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.

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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.

Palpation of the skull revealed no area of oedema or tenderness, and all localizing signs and symptoms were absent. The patient, however, became daily more drowsy, sleeping the greater part of the day whilst lying on the right side.

Operations.

The presence of marked optic neuritis, the relatively slow pulse, the increasing mental lethargy, and a leucocytosis of 20,000 all pointed strongly to some intracranial collection of pus. On December 7th the mastoid antrum was exposed and found full of cholesteatoma. The bone was then chiselled away in an upward direction, in order to fully expose the supratentorial extradural space and the temporo-sphenoidal region, both of which were fully examined without result.

On the following day the patient was much better, and the temperature fell to 97.6°. During the next few days the conditions remained practically unaltered. The mental condition was much the same, lethargic but not markedly drowsy, the temperature remained constantly subnormal, whilst the pulse-rate varied between 64 and 88. The optic neuritis rather increased than otherwise, and vomiting of the cerebral type occurred on December 13th. On December 14th a flap was turned down over the left cerebellar fossa, and the bone trephined so as to expose the antero-lateral aspect of the cerebellum. During trephination the patient three times stopped breathing, and the operation had to be discontinued pending the performance of artificial respiration. After incision of the underlying dura mater, the cerebellum was explored with trocar and cannula, and an abscess cavity found lying about 1 in. away from the surface of the cerebellum. One ounce of greenish pus was evacuated and the cavity adequately drained.

After-History.

The beneficial effects of the operation were very evident on the next day. All headache had vanished, the patient was bright and cheerful, and the temperature normal.

December 28th. Continued improvement. Papillitis diminishing. Right eye, 3 D. of swelling; left eye, 3.5 D. of swelling. Both visual fields complete. Slight weakness of the external rectus of the left eye.

January 1st. Right eye, 2.5 D. of swelling; left eye, 2.5 D. of swelling.

January 13th. Walking powers only slightly impaired. A tendency still to fall towards the left or affected side when standing with the eyes shut. Right eye, 1.5 D. of swelling; left eye, 1.5 D. of swelling.

On January 30th the patient left the hospital for the convalescent home, returning to report himself again on March 1st. He then appeared in excellent general health, but complained of pain over the left parieto-occipital region and of inability to see objects in the right visual field. The gait was also slightly staggering in nature, and there was a decided tendency to lurch towards the left side when standing with the eyes shut. He also stated that, two or three days after leaving the hospital, some weakness was experienced in the left upper and lower extremities.

The general condition was as follows:

Attitude: Head held slightly on one side, occiput to left, chin to right.

Intelligence and Memory: Good.

Cranial Nerves: Second, third, fourth, and fifth nerves, normal; sixth nerve, slight paresis on left side; seventh nerve, complete paralysis on left side; eighth nerve, markedly impaired on left side.

Eyes: Slight nystagmus on left lateral deviation, not sustained, and rather coarse in character. Papilla slightly blurred on left side, and about 1 D. of swelling. Visual fields normal.

Motor and Sensory System: Normal.

Reflexes, Superficial and Deep: Normal.

The examination completely negated any further complications, and the patient was therefore discharged. He returned to work, and remained perfectly well till December, 1908, when he was admitted for further aural treatment, as a slight discharge from the ear still persisted. The general condition was all that could be desired, the discs were clear, and there was no evidence of optic atrophy.

In this case there are some features of clinical interest which merit further mention, and for the purpose of estimating their value the records of five other cases of cerebellar abscess have been examined.

Optic neuritis was observed in 4 cases, equally marked on the two sides. In one case the condition of the patient was so desperate that no examination could be made, whilst in the case of H. C. both discs were affected. On admission no papillitis was visible; five days later optic neuritis first became evident, and rapidly increased up to 6 D. of swelling. The cleaning out of the mastoid antrum exercised no effect on the degree of swelling, but the inflammation began to subside immediately after the evacuation of the abscess. Seven weeks elapsed before the discs returned to the normal condition, and at the present date (thirteen months after operation) the discs are clear and vision excellent. Throughout the acute stages of the illness the disc on the left or affected side showed a slightly higher degree of inflammation, and the subsidence of the swelling on that side was rather more protracted.

Temperature Changes.—In 3 cases the temperature remained subnormal throughout; in 2 cases, both of which were associated with lateral sinus thrombosis, pyrexia and rigors were present, whilst in the case here recorded the

temperature varied between 101° and 103° until the mastoid antrum had been cleared out. This source of infection being removed, the temperature at once fell to the subnormal type so suggestive of cerebral or cerebellar abscess, rising again to normal immediately after the evacuation of the abscess. It is obvious, therefore, that too much attention must not be paid to the temperature chart by itself, since septic absorption from the antrum and middle ear may upset the typical subnormal temperature of an otherwise uncomplicated case. In

1. The temperature on admission. 2. Clearing out of mastoid antrum and exploration of temporo-sphenoidal lobe. 3. Evacuation of cerebellar abscess.

such cases the relation between the pulse-rate and the temperature is of far greater clinical value.

The Abscess Cavity.—In five cases the cerebellum was infected from the middle ear, whilst in the sixth no cause could be found. In all, the abscess occupied the lateral lobe of the cerebellum, and was so situated that no direct pressure could possibly have been exercised on the pyramidal fibres. In two cases the abscess was double, the cavities being superimposed and communicating with one another in front by a narrow channel, so narrow, indeed, that the evacuation of the lower of the two cavities would in no wise have afforded a means of efficient drainage of the upper. Mr. Ballance, in the Lettsomian lectures of 1906, laid stress on the not infrequent presence of two such cavities. The abscesses contained from a half to two ounces of greenish pus, sometimes sterile, but usually yielding abundant cultivations of *Staphylococcus pyogenes aureus*.

Respiratory Failure during Trephination.—This phenomenon has been alluded to on several previous occasions. Artificial respiration should be resorted to whenever necessary, but no effort should be spared to remove the disc of bone as speedily as possible in order to relieve the intracranial pressure, when the condition of the patient will at once improve. In most fatal head cases death results primarily from respiratory failure, the heart beating for many minutes after the cessation of respiration. The respiratory failure

during trephination must, therefore, be regarded as the danger signal indicating the urgent necessity of relieving the intracranial pressure.

TOTAL ENUCLEATION OF THE PROSTATE FOR RADICAL CURE OF ENLARGEMENT OF THAT ORGAN.

A FURTHER SERIES OF 119 CASES OF THE OPERATION.

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In my last paper on the subject of total enucleation of the prostate, published in the *BRITISH MEDICAL JOURNAL* of October 7th, 1905, I dealt with a series of 96 cases of the operation performed by me during the year ending July 20th, 1905, and concluded with a brief review of the results obtained in 206 cases of my operation performed by me down to that date. During the period that has elapsed since my return from my holiday on September 6th, 1905, to the end of July, 1906, I have operated on a further series of 119 cases, of which 30 were in hospital and 89 in private practice. The object of this paper is to place before the profession at large the results obtained from these operations. In my earlier series I gave full details of every individual case, and in my last two papers details of many of the cases, adding tables giving the date of operation, age of the patient, and medical man with whom seen or by whom sent, of each individual case. The present series is, however, such a large one that it is impossible within reasonable space to give in detail more than a few of the cases, illustrative of some important features of the operation. Where almost every case is replete with interest it is difficult to make a selection.

CASE CCVII.

L., aged 60, seen with Dr. H. Murray Norris (London), September 8th, 1905. Prostatic symptoms for three years; latterly intense frequency of urination and much pain. Catheter passed September 6th by Dr. Norris, and a large quantity of residual urine, which was alkaline, drawn off. Passed no urine subsequently except by catheter. I drew off 9 oz. residual urine, thick with pus and phosphates. Prostate enlarged to the size of a Tangerine orange, round, soft, movable. Patient very stout; intensely nervous. Next day there was much difficulty in introducing the catheter, which had to be tied in. Patient in great distress.

On September 11th, Dr. Norris assisting, I enucleated the prostate, which weighed 1½ oz., entire, with some difficulty, owing to adhesions caused by cystitis. Several small calculi were imbedded in the substance of the prostate and removed therewith. There were about a dozen calculi in the bladder the size of peas.

The patient passed several ounces of urine per urethram on October 5th, and wholly in this way after October 11th. He left for home October 18th in excellent health and spirits, able to pass and retain his urine as well as he ever did. I saw this gentleman recently in perfect health.

I have noticed that prostates containing calculi imbedded in their substance are more liable than others to be attended by severe cystitis, and that they are more difficult of enucleation owing to adhesions contracted with the sheath and mucous membrane of the bladder.

CASE CCXLIV.

On May 15th, 1905, an American gentleman, aged 65, resident of New York, consulted me on the advice of Dr. Kraus of Carlsbad. Prostatic symptoms had existed eight years.

Catheter employed for six years, during which time patient was practically dependent thereon. Prostate much enlarged, bilobed, smooth, movable, and bimanually felt prominent in the bladder. Urgent business required his presence in America, so operation was postponed till his return in November, when there was much difficulty in introducing the catheter and the urine was putrid.

On November 29th, 1905, I enucleated the prostate entire, Mr. C. Braine being the anaesthetist. The time occupied from commencing the suprapubic cystotomy till the prostate was delivered from the bladder was 5 minutes. The recovery was uninterrupted. Some urine passed naturally December 15th, and next day the suprapubic wound was dry. On January 2nd, 1906, he left the surgical home in excellent health, able to pass and retain urine, which was normal, as well as he ever did.

The prostate (Fig. 1), which weighs 2½ oz., is of peculiar shape, presenting a gutter-shaped outgrowth in the bladder 2 in. long resembling an epispadian penis. This is the second prostate of this shape that I have removed.

CASE CCLIV.

This gentleman, aged 75, consulted me, September 12th, 1905, on the advice of Dr. McAfee, West Kirby. Twenty years previously he had retention of urine whilst travelling in Italy. Catheter employed for three days, after which the urine was passed naturally till two years ago, when the catheter was resumed. Has had cystitis, orchitis, and haemorrhage occasionally. Residual urine 11 oz., containing much pus and mucus, though the bladder was washed out daily. Prostate enormously enlarged, bilobed, soft, movable. General health fair; patient very stout, with tendency to chronic bronchitis. Operation advised but postponed at patient's wish.

On December 15th I was summoned to Crowborough to see the patient with Dr. Basden. He had been confined to bed for nearly three months with cystitis, attended by rigors, high temperature (105° F.) and delirium from time to time. Condition very feeble; pulse irregular and intermittent, so that I did not consider it advisable to undertake the operation at that distance. On December 29th he was conveyed to London by ambulance. Health somewhat improved, but still feeble and flabby. On January 2nd, 1906, I enucleated the prostate entire, Dr. Basden, Dr. Adam Simpson, Liverpool, and Dr. L. E. Schmidt, Chicago, being present. The prostate (Fig. 2) was the size and shape of an enormous pear, two-thirds of which projected in the bladder. The right lobe had several nodular outgrowths. Weight 9½ oz. The enucleation was easy considering the size of the prostate and the stoutness of the patient, the time being seven minutes. There was little haemorrhage, and the operation was well borne.

Progress was on the whole satisfactory, though slow during the early days after operation, but the urine was foul and there was nightly delirium. Had slight orchitis during the third week. When sitting up and convalescent, on February 18th, a sharp attack of bronchitis set in, for which I had the advantage of Sir Thomas Barlow's care of the patient. By March 2nd the patient was again out of bed. A small fistula remaining, I tied in a catheter for a week; after its removal the urine was passed naturally. By March 14th the wound was firmly healed and the patient walking about, able to pass and retain his urine, which was quite clear, as well as he ever did. The patient is now in excellent health. The case gave Sir Thomas Barlow and myself much anxiety. Considering the patient's condition his complete recovery was remarkable.

CASE CCLXI.

Gentleman, aged 75, seen with Dr. R. Roche, London, January 3rd, 1906. Prostatic symptoms had existed two years. Had retention in June, 1905; relieved by catheter, which had been irregularly employed ever since. Residual urine, 8 oz., contained much pus. Latterly there had been much difficulty in introducing the catheter. For several days he had suffered from pyrexia, the temperature during the last two being 104° F., with mental symptoms amounting almost to acute mania, the result evidently of blood poisoning and uraemia. The prostate was enlarged to the size and shape of a small pear, being bilobed, smooth, dense, and very tender on examination per rectum.

Fig. 1.—Prostate weighing 2½ oz. removed from patient aged 65 (Case ccxlv): B, Right lobe; A, left lobe; C C', outgrowth in bladder; a a', contracted neck, indicates boundary between intravesical and extravascular portions.