the absence of shooting pains or profound sensory phenomena, of visceral crises and trophic lesions, and the comparative immunity of the sphincters would all tell in the same direction, as would also the absence of optic nerve atrophy and of the Argyll-Robertson pupil, which latter is said always to be a syphilitic manifestation, and no one has ever traced any connexion between Friedreich's ataxy and syphilis.

The mention of syphilis leads me to say it has been pointed out that the form of true tabes which raises a real difficulty in the diagnosis of Friedreich's ataxy is that which occurs in young people as the result of a congenital syphilitic taint, for in these there may be weakness of the muscles combined with the ataxia, and there may be some speech defect. The general aspect of the patient if indicative of congenital syphilis, the presence of Hutchinson's pegged teeth in those who have attained to the time of the second dentition, the condition of the corneae if indicative of former diffuse inflammation, and above all the presence of reflex iridoplegia, would lead us to diagnose true tabes.

There is a form of hereditary ataxia associated with a congenital defect in the cerebellum, and described by Marie, which tends to affect several members of the same family, but in this the gait is reeling rather than ataxic, the deep reflexes are increased, the Argyll-Robertson pupil is sometimes present, there is frequently optic atrophy, and the affection usually comes on earlier in life. When, however, we consider that occasionally retention or even exaggeration of the knee-jerk has been noted in cases conforming in other respects to Friedreich's type of the disease, and that in this condition also atrophic changes have been noted in the cerebellum, we must feel that a sharp distinction between the two conditions is either a matter for future elucidation or does not in truth exist.

Dr. Trevelyan has called my attention to the fact that at a meeting of the Neurological Society held on July 14th, Dr. James Taylor exhibited a patient presenting the cardinal features of Friedreich's ataxy, who was also the subject of double optic atrophy. If cases of this kind should occur with sufficient frequency definitely to put the explanation of mere coincidence on one side we shall have to attach less importance to the presence or absence of optic atrophy as a sign of diagnostic value in doubtful cases.

Gross disease, such as tumour of the cerebellum, may be associated with ataxy and absence of the knee-jerk, but the presence of pain, vomiting, and optic neuritis, as well as the reeling character of the gait, would probably prevent its being confounded either with true tabes or with the hereditary form.

In ataxic paraplegia there is, as in Friedreich's disease, a combination of ataxia with weakness, and the plantar reflex is of the extensor character, but the knee-jerk is increased and there may be ankle clonus; there is no tendency for the disease to affect several members of the same family, and it usually begins at a later age.

I have under my care in No. 1 ward at the present time a female patient with well-marked signs of disseminated sclerosis. In her case the early symptoms were, as they frequently are, those of spastic paraplegia, and at no time has there been any resemblance to Friedreich's ataxy, but there is inco-ordination, nystagmus, speech defect, and the extensor variety of plantar reflex, and in the absence of marked spasticity such a combination must always raise the possibility of a case being one of Friedreich's ataxy. The tremor is, however, usually more irregular and bizarre, the speech is staccato rather than slurring; early and transient diplopia is common, and there is a great tendency to the occurrence of optic atrophy. On the other hand, the characteristic deformities are not present.

The superficial resemblance to this affection of certain cases of chorea, especially if muscular weakness and absence of the knee-jerk exists from the use of arsenical treatment, could not, I think, deceive any one exercising ordinary care, though I may remind you that two of our patients were thought by their parents to be the subjects of St. Vitus's dance.

In discussing my cases with you I have called attention to an undue hardness of the muscles of the calf in some of them, and have shown you that in these particular patients the limit of dorsal flexion of the ankle-joint is soon reached, and that there is some tendency to a draw-

ing up of the heel when this is not counteracted by the weight of the body. Were I, as an isolated but I admit highly prejudicing demonstration of the patients, John T. or Mary Eliz. T., to call your attention to these points and then direct them to get up from the lying posture, you would at once admit that pseudo-hypertrophic muscular palsy must be added to the number of diseases from which Friedreich's ataxy may have to be distinguished. The resemblance is at best but a superficial one, and additional distinctions to those I have mentioned earlier will be found in the character of the spinal and foot deformities, in the nystagmus and speech defects, in the absence of any wasting of the lower part of the pectoralis major, and in the plantar reflex being of the extensor variety.

Friedreich's ataxy is a family disease, and in this respect it resembles pseudo-hypertrophic muscular palsy and the other muscular dystrophies, cerebellar ataxy of the family type, and that form of lateral sclerosis which occurs in members of the same family, and of which I had the opportunity of showing you two examples some twelve months ago. Its essential nature is shrouded by an obscurity as great as that which envelops these other affections, and of its actual causation we know as little as we do of theirs. Imperfect development of those parts of the nervous system which are affected is accepted by some as the explanation, but others regard their premature decay as the essential factor. Both theories remind one of Professor Osler's expression, when he is trying to account for the incidence of premature arterio-sclerosis in certain families, that "in the make-up of the machine bad material was used for the tubing." If the explanation is of this character, you will not be surprised that treatment should prove quite ineffectual. Beyond encouraging the patient to take exercise and continue his work, employing massage and passive movement, and using measures to maintain a high standard of general health and ward off complications, we are powerless to do anything to check its progress, which, however, may be very slow.

Note.

To obtain the full stereoscopic effect of Figs. 3 and 4 they must be viewed through a stereoscope, or, if the observer possesses the power of obtaining stereoscopic vision by altering the axes of his eyes, superposition must be obtained by relative *divergence* and not by *convergence* of the eyes.

An Address

ON

THE TREATMENT OF INCIPIENT AND BORDERLAND CASES OF INSANITY IN GENERAL PRACTICE.

DELIVERED BEFORE THE SEVENOAKS AND TONBRIDGE
DIVISION OF THE BRITISH MEDICAL
ASSOCIATION.

BY ERNEST W. WHITE, M.B.LOND., M.R.C.P.,

PROFESSOR OF PSYCHOLOGICAL MEDICINE, KING'S COLLEGE, LONDON;
LATE RESIDENT PHYSICIAN AND SUPERINTENDENT, CITY OF
LONDON ASYLUM, DARTFORD.

THE strenuous life to which in this latter-day civilization our race is subjected has brought into prominence as a sequel many states of mental unsoundness which are not definite insanities in the legal sense, but which demand none the less more than ordinary care in management and definite lines of treatment. For convenience sake I shall classify these under the three epochs—early life, adult life, and old age.

FORMS MET WITH IN EARLY LIFE.

The Backward or Deficient.

Parents blind themselves to anything abnormal in their offspring, and hence it is only when this abnormality is confirmed that the medical attendant is consulted. Head measurements may show the infant to be microcephalic and the skull ill-shapen. This condition was formerly attributed to premature closing of the sutures, an explanation no longer accepted. It is an original defect. Or there may be a tendency to hydrocephalus, with the transverse and antero-posterior diameters of the skull nearly equal, and the fontanelles raised and widely patent, or there may be simple congenital defect with no abnormality of skull,

but an animal expression—thick lips, pug nose, and small forehead—what we term a Mongolian type of face, having broad features and an upward slant of the outer arch of the eyebrows. The last-named class may be fairly educable.

Often, however, professional advice is only sought when the child fails to begin to talk at the proper age, or does not take interest in its environment. Little can be done in these early developmental failures. They represent states of amentia. The faculty of observation can be alone encouraged. It is generally, however, some time after education has commenced that advice is sought for backward children. You are told the lesson is not learnt, or if learnt is quickly forgotten, and has to be repeated the next day; that after a fair exhibition of intelligence for an hour or so, the child becomes suddenly irritable or dull and dense—apparently quite incapable of reception—and in consequence is far behind those of a similar age. The course of treatment is definite. The higher education (the Classics, German, French, and all but elementary mathematics) must be discarded once and for all. The powers of observation must be utilized as far as possible, and a special scheme of instruction adopted, such as is carried out by Drs. Beach, Shuttleworth, and Langdon Down in their establishments. Boys can be taught the handicrafts, girls the ordinary domestic duties and music, at which they often excel, while intellectual efforts must be restricted to that knowledge which is essential in life. Physical exercises, cycling, sports, and outdoor games should be encouraged with daily regularity; and constipation, which is often habitual in these cases, guarded against, for we must remember a sluggish circulation always accompanies a dull intellect.

The Epileptic.

Epilepsy is both an accompaniment and cause of mental unsoundness in the young. As you know, many imbeciles have fits in very early life. These cases are not improvable. In those cases, however, in which the fits occur before puberty, and have a definite cause, such as local irritation of teeth, worms, etc., if the cause can be removed and the fits kept under by medicinal treatment, normal mental development may ensue. If epilepsy occurs with puberty, the previous mental state having been apparently normal, the outlook is not good. It is the outward expression of original defect. The fits are not easily controlled, and slow but certain progressive mental deterioration results. The boy, if at school, must be removed at once and educated privately with only two or three others. His hours of study must be limited. He must live as much as possible out of doors, and have abundance of exercise, and must not sleep alone at night. Many epileptics are borderland cases. In the intervals between the fits, apart from a little irritability, they are normal mentally, but shortly before or occasionally after the fits they are quite unreliable; they lie, take violent dislikes, are irritable, act impulsively and even criminally. Curiously enough, their minds often have a religious bent with moral deterioration. In some cases these symptoms of mental aberration replace the fits. What, then, is to be done with the youthful epileptic who is a borderland case and incipiently insane? He must lead a country life, with outdoor employment and exercise, and follow some handicraft in preference to brain work. For the lower classes the epileptic colony offers a suitable residence. The upper and middle classes can be treated as single patients under medical supervision in the country; or in twos, threes, or more, up to half a dozen, in villas. It must ever be remembered that the periods of mental unsoundness in the epileptic occur either before or after the fits, or when unsoundness replaces the fits in masked epilepsy. Youthful epileptics are much addicted to masturbation. For this they must be watched and corrected; cold baths in the morning, plenty of exercise during the day, a minimum of animal food, a hard mattress, and cool bed tend to overcome this moral defect.

The Nervous.

The children of neurotic, ill-balanced parents require careful management in the upbringing. Often we have on one or both sides in the parents a history of drink, epilepsy, paralysis, or insanity. The child is highly-strung, restless, excitable, thin, and delicate, with a weak digestion and tendency to diarrhoea and similar ailments. In these cases the educational strain must be carefully

adjusted. Such patients are often very receptive and intelligent. They must have short lessons, reside or go to school preferably at the seaside, where the climate is bracing and they can get salt-water baths, etc., and they must have abundance of outdoor air and recreation, but no unnatural excitement. Chorea, hysteria, and such ailments often fall to their lot, and if overtaxed mentally they may ultimately become the victims of premature dementia.

The Moral Imbecile.

The child with this failing is the greatest anxiety to parents and medical practitioner. Many would say, "What is a moral imbecile?" I would define him as one with a morbid defect in the feelings, affections, inclinations, temper, habits and moral dispositions. Intellectually there is but little if any abnormality. The parents have not observed any backwardness in talking, early receptiveness, or any difficulty of education. But as he grows up it is noticed that his moral sense is defective. He is unkind to his brothers and sisters, cruel to animals, irritable and hasty in temper, sulks when corrected, and becomes sullen and morose; tends to associate with those beneath him in the social scale, tells lies, and does not fully grasp the difference between right and wrong. As he gets older he is addicted to petty thefts, which are often concealed with much cunning. When found out he does not appreciate the enormity of his offence, and exhibits no sense of shame. He cannot estimate the value of money, and is reckless and extravagant in his expenditure. He is often addicted to bad habits, sexual immorality, masturbation, and sexual perversion. This is especially a source of anxiety in the female, who loses her chastity and gets into trouble, thereby bringing disgrace upon her family. The more advanced cases swell the ranks of the criminal insane.

What, then, can be done with the moral imbecile? As soon as the defect is observed the boy or girl must be placed under strict discipline. They are ineligible for school life. They must be educated with at most one or two others, under a strong guiding hand, and made to feel, if possible, that wrong-doing has its quick punishment. Some country clergymen who have been schoolmasters deal well with these boys, and the girls can be treated in nunneries (Church of England or Roman Catholic). Some are capable of improvement; many are not. They are generally of strong frames and robust constitutions, so need abundance of physical exercise, and when grown up are qualified for employment demanding this.

The Incipient Melancholic and Maniacal.

Mania is very rare before puberty is fully established. Melancholia is rare also, but less so than mania. Mental unsoundness is, however, frequently associated with developing manhood and womanhood, especially in the upper and middle classes. Luxury, indolence, and defective education have much to do with this, which is the outcome of the unnatural life of modern civilization. The girl at home after leaving school leads a life of self-indulgence, has no definite occupation, and becomes self-centred and morbid. She has many imaginary ailments, lies in bed, eats too much, and takes too little exercise. Often she has acquired at school the vicious habit of self-abuse. Next she becomes very religious, and imagines she is unworthy, and has no part to fill in life. These delusions of unworthiness develop rapidly. She shuns society, seeks solitude in her bedroom, and becomes irritable, impulsive, and melancholic. Her manner has changed; she is abnormally shy and evasive, her complexion is muddy, her bowels are confined, and her menses irregular. The family medical attendant is consulted. What must he advise? In the first place he must at once be on his guard against accident. All these patients are liable to act impulsively and without warning. They may become impulsively violent, and suddenly attack those nearest and dearest. I have known one sister attempt to strangle another asleep in bed beside her. Frequently they attempt suicide by precipitation, drowning, hanging, strangulation, or otherwise, in consequence of their sense of unworthiness. Removal from home and change of surroundings are essential. They can be well treated as single cases, even without certification. A well-trained, certificated mental nurse to sleep in the same room, eight hours' rest, early rising, morning bath (cold or shower), a light

diet with but little animal food, regular exercise, plenty of cycling and outdoor games, free aperients, attention to the disordered menses (avoid iron, if possible), and pleasant and variable social surroundings, will generally ensure recovery. For medicines, if impulsively excited, the bromides and valerian; if much depressed, the morphine preparations, with sulphuric ether, should be given, and rest at night must be ensured by hypnotics. When mania occurs in the young there is generally some insane inheritance and definite exciting cause, such as sudden grief or shock, overstudy, and overwork generally. The mania is usually preceded by an incipient stage of depression. If this be recognized, the cause, if possible, removed, the liver and bowels acted freely upon, and sleep ensured at night by veronal, trional, or paraldehyde, the attack may be cut short in its initial stage. What I have said for females applies also for males. A sea voyage should never be recommended in cases of incipient or borderland melancholia; the risk of suicide by drowning is too great.

The Borderland Delusional.

Many hypochondriacal cases come under this heading. Hundreds of people with hallucinations and delusions are uncertified and lead fairly natural lives. They are classified as eccentrics, and can often conceal their mental defects from the unskilled. As long as their actions, the outcome of these delusions, are not of such a nature as to be a source of danger to themselves or others, the State does not interfere with them. I have noticed that the mental unsoundness associated with self-abuse in the young adolescent is often characterized by hallucinations of ordinary sensation. The men complain that they suffer from electric shocks down the spine, and that batteries are turned on them at night. The women say that they are annoyed by machines, of course meaning electric machines. For the borderland delusional case, correction of bad habits, employment, change of mode of life, scene and surroundings are the desiderata.

The Premature Dement.

These are the cases of so-called "dementia praecox," a most unfortunate term, and which we trust may soon disappear. Premature dementia depicts the mental decadence occurring between puberty and adolescence. It affects the better educated and highly strung. Amongst the poorer and agricultural classes it is comparatively rare. It is a disease of civilization in which the original nerve vitality of the individual is limited, and the powers of resistance prove unequal to the strain to which the brain is subjected before development is fully completed. The patient in early youth may have been exceptionally bright and clever, have passed difficult examinations, excelled in music and other ways, yet more or less suddenly and often without definite cause, breaks down and becomes demented. The predisposing cause I believe to be a neurotic inheritance in town dwellers where hyper-civilization obtains, and the exciting causes over-education, febrile disorders, influenza, and stress. If you suspect this disease from failure of memory, loss of attention or interest in environment, you must at once endeavour to remove as far as possible the causes indicated, give nerve tonics, and ensure mental rest with change of scene and mode of life.

FORMS MET WITH IN ADULT LIFE.

Incipient Mania and Melancholia.

The early symptoms of mania and melancholia should be recognized and treated by the medical attendant in order to cut short the attack if possible, and to guard against accidents, violence, homicide, suicide and the like. The chief premonitory symptoms of mania are restlessness, incapability of concentrating the attention, loss of coherence in conversation, garrulity, irritability, loss of self-control, boastfulness and extravagance of ideas, change of feelings and affection, loss of moral tone, increased mental activity and insomnia. If to this condition is added an insane inheritance, the diagnosis is confirmed. Mania is often preceded by a short period of depression without febrile symptoms, but with abnormal rapidity of pulse, faint breath and a muddy complexion, white furred tongue and constipated bowels. It is unnecessary for me to detail the early symptoms of melancholia; I have already alluded to many of them under my Early Life section. Now, what is to be done in cases of

incipient mania and melancholia in adult life in the upper and middle ranks of society? First, the patient and those around him must be safeguarded. He must never be lost sight of. All sources of danger must be removed, such as razors, knives, glass and unnecessary furniture. He must, if possible, sleep at night and live by day on the ground floor. If that be not practicable, the lower sash of the window at least must be fastened by screws. The friends must be informed of his mental state, and early arrangements made for institution treatment should such be necessary. In early mania it is well to commence the medical treatment with a free aperient—calomel and colocynth or some other hydragogue. Pot. brom. ʒss, chloral hyd. gr. xv, syr. tolut. ʒj, aq. ʒj, three times a day, and veronal gr. viii to x or trional gr. xv to xx at night—a light dietary of eggs, fish, fowl and farinaceous foods, no stimulants, absolute freedom from excitement, and daily exercise for an hour or so morning and afternoon in a quiet garden. You are never justified in employing restraint by strait waistcoat or otherwise. The patient only frets under bodily restraint and struggles to exhaustion. Many a life has been lost thereby from cardiac failure. During thirty-three years of public asylum service I never saw a strait waistcoat. I have had patients brought for admission in them, but have always had the waistcoats removed before examination. They are an abomination! In incipient melancholia you must also clear out the bowels, but with enemata or saline aperients, not the mercurial preparations, for you must not add to the already disordered digestion. The stomach and mucous membranes generally require careful attention, and autointoxication must be guarded against. For medicines give liq. morph. acet. ℥xx to ℥xxv, sp. aether. sulph. ℥xv, aq. camph. ʒj, three times a day, to allay distress, and paraldehyde ʒss to ʒjss, or even ʒij, at night. A prolonged hot bath is good in mania, and a warm bath of short duration in melancholia before retiring to rest. In melancholia the outdoor exercise must be limited. More rest must be taken, and sun baths do good. The dietary also must be more liberal and contain red meats and stimulants. You must ever remember that the melancholic patient who most dreads injury at the hands of others, and who, in consequence, you would think least likely to commit suicide, is in reality most prone to self-destruction. He seeks relief by death at his own hands to escape the injury with which he believes he is threatened at the hands of others.

Borderland Delusional Insanity.

Delusions of persecution are common. Many refer to the nerves, viscera, and sexual organs. Many people with these delusions are harmless and can be treated at home. Others are highly dangerous and ought to be certified. How are you to distinguish these cases? Each case has to be judged on its merits. Where the delusion refers to a single individual, has no basis of existence, and is often repeated with threats of bodily harm, action must be taken or a criminal assault will undoubtedly ensue. These patients nurture their imaginary grievances for years, and can never be trusted. You must never try to argue a patient out of his delusions, for you will only irritate him. Let him talk; listen, and then change the conversation. These borderland delusional cases are always chronic. When the delusions are of the melancholic type, continued treatment by morphine and sulphuric ether with aperients will ameliorate and occasionally cure the disease.

Incipient General Paralysis of the Insane.

The early symptoms of this disease are change of feelings, affection, inclinations, temper, habits, and moral disposition in persons from 25 to 50 years of age—generally males (four-fifths males and one-fifth females). Then excitement or depression—the former much more common, but during recent years the latter has been observed with increasing frequency. Ordinarily we have restlessness (the patient is ever on the move), irritability, insomnia (he wakes very early in the morning), great sense of *bien être*, boastfulness, and self-assertion, extravagance of conduct, facile manner, loss of facial expression when the face is in repose, fibrillary tremors of tongue and facial muscles, blurred speech, often unequal or contracted pinhole pupils acting abnormally to light, some incoordination in motion, increased rapidity of pulse, altered tendon reflexes, knee-jerks exaggerated or unequal, and

there is at times slight elevation of temperature at night. He now begins scattering his money broadcast, and has delusions of grandeur and importance with benevolence. The general paralytic will always give you freely of his imaginary fortune. What is to be done in these cases? Get the management of his affairs away from him as quickly as possible by power of attorney, or if necessary by application to the Masters in Lunacy, ascertain the cause (syphilis, sexual excess, drink, overwork, or injury), counteract same as far as can be done, treat syphilis with large doses of pot. iod., attend to the primæ viæ, allay excitement or distress, and safeguard against accident or public annoyance. Treat if possible in single care uncertified, or if imperative certified. These patients get into trouble with others owing to their self-assertion. Their bones also become very brittle from nutritive changes, therefore fractures and injuries are common when treated with others.

Borderland Alcoholic Insanity.

Of delirium tremens it is unnecessary to speak, save to caution you against accidents, and against giving the opium preparations in this disease. The bromides, with chloral, sulphonal, trional, or veronal, are the staple medicinal remedies. In incipient alcoholic insanity proper, the outcome of chronic abuse of stimulants, the patient is suspicious, restless, even sleepless, impulsive, untidy in person, with lack of moral tone, and he may have hallucinations of hearing and delusions more or less fixed. The muscular tremors, motor inco-ordination, slight ataxic symptoms, and neuritis, are distinctive features. The treatment is to remove the cause, build up the muscular and nervous systems, and divert the mind by change of scene and surroundings.

Associated Mental Unsoundness.

(1) Where mental symptoms occur with and underlie certain other diseases—syphilis, phthisis, rheumatism, heart disease, influenza, myxoedema, anaemia. Also (2) where associated with child-bearing (pregnancy, puerperal, and lactational), and change of life (climacteric). In (1) you must treat the coexisting disease. The mental symptoms are generally of the melancholic type, so safeguard the patient against suicide. In (2) during pregnancy we may have either mania or melancholia, generally the latter; these cases usually recover soon after childbirth. You may suspect and recognize true puerperal insanity coming on by change in the manner of the patient, aversion to husband or child, irritability, restlessness, sleeplessness, garrulity, suspiciousness; by her muddy complexion, clammy skin, haggard look, rapid, small pulse, slight elevation of temperature, especially at night, cessation of milk secretion, and diminished lochia. Then we get obscene language, erotic tendency, hallucinations, delusions often of poison, impulsiveness, tendency to suicide and infanticide. These cases are always difficult to treat at home, from lack of moral control and from the frequent necessity of artificial feeding. If home treatment be attempted, the patient must reside on the ground floor; there must be a competent staff of trained, certificated mental nurses, and outdoor exercise must be obtainable. In puerperal mania give trional, paraldehyde, sulphonal, and the bromides with chloral; a very liberal diet is also necessary. Climacteric insanity is generally insidious in onset and of the melancholic type. The treatment is by morphine with sulphuric ether, strychnine, iron, quinine, change of scene, salt-water baths, fresh air, and exercise carefully regulated.

FORMS MET WITH IN OLD AGE.

Incipient Senile Mania and Melancholia.

The expression, manner, and gait all reveal increasing years. Next the memory is at fault, especially for recent events, and tales are oft repeated. Irritability, excitability, restlessness, and mania may follow. These patients are especially noisy at night—or melancholia with rapid loss of flesh takes the place of excitement. These cases are better treated privately; they require skilled nursing, a liberal diet, stimulants, and suitable sedatives; the opium preparations are good. In some cases of mania the hydrobromate of hyoscyne, veronal and trional, may be given.

Borderland Paralytic Insanity.

The mental symptoms here are of the emotional type,

with failing memory, irritability, and occasional excitement or depression; at times, however, these cases are very troublesome and noisy, and such sedatives as veronal, trional, sulphonal, and paraldehyde must be resorted to at night.

Incipient Senile Dementia.

The early symptoms of the old man nearing his dotage are well known to you. You must safeguard his property by impressing upon him the necessity of attending to his testamentary duties and by his giving to his next of kin legal power to act for him, or by application to the Masters in Lunacy. You must also safeguard the patient against indecent exposure of the person and other acts, the outcome of forgetfulness or senile imbecility, and you must deprive him as far as possible of all individual action and manage him as in the days of childhood.

GENERAL CARE AND TREATMENT.

At last the State is recognizing its duty to protect the incipient and borderland insane in England. A Bill was introduced in the last Parliament and will be reintroduced shortly, containing clauses to regulate the care and treatment of the incipient insane, and to render necessary their notification and supervision without the stigma of official insanity. To be complete, any Bill must have provisions to ensure that all houses into which such patients are received are registered as suitable, and inspected by the Commissioners in Lunacy or their deputies as properly staffed and managed, and furthermore to ensure that all custodians of these patients are upon a register as properly qualified to receive, take care of, and, if medical men, to treat them.

There should be similar clauses for the chronic borderland insane. The voluntary boarder system existing for registered hospitals and licensed houses must be extended to county and borough asylums receiving paying patients, to be used for patients of this class. Thus additional means will be obtained for skilled treatment in the early stages of mental disease. Since contact with certified insane persons undoubtedly has a demoralizing and injurious effect upon many of the incipient insane, individual treatment in single care, uncertified, with all the surroundings and comforts of home, is much to be commended. The tendency very rightly is at the present time to this decentralization and segregation, and I believe the best results will be obtained thereby.

A CASE OF CEREBELLAR ABSCESS : EVACUATION : RECOVERY.

By LOUIS BATHE RAWLING, F.R.C.S.,
ASSISTANT SURGEON, ST. BARTHOLOMEW'S HOSPITAL.

CEREBRAL and cerebellar abscesses may give rise to such localizing symptoms that the diagnosis as to the site of the lesion is fairly obvious. Such definite symptoms are unfortunately often either conspicuous by their absence or fallacious as to their significance, whilst the general condition of the patient may be such that the main localizing symptoms are incapable of demonstration. An exact diagnosis as to the site of the abscess may therefore be impossible, and more than one operation may be needed before the desired result is arrived at. The following case exemplifies this statement:

H. C., male, aged 21, was admitted into the hospital on December 1st, 1905. For four months he had suffered from a purulent discharge from the left ear. Three weeks previous to admission pain was experienced in the ear, associated two weeks later with chronic frontal headache. During this period he complained also of feeling ill, of inability to fully close the left eye, and that the face was drawn over to the right side.

Condition on Admission.

A delicate youth. Complaints of pain over the frontal region and in the left ear. Complete paralysis of the left facial nerve. Pupils equal and react. No nystagmus or paresis. Discs normal. Motor power, sensation, and reflexes all normal. Some slight unsteadiness of gait, and sways to the left side when standing with the eyes shut. Faculties unimpaired. All questions answered promptly and to the point. Temperature 101°, and pulse 80. During the next few days the temperature varied between 101° and 103°, but the pulse was relatively slow—80 to 90 to the minute. Optic neuritis first became evident on December 5th, developing rapidly, and showing 5 D. of swelling on December 8th. The papillitis was slightly more marked and more rapid in onset on the left side.