishes valuable information, as in the following case: A girl of 11, liable to migraine, and overworked at school, became unduly quiet and forgetful. Her nights were disturbed by terrifying dreams, and when a little poorly from a cold or toothache, she suffered from hallucinations, seeing rats and other animals in her room. There was some tremor of the closed eyelids, and a little loss of sensibility over the left side of the forehead and the back of the left forearm. Again, in traumatic cases especially, the repetition of dreams relating to an accident is very suggestive of an hysterical condition.

I have only met with one or two typical examples of hysterical amnesia. One of these was a girl who, when admitted and for many days after, could give no particulars of herself or of her illness—we learnt that she had been frightened and had fallen down in a hysterical fit a week before she entered the hospital. In a little over a fortnight

she was able to give a clear account of her past up to the time of the fright; after this there was a hiatus in her memory covering three weeks.

The history of an hysterical fit or some other paroxysmal form of hysteria, if obtainable, furnishes a valuable indication, and almost of equal significance are the syncopal attacks, the various modified crises, half faints, choking sensations, spells of vertigo, confusion, and weakness. These fragmentary paroxysms are, relatively to the complete seizures, much more common in men than in women. I have found that almost four-fifths of the men suffering from traumatic hysteria complained of transient giddiness, dimness of sight, and confusion. Dr. Buzzard long ago directed attention to the significance of defective plantar reflexes in hysterical paralysis. In my experience these reflexes are often lessened in hysteria in the absence of paraplegia, and not infrequently particularly diminished on the side where the sensibility of the surface is the more deficient. I found the plantar reflexes absent or much diminished in 81 of 112 cases of traumatic hysteria. I may say that I have never met with true ankle clonus in an uncomplicated case of hysteria.

Hysterogenic zones, when present, are necessarily unequivocal signs of hysteria. In 1867 I saw a case of hystero-epilepsy with hysterogenic zones in St. Bartholomew's Hospital, under the care of the late Mr. Luther Holden. It is described in the third volume of the reports of that institution as "an anomalous affection of the nervous system." The patient, a boy, had a lipomatous tumour at the back of his neck; every time this lump was touched he had a convulsion followed by "clownism," in which he turned head over heels; next he became maniacal and delirious, and lastly crowed like a cock and barked like a dog. Some years afterwards I met with a very similar case, also in a boy. In the last stage of a fit he crawled about on the floor, biting the carpet as if attempting to pick up something with his teeth. The milder hysterical ebullitions of ordinary hysteria excited through hysterogenic zones would be of greater clinical value were these areas more frequently present.

Frequently the victims of hysteria exhibit no very obvious signs of the affection. They complain of neuralgic pains, sleeplessness, giddiness, nervousness, and so forth. When in such instances the stigmata are found a new light is cast on the nature of the case. Doubts that were perhaps entertained as to the reality of complaints are removed, for the subjective symptoms are found to be consistent with the objective, and acquire a genuine significance.

In examining the subjects of what is popularly termed "nervous shock," with symptoms so often of an entirely subjective nature, the greatest assistance is afforded by conducting the investigation after Charcot's method. In this way hysterical and neurasthenic cases are readily differentiated and clinical data are furnished for a positive opinion. Out of 160 cases of nervous shock I have examined, 112 were suffering from hysteria or hysteria combined with neurasthenia, and 48 from simple neurasthenia. Of the hysterical cases, only 17 were females and 8 were boys, for the large majority of subjects under examination were labourers seeking compensation under the Workmen's Compensation Act.

The case of a boy of 11 was of special interest, as it simulated meningitis. After a blow on the head he complained of violent headache and vomiting, rigidity of the neck, and partial ptosis, more marked on one side. Certain of the hysterical stigmata were present, and the plantar reflexes were absent. In a few days he made a good recovery.

The presence of Charcot's stigmata points to the existence of an hysterical condition, but does not indicate that the actual symptoms are necessarily dependent on this disorder.

In certain subjects any affection attended with pains and sleeplessness or leading to deterioration of health may give rise to and be attended with hysteria, and some affections, organic and functional, show a particular proneness to occur in association with the disease by reason of some predisposition common to both—age, sex, and constitution. In many instances the presence of the functional disorder may not lead to any difficulty of diagnosis, but in its recognition an explanation may be found of certain symptoms—obscure pains and sleep-

lessness—and the diagnosis thereby be rendered more complete. In other cases the presence of a complicating hysteria may, particularly in a hurried examination, lead to error. I have met with two instances where patients with disease of the middle ear attended with hysteria were sent into the hospital as cases probably of intracranial abscess. One was a man of 24. He complained of excessive giddiness and had fallen several times. His temperature was slightly raised. He had much headache, with partial loss of power of the right leg and arm, and was unsteady in walking. The pupils were normal, and there was no optic neuritis. On the other hand, there were plenty of hysterical stigmata. The other was a boy, aged 12, under the care of Dr. T. R. Bradshaw. He had suffered from otorrhoea for some years, and recently complained of headache and had fits. The fits proved to be hysterical. The only evidence of hysteria in this patient, other than the characteristic fits, was absence of the faucial reflex. I have known the headache of hysteria to be mistaken for that of uraemia in a young woman with renal trouble who happened to be hysterical, and an hysterical fit to be regarded as a uraemic convulsion in another case of kidney disease. A girl with indications of lead poisoning, a history of colic, and a blue line on her gums, with partial hysterical paraplegia, was sent to the hospital as a case of lead palsy.

I might multiply these instances almost indefinitely, but must turn to the systematic consideration of my subject of hysteria as I have met with it in association with epilepsy, chorea, chlorosis, Graves's disease, stomach disorders, diseases of the heart and nervous system.

The neuroses, epilepsy and hysteria, frequently coexist in the same individual. About 20 per cent. of the epileptics I have met with presented the stigmata of hysteria, and in a majority of these there were other more demonstrative symptoms of the disorder. In four instances the epileptic attack towards its termination presented all the features of an hysterical crisis. Sir William Gowers has drawn attention to these complex forms of convulsion. A girl aged 13 had suffered from fits for many years, in which she bit her tongue and hurt herself in falling; at the time of admission she had rhythmical spasm of one corner of her mouth; in the hospital she had an epileptic fit, at the termination of which she screamed, struggled, and pulled her hair. A girl aged 19 was brought into the hospital in an insensible condition. The day after she had convulsive attacks characterized by tonic and clonic spasms and biting of the tongue, and later by rigidity of the limbs with opisthotonos, purposive movements, and screaming. In my experience it is more common to meet with cases where epileptic and hysterical fits in the same individual occur independently. I have notes of 8 cases of this description. I will only cite two in illustration. A young woman aged 22 had suffered from epilepsy from the age of 15, the fits occurring as a rule on rising in the morning. In the hospital she had a fit in which she fell and cut her head; she also had many other attacks unattended with loss of consciousness in which her limbs became rigid. A woman aged 27 had been liable to fits for thirteen years; in them she bit her tongue and passed urine. She also had attacks in which she only partially lost consciousness, and screamed and struggled. She was warned of the approach of the latter by a choking sensation and giddiness, but the epileptic seizures were not preceded by any aura. As far as could be ascertained the epilepsy in the majority of these cases was the earlier to develop. In 9 of the remaining 12 cases of epilepsy the symptoms, besides the stigmata pointing to hysteria, were neuralgic pains, headaches not connected with the fits, palpitation, sleeplessness, vivid dreams, tremor, and pain over the heart.

Chorea is at times associated with hysteria, and that these neuroses should occur together in the same individual would seem probable, for either may be excited by the same proximate cause, a violent emotion or rheumatism, though in the case of hysteria the latter plays a less active part; moreover, both diseases are found in those of a neurotic temperament.

The recognition of hysteria rested not only on the presence of the stigmata, but also on the existence of other manifestations. In both disorders similar forms of mental trouble may be met with, as a tendency to undue emotional excitement, fretfulness, loss of will power,

stupidity, terrifying dreams or transitory visual hallucinations. I have, therefore, not regarded any of these phenomena as hysterical in origin. I have collected 104 cases of chorea from my hospital notebooks—96 of Sydenham's chorea, 25 of which were complicated with hysteria, and 8 of hysterical chorea; I include rhythmical spasm and coarse tremor under this term.

Dr. Bristow, in his *Theory and Practice of Medicine*, treating of chorea, states: "Impairment of sensation is observable in many cases and its degree is more or less in relation to the severity of the convulsion or to the amount of paralysis present, occasionally the anaesthesia is on one side and may be absolute." In the 25 cases I refer to the defective sensibility of the skin was generally associated with lessened sensibility of the mucous membranes, conjunctiva and tongue, with, when the fields of vision could be taken, restriction of the visual fields and achromatopsia, and often with defective faucial or plantar reflexes. In 3 cases where there was complete hemianaesthesia the chorea was of medium severity with no pronounced paralysis.

In one, a girl of 17, together with the movements of typical chorea there was rhythmical blinking of the eyelids at the rate of 80 per minute. Another, a girl of 20, complained much of pain and tenderness on the top of her head, and in the right iliac fossa, the side of the anaesthesia, and occasionally of retention of urine.

In a third the hysterical chorea immediately followed ordinary chorea. This patient, a girl of 16, had suffered from rheumatic fever and chorea, and after being two months under my care was discharged from the convalescent ward, but was again admitted in two days stating that the St. Vitus's dance had returned. On this occasion all the limbs underwent rhythmical jerks while in bed, the hands at the same time being pronated and supinated at the rate of sixty times a minute. The movements were more marked on the right side, the seat of hemianalgesia.

A child of 13 with ordinary chorea had extreme photophobia, with hysterical stigmata. A girl of 15 had the typical barking cough of hysteria and was, for a time, a nuisance in the ward. A boy of 16, a typical degenerate, was admitted with chorea limited to the upper extremities and face, and with his legs closely flexed against his abdomen. He also could not, or would not, speak, and had not done so for three months. There was a history of fright, but not of rheumatism. In the hospital he complained of headache, writing with a shaking hand, and answered questions in the same way. There was some grimacing and twitching of the lips, but the tongue was protruded normally. Charcot's stigmata were present. At the end of a week he had much improved. He spoke sensibly and his legs assumed a normal position, but after a visit from his friends he had what appears to have been an hysterical fit. His legs returned to their former position and he became silent. In a day or two he had again improved and was quite talkative. The irregular movements continued a little longer, but under rest, massage, and cold sponging he was well in a month.

A boy aged 12 came across his father hanging in an outhouse. His shrieks were heard by his friends, and he was found in what appears to have been an hysterical fit. For weeks afterwards he was sleepless and nervous, and would not be left alone, and at the end of two months was attacked with what appeared from his doctor's description to have been ordinary chorea. Two years afterwards, when 14 years of age, he came under my care with a relapse of the convulsive movements, but this time the chorea did not seem to be of the ordinary character. There was no grimacing, the tongue was protruded and withdrawn in a natural way, the irregular movements were limited to the arms and hands, and were of the usual choreic character, but there was also well-marked vibratory tremor of the left hand, associated with left hemianalgesia. He took his food, when not watched, with perfect ease, and his limbs were at times quiet for an hour or more.

A married woman, aged 23, was admitted as a case of chorea. She stated that as a child she had suffered from St. Vitus's dance and rheumatism, that she had been worried at home, and had had some difficulty in using her hands and in walking for about a month. She complained also of pains over her heart and in her back, of headache and sleeplessness. There were inco-ordinate movements of the

upper limbs when she used them, but only then, also some tendency to slight rotatory movement of the legs when she walked. She walked feebly, as there was considerable loss of muscular power of both legs. Many hysterical stigmata were present. It seemed to me that in these two cases the chorea was simply a subconscious revival of the former attacks, and that they were hysterical in origin, for it is likely that hysteria is capable of creating a clinical picture of true chorea.

In the remainder of the 25 cases there was in the majority some symptom or symptoms other than the existence of the hysterical stigmata suggestive of hysteria. Neuralgic pains and tender spots in 10; vomiting without apparent cause in 2; aphonia in 2; semi-hysterical attacks and globus hystericus in 4.

Few manifestations of hysteria are more typical of the affection than the rhythmical tremors and spasms, and I venture to wander from my subject to refer to one case of salutation spasm. A girl aged 11, who two months previously had suffered from ordinary chorea, was admitted into the hospital for rhythmical nodding movements of the head due to the action of the sternomastoids. Synchronously with these there were rhythmical contractions of the muscles of the abdominal wall and of the first and second fingers of both hands. Her gait was interrupted by regular bowing movements of the head and trunk. There was left hemianalgesia and other stigmata.

I also exhibit a few tracings from cases of hysterical rhythmical tremor, and two photographs of patients with glosso-labial hemispasm—one of a little girl, the other of a man aged 60, in whom the spasm was associated with a complete hemiplegia and hemianaesthesia.

Rheumatism, typhoid, influenza, tuberculosis, and other specific disorders are recognized as antecedent causes of hysteria. At times, however, hysteria may develop during the course of these diseases and complicate them. A woman, aged 38, complained of pain and swelling of her ankles, knees, and wrists. She sweated profusely, and her temperature ranged between 100° and 102°. Under salicylates the rheumatic symptoms were relieved, but though there was no evidence of joint trouble she still lay almost motionless, and complained of much pain in her knees and over the heart, also of broken sleep and vivid dreams. On examination, there was much tremor of the right hand with loss of muscular power, complete right hemianaesthesia, loss of the senses of smell and taste on the same side, great hyperaesthesia of both knees and of the left breast. The left breast was the seat of a hysterogenic zone, pressure there causing her to tremble, choke, and weep.

A young woman, aged 21, was admitted with pain and swelling of one elbow, both knees, and one ankle, and a temperature of 101°, and with evidence also of slight mitral trouble. She moreover complained much of headache and tenderness on the top of her head, of pain over the heart, and flatulence. On several occasions she had attacks when, according to the nurse, she was choking and could not breathe.

Another girl, aged 25, came in with slight pyrexia and swollen ankle-joints. She had been ill for a week, and during that time had suffered much from headache and vomiting. The latter was at first put down to her medicine, but it continued in the absence of all physic, and was only checked after she had recovered from the rheumatism, and had been convalescent a week. The usual hysterical stigmata were present.

A girl, aged 20, was carried into the ward, as she appeared to be unable to stand alone or walk. As a child she had suffered from rheumatic fever and chorea. She had been laid up about a fortnight before admission. There were indications of slight rheumatism with some fever, and a little effusion into one knee-joint, but there was great loss of voluntary muscular power in both legs, with absence of the plantar reflexes, and hypaesthesia. She also complained of constant headache and pain in the back and of something rising from the left groin to the throat, causing choking sensations.

A lad of 19 came under my care suffering from sub-acute rheumatism, and also complaining of shortness of breath occurring in spells. He stated that he had been ill about a week and could hardly sleep at night owing to difficulty of breathing. His respirations on admission

were 35 to a minute, and at times considerably quicker. There was no cyanosis or wheezing. The lungs and heart were perfectly normal. Well-marked hysterical stigmata were found. He made a rapid recovery. I looked upon the case as one of hysterical dyspnoea, a not uncommon manifestation of hysteria to which Sir Samuel Wilks directed attention.

Another patient, a girl of 20, while barely convalescent from acute rheumatism, developed an hysterical knee. The joint remained exquisitely painful and tender after all the local signs of rheumatism had gone. She also complained of sleeplessness, noise in the ears, and choking sensations. The usual hysterical stigmata were present.

A young Greek girl, during the first week of a mild attack of typhoid, developed hysterical symptoms. She had what was called a "faint," and this was followed by prolonged shaking and trembling without her temperature of 101° rising. Subsequently she talked nonsense and for a time refused to take food. The disease progressed favourably, but the headache characteristic of the early days of typhoid never left her. Her sleep was much disturbed and she was unduly irritable. While convalescent she developed an hysterical paraplegia. The end of this case was so exceptional and tragic that I will narrate it.

She next suffered from hysterical anorexia, and the year afterwards from spasm of one arm. For this she was isolated in the country with a nurse, and after a while recovered. A year later, as she seemed perfectly well, she was sent to a school abroad to finish her education. She was a clever girl, and her letters home and her behaviour at school seemed to indicate that she was perfectly happy. However, while engaged one afternoon with others in study, she suddenly rushed to an open window, threw herself out, and was instantly killed. As far as could be ascertained she had been in her usual spirits that day, and nothing had happened to provoke or worry her.

I hesitate to attribute this act to hysteria, as mental degeneracy may have been associated with it. At the same time many observers, as Le Grand-du-Saule, Gilles de la Tourette,² Huchard and Pitres, have met with suicide in the victims of this disorder. Pitres,³ on suicide in the hysterical, states: "It is quite evident that the suicide of the hysterical is, in general, the result of sudden impulse, and not of a comedy played by simulators to render themselves interesting or alarm those about them."

A man, aged 28, during the third week of typhoid, although the temperature was falling and the pulse-rate coming down, complained of sudden pain in the abdomen and over his heart, and oppressed breathing. There was much tremor of the hands, and closed eyelids, and involuntary clonic spasms of the frontalis muscle. The hysterical stigmata were well marked, and in two days the symptoms above described passed away.

A woman, aged 25, suffered from typhoid of moderate severity. During the whole course of the disease she complained of headache and pain in the epigastrium and vomiting. Her sleep was much disturbed by dreams, and she was worried by hallucinations. All this time her temperature was moderate, and her pulse not over 80. General anaesthesia was noted with absence of the plantar reflexes. These stigmata remained during convalescence, when the fields of vision were taken and found to be much restricted.

Chlorosis is, for obvious reasons, very frequently associated with hysteria. I find that out of 164 cases of chlorosis, 45—rather more than 25 per cent.—were hysterical. As general nervous disturbances—sleeplessness, headache, giddiness, neuralgic pains, and indigestion—are often associated with this disease, it is difficult to determine how far an hysterical condition may be responsible for such symptoms when they are present. In the great majority of the cases where the hysterical stigmata have been found it has seemed to me that the above nervous symptoms are intensified. The sleep tends to be disturbed by terrifying dreams, the headache is severe, and perhaps associated with tenderness of the scalp; the gastric pain and vomiting are often marked. In 20 out of the 45 there was much headache, as a rule vertical, with restlessness at night and vivid dreaming; 18 suffered from more or less obstinate vomiting and gastralgia. The symptoms in many of those patients so closely resembled those of gastric ulcer that, for a few days, they were treated as cases of this disease; 5 had hysterical fits in

some form, 8 exhibited fine tremor of the hands; 4 complained much of pain and tenderness over the lower part of the spine, and 3 of great weakness of the legs, in 2 of these amounting to a partial paraplegia of an hysterical nature, with defective sensibility over the limbs and absent plantar reflexes. Two developed hysterical anorexia.

In Graves's disease I have found the hysterical stigmata present in about 35 per cent., and in a few symptoms which could be fairly set down to hysteria. One, a woman, seemed to develop exophthalmic goitre and hysteria together after a fright. She had several mild hysteroid fits in the hospital. Another suffered from marked loss of power of the legs, with analgesia of their surface; and another, after a squabble with a nurse and a bad night, had a fit and was delirious for a short time. In a third there was much more tremor of the left hand than of the right, and the left side was the seat of a hemianalgesia. The case of a fourth was singularly complex, as she, together with Graves's disease and hysteria, exhibited symptoms of disseminated sclerosis—nystagmus and volitional tremor.

Sir Clifford Allbutt, in his lucid and interesting Goulstonian Lectures on the Visceral Neuroses, devotes a chapter to neuralgia of the stomach as it is met with in those who are predisposed from their neurotic tendency to neuralgic pains and such nervous troubles as migraine and asthma, but he only briefly refers to the gastralgias of the hysterical. In about three-fourths of the cases of simple gastralgia I have met with in young women there has been evidence of hysteria in the presence of the stigmata, and in a few there have been other symptoms of this disease as well.

It is not likely that the hysteria was only accidentally associated with the gastralgia, and the fact that they were found together in so many instances negatives this assumption. Moreover, the hyperaesthesias and pains are just as characteristic a feature of hysteria as are the anaesthesias; indeed, Oppenheim³ states that pain is never absent in hysteria. Savill estimates that pain of some kind occurred in four-fifths of his cases of hysteria. This, I think, is nearer the mark.

In 35 cases of hysterical gastralgia there was a history of migraine in 10, of liability to ordinary headaches in others; one was a somnambulist. Besides various hysterical stigmata, a few presented other symptoms of hysteria—for example, hysteroid fits in 3, rhythmical tremor in 1, partial paraplegia in 2. In 2 there was a hysterogenic zone over the epigastrium, a light touch causing vomiting, tremor, palpitation, and faintness. Many of these patients were anaemic, but are not included among the chlorotic cases above referred to. In most of these cases the diagnosis was made with fear and trembling, and not a few, for a day or two, were treated as cases of gastric ulcer. In 25 other patients the stomach symptoms still more closely resembled gastric ulcer, inasmuch as gastric pain and vomiting followed the ingestion of food. Two of these women came in with a history of haematemesis, and in the hospital thin serous blood-stained fluid of alkaline reaction was vomited, or more probably hawked up with some retching.

I have been guilty of a digression, but must ask your pardon if I transgress still further and refer for a moment to that serious hysterical affection, anorexia. The ages of fifteen patients I have seen with this disease varied from 14 to 22, and one was a woman of 44. Certain of the hysterical stigmata were present in all, and in one there was oesophageal spasm. The middle-aged woman suffered from incessant vomiting associated with distaste for food and great emaciation, and it was, perhaps, rather a case of hysterical vomiting than of true anorexia nervosa. Another subject of the disease may be referred to as it is of exceptional interest, the victim of the disorder being a boy. He was 11 years of age. His father was asthmatic and his mother had fits of some kind. He was very intelligent, but of an irritable, nervous disposition. For six months he had refused ordinary food, only taking biscuits and a little water. Next he became mute, then had fits, in which his friends said he arched his back and jumped like a salmon. When I saw him he was terribly emaciated. Another case is also of special interest. A young lady, aged 15, for several months lived on cakes and water, and for a great part of that period attended a neighbouring school.

Medical advice was procured after a while, and she was put to bed under the charge of a nurse. She was reduced to a skeleton, the skin was wrinkled and dry, the abdomen retracted, the extremities cold and blue and the pulse feeble. The nurse failed to make her take more food, and two days after my visit she became insensible, was looked on as dead and was measured for her coffin. Fortunately her medical attendant, Dr. Wylie of Seaforth, happened to call, and found that though she had been apparently dead for two days, her body was not cold, and that there was feeble shallow respiration. Stimulants were given and forcible feeding resorted to, and she eventually recovered. Two of my patients died, one was a girl of 13 who was taken to a nursing home when she was hopelessly weak; the other was a woman of 22, who, under isolation and other prompt measures, recovered, but within a year suffered from a relapse. On this occasion her mother would not consent to her removal. She was treated at home and died.

I found the hysterical stigmata in 23 per cent. of my cases of gastric ulcer in young women—that is, in patients with a history of haematemesis or melaena, and in some of these there were other hysterical symptoms. In one or two the vomiting was particularly frequent, in others there was a history of slight hysterical fits. One patient, who had previously vomited blood and fainted, was a fortnight after this accident sent to the hospital under the idea that she had suffered from a further haemorrhage, as she had fainted again. No blood, however, was vomited, and no melaena followed. A further fit in the hospital was distinctly hysterical. In several there was tremor or much headache and sleeplessness; in many neuralgic pains in the head, chest, and back; in one retention of urine.

The relation of hysteria to heart disease is of special interest. Such hysterical affections as pseudo-angina, or simple pain over the heart, and palpitation, dyspnoea, and syncope, when the heart is normal, arouse fears of cardiac disease in the patient, and worry the medical attendant till he lights on the explanation of the symptoms; and when these hysterical accidents occur in cases where there are signs of organic heart disease they are likely to cause the patient's condition to appear more serious than it is. Further, as nervousness, sleeplessness, and pain are usually associated with hysteria, the symptoms due to heart disease tend to be aggravated. A fireman, aged 25, was treated for heart disease, and kept in bed for three months in a hospital; he had slight mitral regurgitation with perfect compensation, but suffered from angina-like attacks, the pain over the heart extending to the left arm and shoulder with a sensation of suffocation. He also had occasional crises characterized by choking feelings, giddiness, and palpitation, as well as cramping pains in the stomach and vomiting. There was much fine tremor and other stigmata. A woman, aged 30, had mitral stenosis, but not pronounced, as the pulse was of good volume, and the right ventricle not dilated. Up to an attack of influenza she had led an active life; after this illness she broke down, suffering from pains about the left side and head, sleeplessness, and shortness of breath. Her lungs were quite healthy, but her respirations, even when in bed, were 30 or more for two or three days. She exhibited many signs of hysteria, and, like the previous patient, was soon relieved.

A girl aged 20, with slight mitral stenosis, was liable to attacks of angina, with the usual hysterical characteristics; she was a somnambulist, and her father suffered from true angina.

A girl of 17, with well marked mitral disease, was sent to the hospital as a case of cerebral embolism, as her left arm had become suddenly weak after a faint; the paralysed limb was anaesthetic, and there was also left hemianalgesia and other stigmata. The rapid and perfect recovery of the arm in four days proved, if proof were wanting, that the affection was hysterical. A middle-aged single woman, with aortic regurgitation, who complained of preternatural pulsation in the epigastrium, had been kept three months in bed, half-starved, and dosed with potassium iodide, under the idea that she had an aneurysm. Positive indications of this affection were wanting. She was hysterical and neurasthenic, and did well under a different line of treatment. I have notes of 18 cases of

heart disease complicated with hysteria, but must not further refer to them. I will only say that in 13 out of the 18 sleeplessness due to restlessness or pain was a prominent symptom, and tended to aggravate the condition of the patients; 4 of the 18 were males between the ages of 18 and 30. The remainder were females from 16 to 35, with one exception, a woman of 45.

The alliance between functional and organic diseases of the nervous system claims much closer attention than I can give. As Charcot affirmed, neurasthenia is often found united with hysteria, particularly in men as a result of traumas and in women at the menopause. As regards the former class, he considered that neurasthenia was the first to evolve under the influence of the sudden violent shock, and that later the physical and mental depression prepared the way for hysteria.

My experience in the examination of men who have met with accidents leads me entirely to agree with this statement, for not a few of these subjects in a month or two after an accident, become worse rather than better, and on examination prove to be hysterical. It is difficult sometimes to estimate how far symptoms belong to hysteria or neurasthenia. In some traumatic cases, however, the neurasthenic symptoms are pretty definite—namely, psychical asthenia, characterized by diminished power of attention, want of energy, muscular weakness, constant headache or pressure in the head, and backache.

The frequent association of hysteria with the mental stigmata of degeneracy has led to the misconception that the hysterical were necessarily deceitful, that they lied for the sake of lying, that they were simulators and charlatans. As Jane points out, though their mental condition tends to be modified in certain directions (as memory, will, power of attention), and their disposition becomes mobile and contradictory, their character, as the character of every one, depends upon their primary intelligence and their early surroundings and education. If time permitted I might refer to cases illustrating the occasional association of hysteria and obsessions.

I must say but little of hysteria as a complication of organic nervous diseases, and shall only refer to it as an occasional adjunct to structural diseases of the spinal cord. Dr. Buzzard directed attention to the relation of hysteria and insular sclerosis, with special reference to diagnosis, to the tendency for "functional symptoms to be mixed up with those belonging to organic change," and to the temporary intervals of improvement. Hysteria is probably more frequently associated with disseminated sclerosis than with any other affection of the cord, and this to some extent is accounted for, since this disease is frequently met with in early life and in women. For a similar reason hysteria is likely to occur in hereditary ataxia. I do not think I have met with more than half a dozen cases of this affection, but two of these—boys between the ages of 14 and 18—were distinctly hysterical. Young people with vertebral caries, too, are at times hysterical. A girl under my care had caries in the dorsal region of the spine with spastic paraplegia and an hysterical monoplegia of an arm. On the other hand, in that very common disease, locomotor ataxia, occurring as it does in adults, hysteria is more rarely found as a complication. I have only notes of four cases where it was present, and two of these were aged 30 and 34.

The recognition of hysteria in these cases accounted for certain symptoms not directly due to the organic disease, and in a few instances there was evidence that temporary improvement followed and depended on mitigation of the hysterical condition. I will only refer to one of several cases which warrants this assumption. A boy of 17 came under my care with such symptoms of disseminated sclerosis as nystagmus, intentional tremor, and also great weakness of the legs, especially the right; he was unable to walk, and he staggered and dragged the right foot. He was a degenerate with badly-shaped head, jug-handle ears, and supernumerary nipples. He had been out of work some time and was in a miserable physical condition. He suffered from occasional attacks of faintness and vomiting. There was anaesthesia of the left forearm and right leg and restriction of the fields of vision. He was treated by massage, faradic current, and cold sponging. He was soon able to walk well, and in two months left the hospital apparently in good health. At this time the only evidence of hysteria was some restriction of the visual field. He

afterwards enlisted, and at the end of two years was discharged owing to some return of his old trouble. At the age of 20 he again came under my care with the former symptoms of disseminated sclerosis. His gait was spastic, but he walked fairly well. There was now complete anaesthesia of the left side of the face and left leg. He again improved under treatment, and left the hospital to seek light employment.

And now, Mr. President and gentlemen, I must bring this lecture to a close. None can be more sensible of its defects than myself. If it should fail in arousing a little more interest in the study of hysteria as it appears in association with other diseases, the want of success in this direction will be due to my incapacity rather than to the nature of my subject.

REFERENCES.

¹ *Hystérie*, par le Dr. Voronoff, p. 65. ² Gilles de la Tourette, *Traité de la hystérie*, vol. i, p. 541. ³ Oppenheim, *Textbook of Nervous Diseases*, translated by Alexander Bruce, vol. ii, p. 1061. ⁴ *Leçons du Mardi*, 1888-9, p. 457.

THE RATIONAL TREATMENT OF CHRONIC BACILLARY DYSENTERY;

AND THE ADVANTAGES OF ENEMATA OF SILVER GELATOSE.

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ACUTE bacillary dysentery is essentially an inflammation of the mucous membrane of the large bowel, and the causative organisms are limited to the intestinal tract, except in a very few acute instances in which they invade the blood stream. In early cases the serum and saline treatments are usually effective in dealing with the toxæmia and congestion of the mucous membrane, and commonly subdue the disease before much lasting damage has been done.

Cases of chronic bacillary dysentery in which extensive ulceration has already been produced before the patient comes under skilled treatment are much more difficult to deal with. I have frequently found the saline treatment do more harm than good, while in one large Calcutta hospital, where several hundred cases are treated yearly, the mortality from this distressing disease is about 40 per cent. In fact, I know of no common tropical disease in India at the present time which is more difficult to deal with successfully, with the single exception of the terrible kala-azar. Contrary to the experience of some other writers, I have not had good results with stock Shiga dysentery bacillus vaccines, as recommended by Forster, and, owing to the great toxicity of Shiga's bacillus, they require to be used with caution. Sensitized dead dysentery bacillus vaccines, I think, promise better, but I have not yet been able to try them. Occasionally I have obtained good results with an autogenous dysentery vaccine, but in other cases even this failed, while the method is obviously not of general applicability, as, apart from the time and expense required to carry it out, there are few laboratories in the tropics.

In short, it may be said that the treatment of chronic bacillary dysentery is in a very unsatisfactory state at the present time, especially as compared with the formerly intractable amoebic variety of the disease.

THE CHARACTER AND DISTRIBUTION OF THE BOWEL LESIONS AND THEIR BEARING ON TREATMENT.

An analysis of considerably over one hundred *post-mortem* examinations made by me in Calcutta during the last twelve years has brought out a fact which appears to be of great practical importance in connexion with the problem under consideration. I refer to the very marked contrast in the distribution, as well as in the character, of the bowel lesions in acute and chronic fatal bacillary dysentery respectively. These features of the disease are fully described and illustrated in my recently issued small work on dysenteries, and I only need here refer to the points of importance in practice.

Briefly it may be said that in fatal acute bacillary dysentery the whole length of the large intestine and the lowest part of the ileum are uniformly involved in