No 1. February, 1907 Vol 1.

Bulletin

OF THE

Ontario Toronto Hospital for the Insane

A Journal devoted to the interests of Psychiatry in Ontario

Printed by Order of the Legislative Assembly

Printed by L. K. CAMERON,
Printer to the King's Most Excellent Majesty

Toronto:
Warwick Bro's & Rutter, Limited
1907

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Psychiatry, which deals with diseases of the mind, has for many years received little or no attention from the general practitioner or from specialists in other branches of medicine. The reason given, in many cases was this: clinical instruction in this department was of such a nature that a man during his undergraduate days was quite unable to get any grasp of the subject, and after graduating and going into practice it was considered sufficient to be able to write a certificate of insanity and send the unfortunate to an asylum; there the matter rested. In the home the patient's name was mentioned with bated breath, not in the way they would speak of a member of the family who had been stricken with physical illness—on such a one all tender care would be lavished—but the mental sufferer went away under a cloud—from the family view-point. So both from the stand of the medical man and that of the laity the situation could be little, if any worse.

However, within the past few years light has begun to shine forth, the outlook is much brighter, and because it is of vital interest to the public at large (*i.e.* those to whom we look for the maintenance of the public institutions) and to the physician, we may be pardoned for

dilating still further and noting some of the modern advances.

First and foremost the status of the patient is essentially different. He is now treated after the best methods in vogue in general hospitals, with certain modifications adapted to his particular needs. He is no longer regarded merely as a menace to public safety or to his own welfare; on the contrary, we are most impressed with the fact that it is a *sick* man with whom we have to deal, a man who is at daggers drawn with his environment, who can no longer accommodate himself to the requirements of organized society; the victim of a diseased personality—often accompanied by manifestations of various physical disorders.

To accomplish the most good; to aid the patient most intelligently; to practice preventive medicine by timely advice and counsel should be the aim of every one engaged in the special practice of psychiatry, because to him the rest of the profession look for assistance, in order that the general practitioner may be kept in touch with the work being done.

This little periodical is issued with the hope that by a fuller co-operation between the outside medical man and his patients, on the one hand, and the psychiatrist on the other; we may gain a clearer insight into certain conditions that at the present time are of immense practical importance, but not at all clearly understood.

That we may succeed in this undertaking it is most essential that we enlist the aid of those engaged in general medical work everywhere, so that our case histories of the patient up until his admission may be complete; not mere isolated facts; of no value unless correlated. A

form of history will be gone over and suggestions made as to the information of most importance and methods of obtaining it.

In order that a diagnosis may, in certain cases be made before the patient is sent to the hospital, and more satisfactory information given to the friends regarding the probable outcome of the case, clinical pictures of type cases will be presented; all the features being duly emphasized, the prognosis offered, and the plan of treatment outlined.

Psychiatry is making rapid progress in many foreign lands and an awakening of interest is all that is necessary in Ontario to enable us to be pioneers in a work of the utmost importance from an economic, sociologic, and humanitarian point of view. The most casual observer cannot fail to be impressed by the seriousness of the problems presented, and apathy is much more likely than open opposition to cause retardation, so it is earnestly hoped that the question may be faced fairly and squarely and an endeavour made by all to aid in the solution. The scientific observations of the laboratory worker and the clinical studies of the man on the wards will serve only to partly solve the problem; those already indicated must furnish the rest. The physician must be the high priest, giving advice and counsel based on accurate, careful and painstaking observations of his fellow worker in this special branch, further aided by his own knowledge of the conditions in each case.

It is hoped that this journal may also be of special interest to all engaged in the specialty, for that reason items of scientific and personal interest will find their way into its columns from time to time. Book reviews, ab-

stracts, methods of work, etc. being referred to, when considered of sufficient value.

The Bulletin being published purely for the reasons already enumerated will appear more or less irregularly, but it will aim at coming out sufficiently often to keep in touch with those whose interest in the work has been enlisted.

A Psychiatric Clinic.

Ontario has an opportunity to score a veritable triumph if she will wisely accept the opening. With the reorganization of the University, the building of the Provincial Hospital, and the accepted policy that Toronto Asylum has outlived its usefulness, comes the chance to do something that will, at last, lift psychiatry to its proper position, as one of the most practical and important branches of medical science. This would mean the establishment of a Psychiatric Clinic upon a site near the new Hospital. The building would be a self-contained establishment, under Governmental control, would embrace every modern requirement for the scientific treatment of acute cases of insanity—laboratories and lecture rooms and provision for the prosecution of research work in pathology, physiology and psychology.

The educational side of the Clinic would be of just as great importance as the curative, and the general practitioner and student would have abundant opportunity to acquire some insight into the nature of mental diseases. This clinic would have an intimate relationship with the Provincial University and Provincial Hospital and should also have a Dispensary Department.

If Toronto University is to become as great a Mecca (and why not even a greater?) as Johns Hopkins, the

Psychiatric Clinic is an absolute necessity, and there is no reason why we should not lead the way in America. Kraepelin's Clinic at Munich has revolutionized psychiatry in Germany, and has had a profound influence in directing the attention of the whole psychiatric world to new and practical problems. If the Government is alive to the demands of the situation, and it has of late shown a keen interest in the bettering of the service, the most momentous advance in the interests of the insane, in Ontario, that has been undertaken, will occur.

Form of Physical Examination.

The following form of physical examination laid down to be followed by the Assistants in the Toronto Asylum, may prove of interest to a physician called in to study patients suffering from mental disease.

Note the patient's general make up, breadth, and stretch of arms.

Chest Measurements, depth and breadth.

Head Measurements. Occipito-frontal diameter. Bi-parietal diameter, bi-temporal diameter. Cephalic index.

Patient's weight, normal and present; note scars and bruises.

Facial Asymmetry. Color of the hair and quantity, and general complexion. The condition of the skin, of mucous membrane. *The Ears*, size, helix, and antihelix. *Lobules*, whether adherent or not, whether there is any discharge from the ears. *Hearing* with the tuning fork.

Hypertrichosis: Eyebrows continuous, or overgrowth on any other part of the face or body. *Eyes*: first the lids, whether granular or not, position of the eyes, straight or whether any strabismus. Pupils, whether

concentric, the size, the equality, outline, the reaction to light, directly and consensually, reaction on accommodation to near vision.

The Vision, hemianopsia, presence of the arcus senilis, examination of the optic disc if necessary.

Taste and Smell if necessary, then the mouth and teeth, mucous membrane. *Tongue*, *Palate Arch*, presence of a torus.

Pharynx and Tonsils.

Pharyngeal reflex.

Chest Malformations, *Costal Angle*, *Lungs* inspection, palpation, percussion and auscultation.

Development of mammae.

Heart: Inspection, palpation, percussion, and auscultation. Outline R. C. D.

Abdomen, first whether held rigidly or flaccidly. Quantity of panniculus. The abdominal skin reflex, tenderness on deep palpation.

Gastro—intestinal condition, vomiting etc.

Localized rigidity. Outline *The Liver* (R.H.D.)

Floating Kidney. Presence of ovarian pain or tenderness.

Genitalia and *Cremasteric* skin reflex.

Malformation of Extremities.

Evidence of Lues.

Reflexes, McCarthys, Massester, Mechanical irritability of Facial, Arms, Knee Jerk, Achilles, Plantar skin reflex. Presence of Clonus. (*Babinski*,) Cutaneous sensibility and stereognosis.

Motor Functions, gait, station, grasp with dynamometer, speech, and in each case a specimen of patient's handwriting.

Organic Reflexes: Tremors, coarse and fine, fibrillary twitchings.

Subjective Complaints. Note :—Having made a thorough examination, varying it to suit the needs of each particular case, not limiting the scope of the examination to the foregoing headings.

These are understood merely to be land marks in the examination of the patient.

To ascertain Mental Status :—

Wernicke Reflex Arc; indicating the psychosensory, central and psychmotor sides, will be found very useful as a guide in ascertaining in a general way the location of the lesion.

To determine the patient's condition still further, the general reaction is noted, and this is often well obtained by asking the patient a number of questions, and making verbatim reports of the answers, with the questions asked.

(1). It is understood that the observer has tried in every case to ascertain the patient's normal mental make up.

(2) Having noted the general re-action, next ascertain whether the patient is oriented in the three spheres, autopsychic, somatopsychic, allopsychic. Here, of course, the question of clouding of consciousness enters.

(3) The presence of sensory disturbances.

(*a*) F. S. P. (Hallucinations.) (*b*) Illusion.

(4) Note the delusional fabric, showing the growth and development.

(5) The *Memory*, for the events recent and remote. Test the retention with the three word test, *desk*, *chair*, *table*.

Calculation: Simple problems, and simple tests in mental arithmetic, such as 2 from 20, and 6 from 100 test.

(7) *The Affect, i.e.* the Emotional tone.

(8) *Association*, Ideation.

(9) *Psychmotor Discharge*, here one would note the presence of stereotypy, mannerisms or negativismus, increased facility in discharge or retardation.

(10) *Insight.*

(11) *Judgment and Critique.*

Here again the form is suggested merely as a guide to the method of procedure.

The examination would vary in many particulars in every case, but it is most essential that the points enumerated, should at least be gone into. Examiners can make further tests if necessary.

These facts correlated with those ascertained regarding the patient's life previous to admission to the hospital, should make a running account of patient's past and present, and in this way a complete survey of the normal and abnormal psyche is obtained. It is much more essential to know in every case all the symptoms that patient presents than to name the conditions, and terms such as "excited," "depressed," "confused," are as a rule absolutely worthless, when used as isolated phrases, because any one of them, or a combination of them may occur at various times in almost every psychosis.

History-Taking.

In obtaining the history of a patient from the friends two things should be kept in mind; first, we are anxious

to learn the patient's normal mental make up, and, second, to learn in what way the patient's present condition differs from the normal.

To ascertain the first it is necessary to go fully into the family and personal history of the patient. A clear running account is of the greatest value; in women the age of puberty and menstrual history should be carefully noted, because menstrual anomalies are often associated with the prodomal periods of certain of the psychoses.

The use of isolated descriptive terms such as: excited, depressed, noisy, violent, etc., should be carefully avoided—describe what happened—do not name it.

Patient's friends often conceal information from best possible motives; that this is an erroneous view should be explained to them, and no one is in a better position to do this than the family physician.

Consanguinity.

One of the studies being taken up at Toronto Asylum at the present time is that of consanguinity.

The work will be greatly advanced if physicians filling in Forms of History will be careful to obtain all the facts possible regarding consanguinity. Negative evidence is just as valuable in the interests of true science as that of the positive order; in other words, accuracy should be aimed at.

The subject of consanguinity has never been thoroughly worked up and much information regarding it is necessary before its importance in relation to neurotic diseases is determined.

PARANOIA

The following case is presented as a type of pure Paranoia, following the clinical picture first described as such by Mendel, in 1881.

The picture differs clearly, however, from various paranoid states which may occur during the course of other psychoses. Of course, where the clinical picture is clear in any other psychosis and where vague persecutory ideas arise, but are fleeting in character and changing in content, the diagnosis would always be clear, but there is one condition in which the necessity for differential diagnosis is present: that is, Dementia Paranoides (Kraepelin).

In true paranoia the condition is, as a rule, of slow development, extending over a period of years, and as was noted in this case, the features are those of an intellective rather than an affective psychosis.

The mental reduction may not occur for many years. The delusions are well elaborated, systematized and are ever growing wider; all ideas are arranged in orderly array, and as a rule nothing illogical (from the patient's point of view) or irrelevant is introduced. Usually fallacious sense perceptions are absent: they are occasionally present but the hallucinatory experiences even in such cases are slight.

In Dementia Paranoides, on the other hand, we have a psychosis which develops earlier, in the second and third decades, although occasionally later. In this the conspicuous features are these:

First—The marked mental reduction going on early and growing progressively more marked.

Second—In the affect sphere the apathy and indifference often being striking.

Third—The delusional fabric is not well systematized and is, as a rule extremely illogical. Activity of unseen agents; mystic devices being constantly complained of. Outbursts of silly laughter or impulsive violence are common without any apparent motive.

These patients often have a history extending back many years; in fact, in a number of cases to childhood. The hypertrophy of the ego, which becomes so conspicuous in late cases of true paranoia, is, as a rule, not a feature in Dementia Paranoides. In the former condition late reduction is the rule; in the latter early and conspicuous deterioration is as a rule found.

The clinical types are clear and distinct. Of course many cases are found which shade off one into the other, and the prognosis in either condition is extremely bad.

Kraepelin says no cases of Dementia Paranoides recover, and there has never been a case of true paranoia recorded in which recovery has taken place.

The patient whose history is here outlined was presented at the clinical conference, at the Hospital as a type of true Paranoia for the reasons already enumerated.

Edward J. M————

January 15th, 1907

F.H.—Father dead; was killed in an accident when 30 years of age. He was a temperate man; was of Scotch Irish descent.

His mother died at the age of 36 of what the patient calls "Paralysis of the Brain." She took sick on the Friday night and died the following Sunday night.

She was conscious until Sunday morning. She did not have a stroke; never had any convulsions or fainting spells, but the patient does not know anything further about the nature of the attack. She was of Scotch descent.

There was no consanguinity.

Patient had one brother who died in childhood. He had no sisters, and as far as is known there was no family history of any psychosis or neurosis, or any chronic constitutional disorder in the family. Patient has a paternal uncle and a paternal aunt living who are both in good health. Two paternal uncles died some years ago.

Other points in his family history may possibly be elicited later on.

P.H.—Patient's father died when he was nine months old; the first six years of his life he lived with his mother, near M————and from time to time when he was six years old until he was ten he lived at G———— There he went to school. His mother died when he was ten years of age. He then came back to T————. This was in the Spring of 1877. When he came back he lived with an uncle and attended R———— school for two years. He then became an apprentice at the M. B. Foundry. At the same time he also had a route on the paper. He got up at 4 o'clock in the morning to do the work, he kept this up for three or four years and made $4.00 per week. He was with the C———— Co. over five years. He then went to G. B———— as a machinist. From here he went to B.E. —— Co. as an electrical worker. About this time he thought he would like to see something of the world, so he took a passage to Glasgow. On arriving there he entered the employ of M. & C., where he worked part of

one year. Having saved up money he travelled about, through England and Ireland and Scotland. He remained abroad one year. He then came back to P——— and secured employment with the P. E. ——— Co. where he remained for three years. He then went with the D.E. Co. and worked with them altogether for about ten years, but he was with the H. T. Co. for a time doing special work. He went on the trial trips of the submarine boats, and had charge of the steering gear. He was earning $38.00 per week, for eight hours a day work. He remained with the H——— people for three years, during this time he went to England, on business for the firm, remaining there three months and he also went to Washington, D. C., with the diving boats, assisting in the demonstration that was given before the special committee of Congress. This was in the summer of 1903. About this time he went back to the E. D. Co. and the reason of this move will be given subsequently in the discussion of the present illness.

He continued in the employ of the D. Co., in P——— until they moved their plant to B ——— He then went with the A.——— A. Co., where he remained only a short time, because of the long hours of work. He then entered the employ of the C.E.Co., where he remained until March 1906.

Patient tells us at that time he had a dream, which influenced his whole future : he did not intend to leave P———, but owing to this dream which he had he changed his mind. The dream was in the nature of a warning that he should leave P———. It was symbolic in character and he interpreted it to mean that he should leave P———. For this reason he came on to T———. On

arriving here he went to work in the K. C. Co., installing electrical apparatus. In this work he had to go to town with his tools, and it was not quite up to the work he had been doing in P——— so he became dissatisfied and made a change. He then went to the L. G. B. Co.; there he remained until September. He then went with the A.——S.—— Co.; where he remained until Christmas 1906. At that time he quit work and has done nothing since.

Alcoholic History:—Patient says that he drank whiskey from the time he was 14 years of age until he was 33 years; at that time he was working with the H. E. Co. and the manager of the firm told him then it would be very much to his advantage to give up drinking, which he did. This was in the summer of 1900. He has taken nothing since that time. He never had any drug habit but formerly used tobacco, both chewing and smoking. However he gave up chewing tobacco about twelve years ago, because he believed it was a bad habit, and one he could very well dispense with. He smoked quite heavily until eight years ago when he gave up tobacco altogether. He has not been a church going man, but says he always believed in God. He is not married.

Sexual History. This dates back to the time when patient was 8 or 9 years of age, and shows precocious development. About this time he had relations with a girl of about 17. This went on for some six months. And again later when he was about 10 years of age, at this time he formed an intimacy with a girl some years older than himself; then until the time he was about 17 or 18 nothing was noted, but from that time on he has had relations regularly. About six years

ago patient met a woman at Atlantic City, who lived with him for three years as his common law wife in P——. He gave this woman up because he believed she was concerned in a plot against him.

His sexual habits have always been most irregular, but apparently he has not been at any time a gross sexualist. He has had no sexual relations at all in the past three years. He had a tripper when 18 years of age. A second attack when 30 years of age, and has probably had others. He denies specific infection. He also says there is no diminution in sexual vigor.

P. I.:—Probably dates back to 12 years ago: patient remembers that as long ago as this, when he went into a saloon to get a drink that certain things happened, which led him to believe that saloon keepers were trying to poison him. At that time, very often when he would put down his glass, after taking a drink, the glass would leave a white mark on the counter: this he believed to be due to something that the saloon keepers had put in the beer, and he once accused a saloon keeper of trying to poison him. He states he was drugged right along "in the Irish saloons;" he says he often spoke to the saloon keepers about it, but never received any satisfaction. However, his troubles became very much exaggerated about six years ago and his subsequent history was much modified by what happened at this time.

At this time he was living in E——, and he believed that people with whom he was boarding put poison in his food; this went on for a time. Finally he could stand it no longer, so he gave up his position and went

up to L. I.—this was in the summer of 1901. Shortly after arriving there he went to board at a place where certain other incidents happened which introduced a new feature into the case. He was boarding with a Mr. S——, and he states that one night the man's wife came to his room. He was very much surprised and upset by this incident and the next day changed his boarding house and moved across the road to a Mr. G——. Some time before this incident, at Mr. S——'s, he believed that his troubles were due to persecution on the part of the Roman Catholics, but after being with G—— for a short time he discovered that poison was put in his food, and as they were Presbyterians he was led to believe that the other Churches were also in the plot, and a few Sundays later, when at church one morning, the Minister, a Presbyterian, made some remarks which he knew applied to him and which to his mind was conclusive evidence that the other churches had been dragged into the affair, and ever since this time people have been drugging him, putting different kinds of poison in his food and drink.

He first noticed about 1901 that the poison began to work, because it made him feel very nervous; his hands would shake and he believed that it caused his hair to turn grey; he believed that if he even went into a restaurant for a cup of tea or coffee it would also be drugged. He often complained to people about the persecutions that were inflicted upon him, but no one ever paid any serious attention to him.

Despite patient's delusions, he continued to work, but all the time his ideas were becoming more crystallized, and the delusional fabric was assuming a more systematic

arrangement. At this time he believed that church people were at the head of the persecutions.

Questioned a little more closely as to anyone being at the head of the band of persecutors, patient replied that it was "The man who stands in the sanctuary and professes to forgive sin." He later explains that this is the Pope, who guides all the churches, Catholic and Protestant, in their persecutions. He then said "They teach a man to be a Protestant, and then try to poison him because he does not believe in the Pope as Christ."

More and more people have been drawn into the plot as time goes by, until now all churches, all religious societies and all secret societies are banded together to harm him. He believes that there are many unwilling persecutors in the plot; that many of the people who annoy him only do so because they are unable to resist the pressure put upon them by the Pope.

Patient has studied the Bible very closely for the past two years, and he has woven many Biblical characters into the delusional fabric, and many of the ideas expressed and prophecies foretold he believes apply particularly to conditions in which he was an active part; that he is the one who is being persecuted.

Questioned as to the part he plays in this great event, patient says that the time is coming when wonderful revelations are to be made, when all men who are now branded with the mark of slavery are to be liberated, and all those who are unwilling accomplices will be free; he is only a humble servant of God, and that he is quite satisfied to be a victim if all these things can be accomplished through his own sacrifice.

He says he has no close relatives, and he would not mind if he had to give up his life to the cause. This altruistic attitude does not appear to be assumed for histrionic effect.

Patient believes that the Masons are to play a large part in the events that are to cause such a stir in the future, although they are, at the present time, in the band of persecutors, but not willingly. He believes when the time comes that they are to be liberated and to lead in the attack on his enemies. Patient believes that the Pope is influenced by the Devil.

One form of persecution which patient went into quite minutely was in regard to certain methods adopted by his enemies to harm him: they put something in the wash-water which caused a bronzing of his hands. They did this in order that his hands might look like Christ's, because he says "I know where it speaks in the Bible of Christ's hands being bronzed." This was done so the people would think that he, the patient, was trying to make others believe he was Christ.

Of course, one of the essential reasons why he was persecuted was because he would not believe false doctrines. He cited in support of his argument the fact that history is being made in the matter of the Church, affairs at the present time, the conditions of the Church and State in France where the Government officially separated itself from the Church; causing the Church to rank with secular institutions.

Patient asserts that the persecutions have been much worse in Toronto than they were in P———. Just a few days before coming into the gaol he went into a restaurant and ordered some fish, and just below the skin some

white oily substance had been put, which was extremely poisonous : it had a peculiar faint smell, which warned him of what was there so that he did not eat the fish. He says that various kinds of poisons have been used at different times, and that his food and drink have been tampered with wherever he was, so that at different times he has only eaten fruit and canned things, which he himself opened. Because of the fact that everything he took to drink also contained drugs, he thought he would drink malt, but the first bottle he took he believes contained some poison, so he at once assumed it had been tampered with.

The fact which led up to his being committed to the Hospital are as follows ;

He stopped work about Christmas, as noted before, and December 30th he crossed to H. P. to have a quiet Sunday and get away from his persecutors ; when he arrived there he climbed up on a second story porch of a cottage, in order that he might take off his shoes and dry his socks. He climbed up because the first porch was covered with snow and slush. He had only been there a few minutes when the policeman came along and arrested him. He was taken to No. 1 police station, where he was charged with trespassing and an attempt at housebreaking. When he was brought up in the police court the charge was changed to one of insanity. He was remanded to the gaol and from there he was committed to the Hospital.

He says that while he was in gaol he was well treated, and although possibly an attempt may have been made to tamper with his food, he does not believe he received any poison while there.

Mental Status. Throughout the recital of the above, patient's demeanour was a very normal one ; he told his story in a calm, deliberate fashion, putting due emphasis on the necessary points ; trying at all times to be clear and logical, but leaving it to the physician himself whether he wished to believe the story ; at the same time clearly indicating that he himself had not the slightest doubt about the truth of it.

This extraordinary delusional fabric, which patient has woven and systematized, has taken several years to get into its present state. Now it is clearly systematized ; events follow one another in a logical sequence and there are practically no gaps anywhere. In regard to the suggestion that there might be hypertrophy of the ego, patient says he is a humble servant in the hands of another, and the following statement was obtained from him in reference to this point: " I think I have a mission different to what I have been following, merely existing for a living ; I feel there is something, but I do not know what it is ; I feel there is something in store for me better than in the past twelve years ; I feel the future is brighter for me : just in what way I cannot tell, but the people trying to make my face and hands bronzed is insanity on their part ; false teaching." " I don't know that I am of any more importance than any one else in this world, but I believe in the hereafter and I believe we are all to be rewarded for our works."

This may be the germ which will later develop and cause the patient to much exaggerate his own relative importance in the world and be the basis of the symptom that is often so striking in all cases of true paranoia.

Patient is questioned closely regarding hallucinatory experiences, but he denies absolutely having had them at any time. He has had illusions of hearing : for instance, he would see people talking and would at once believe that they were talking about him. He has also had illusions of taste and smell ; has tasted and smelt the poison and on one occasion was wakened in the middle of the night by a stiff feeling which came over him, this being due possibly to paræsthesias. He himself believed it to be due to gas which has been liberated in his room. It is quite possible that patient's room was close and stuffy and he misinterpreted an actual condition. At other times he has had definite paræsthesias : on one occasion he believed he was being paralyzed, but he quickly rubbed his arm and leg and warded off the calamity. His misunderstanding of his actual feelings have been most remarkable ; not only in regard to paræsthesias, but doubtless also to organic sensations.

All patient's ideas are clear and logical. He attributes nothing to unseen agencies, mystic influence or electrical devices. Everything can be perfectly well explained by his view Of course, it is at once evident that in certain directions his ideas become quite grotesque and bizarre, but they are never irrelevant. His memory, as will be seen from a perusal of what has already been said, is good for events both in the recent and remote past. There never has been, at any time, any disorientation or clouding of consciousness : no disturbance of either the psycho-sensory or psycho-motor sides of the reflex arc ; the lesions being entirely central and one in which judgment and critique are mainly affected.

Patient's *Affect* accompaniment shows neither marked elation or depression. He takes a lively interest in all that goes on about him; there is no suggestion of apathy or indifference. Regarding the future he is hopeful, but philosophic; willing, if necessary, to be a victim of fate and quite resigned to the fact that he is completely in the power of the enemy. His *attention* is, at all times, easily gained and can be sustained for prolonged periods without any show of fatigue.

That patient has been an extremely good workman we are bound to believe; and, further, that the psychosis has developed in a man of rather strong personality seems true also because from various little things which he tells us it is clearly evident that he always had decided views on many questions, and had the courage of his convictions and was not in any sense a weak character. That he has been worried by the persecutors there is no doubt, but that there has ever been a definite attack of excitement or depression during the progress of the psychosis we have, at the present time, no evidence.

From a careful survey of all the points in the case we clearly have here to do with an intellective rather than an affective condition; the emotional sphere showing no marked fluctuations at any period.

Patient was once asked if it were not possible that all he says could be due to an extremely vivid, but morbid, imagination. Patient does not grow resentful or indignant at the suggestion, but quietly remarks that he does not wish to force his views on any one; he knows what he has said to be true, but it is a matter of indifference to him whether others believe it or not. He thinks, of course, that he should not have been arrested; that he

has done no wrong and that it was an injustice to say that he was insane, but at the same time he is at present undisturbed by any persecutions and he is quite willing to remain in the Hospital until matters are cleared up somewhat.

PHYSICAL EXAMINATION :

Edw. J. M.

Patient is a well developed, fairly well nourished man —height 5 feet, 7¾ inches.

Weight 140 lbs., which is 14 lbs. below normal.

Hair black, quite abundant in places, sprinkled with grey.

His features are slightly asymmetrical.

Nose turns to the right.

Complexion dark.

Skin and mucous membranes are pale.

Ears 7 C. M. in length ; symmetrical and fairly well formed.

The lobules are adherent throughout ; there is no discharge and the hearing is acute.

Head Measurements.

Occipito Frontal. 18 C.M. (i.e., from the external occipital protuberance to the root of the nose).

Bi-parietal diameter, 14.3, C.M. *Bi-temporal diameter* 13.5 C.M.

Eyes are straight and move freely in all directions ; there is no nystagmus ; the sclera slightly injected ; irides hazel ; the pupils are 5 M. M. in diameter ; they are concentric ; equal ; regular in outline ; react to light D. & C. promptly with good excursion. Some hippus movements ; no arcus : vision said to be normal. Taste and smell normal.

Tongue is protruded straight ; dry and red ; dentition regular ; teeth in good condition.

Pharnyx is somewhat reddened : pharyngeal reflex active.

Chest quite well formed ; costal angle 30 degrees, good expansion. On inspection there are a few acne spots on the front of chest ; on palpation, vocal fremitus not increased ; percussion note is clear and the breath sounds normal.

Heart: on inspection and palpation no impulse seen or felt : on percussion R. C. D. from 3 I. S. downwards and from 2 C. M. to the right to 9 C. M. to the left of M. S. L. On ausculation heart sounds are clear and distinct ; no murmurs heard—pulse 60 ; regular in force and rhythm. The radial and temporal arteries are palpable.

The *Abdomen* is held fairly tense R. H. D. from the seventh rib 4½ C. M. to the costal margin in the P. S. L. ; moderate panniculus ; no tenderness on deep palpation.

Abdominal skin reflexes present. Cremasteric reflexes present ; genitalia negative—evidence of lues none.

Dermatographia ; the immediate pressure line is quite heavy ; it fades quickly and is followed by a pink line which slowly appears ; is not very broad ; not intense and does not persist. On the abdomen the reflex is the same.

Reflexes : McCarthys not elicited ; no M. I. F. masseter present ; arms active ; K. J. exaggerated ; Achilles active ; Plantar active ; no Babinski ; no ankle clonus ; gait is normal ; station good ; no Romberg.

Tremors : Fine tremor of the hands ; slight fine tremor of the tongue.

Speech : normal : all words are well pronounced.

Grasp is rather weak; equal on the two sides; cutaneous sensibility; rough tests show no disturbances. Stereognosis normal. There is no disturbance of the organic reflexes, subjective complaint of headache and constipation; the bowels are usually regular.

At present time patient has a slight rhinitis.

The Gross Anatomical Features found at Autopsy in a Case of Congenital (?) Deaf-mutism.

The facts in connection with the case which is presented are follows:

A very meagre history accompanied the patient on admission to the Hospital, a little over two years before her death.

It is stated that she had been an inmate of the House of Refuge for a number of years. While there she had never spoken, but had uttered the guttural sounds such as are usually made by congenital deaf mutes.

There are absolutely no facts in connection with her family history or early personal history obtained.

The reason for her commitment was the fact that she had become destructive and violent and this necessitated her being sent to the hospital.

On admission it was noted that she was apparently a deaf mute as she did not understand either written, spoken or sign language and it seemed probable further that she was markedly defective. She lived an automatic existence while in the hospital; showed only the most meagre signs of any intellectual activity: would become angry when annoyed and sometimes violent if interfered with. Except for these emotional disturbances, no clinical observations were made.

At the time of her death she was 45 years of age. Cause of death was tuberculosis.

An interesting condition, however, which was discovered at the autopsy and which seems worthy of presentation, was the condition of the brain.

The calvarium showed some thickening over the frontal and occipital regions. There were some quite well marked depressions for pacchionian corpuscles. The dura was not adherent to the skull except slightly over the upper occipital cortex. The dura was thickened ; only slightly translucent and was adherent to the cortex over the occipital poles. On stripping the dura a great amount of clear fluid escaped.

When the brain was removed the following conditions were noted :

Weight of brain 1065 grms.

In the right hemisphere a large area 7.5 C. M. in length, 3.5 C. M. in width at the widest part and 1.5 C. M. at the narrowest part and from 2 to 2.5 C. M in depth was seen. This is illustrated in photograph No. 1. The cavity extended, from the occipital region 4.5 C. M. in front of the occipital pole to the frontal region. It is limited below anteriorly by the Sylvian fissure, extending into the temporal region posteriorly. The fissure of Rolando ran into the cavity toward its posterior part.

The area of cortex destroyed was limited chiefly to the parietal and occipital regions above, temporal below, and the occipital posteriorly. The destroyed area was occupied by a distinct cyst cavity, the walls of which were lined probably by pia-arachnoid. A diverticulum of the sac 1 C. M. in width; $1\frac{1}{2}$ C. M. in length extended up into the parietal region following along the

fissure of Rolando to within about 1½ C. M. of the great longitudinal fissure.

There was complete destruction of cortex and white matter, as will be seen from the photograph. On the inner wall of the cyst, about its middle, the cavity was separated from the lateral ventricle only by the layer of pia-arachnoid that composed the wall of the cyst. The destruction of tissue was symmetrical: the convolutions being destroyed en masse. The gyri surrounding the destroyed area were complete and sharply defined. The cyst wall was punctured in removing the dura mater.

In the left hemisphere a depression 2 C. M. in width; 2 C. M. in depth and 3.6 C. M. in length was seen extending backward from 2 C. M. posterior to the ascending limb of the Sylvian fissure, being bounded below by the posterior limit of the fissure of Sylvius. The entire marginal gyrus being destroyed; the area was bounded behind by the angular gyrus: this is illustrated in the photograph No. 2.

The third small area in the frontal region bounded above by the longitudinal fissure, situated about 3 C. M. above the frontal pole; about 5 C. M. in depth at its deepest part. Here also a definite cyst cavity with a wall composed of pia-arachnoid was seen. It was 1.6 C. M. in width at its widest part and 1.5 C. M. in length.

Whether this condition was congenital or acquired one would not feel justified in expressing an opinion, from the extremely meagre history, but the destruction of tissue was evidently due to softening

and the cyst cavities containing fluid filled up the areas where the softening had occurred.

The case was thought to be interesting because of the fact that patient was a deaf mute and possibly a congenital defective.

An examination of the middle ears at the time of autopsy revealed the fact that on the right side an old middle ear trouble existed; pus being found in the middle ear.

The writer regrets exceedingly that owing to the lack of history in the case the interesting anatomical features in connection with the brain cannot be definitely correlated with an exact clinical history.

Photograph No. I.

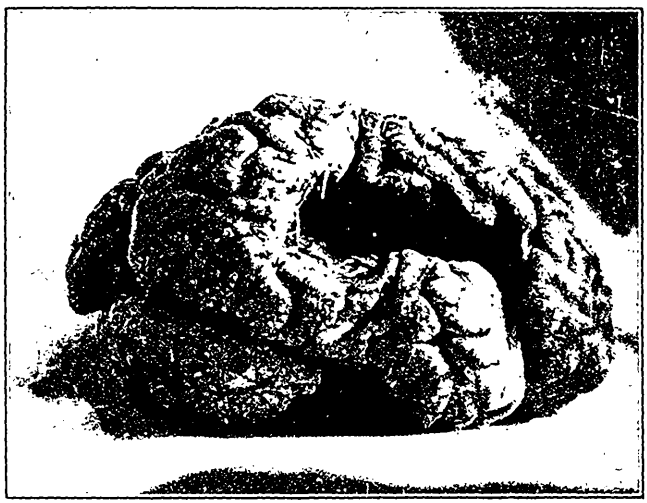
Showing the cystic condition in the right hemisphere, the area of destruction of cortex and the greatly thickened pia-arachnoid, also the increase in size of the vessels, particularly of the veins.

Photograph No. II.

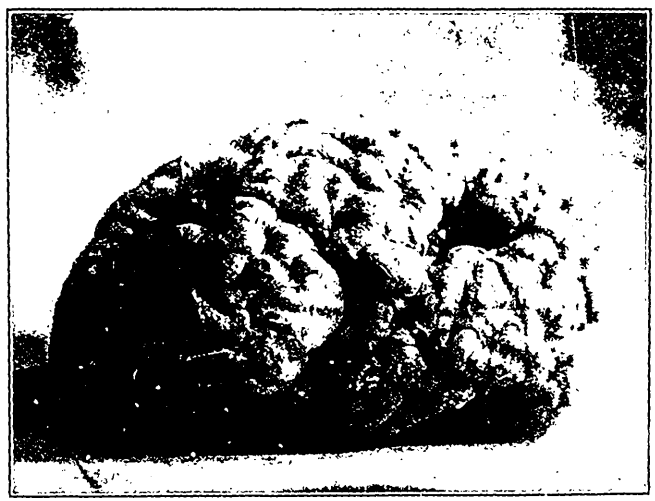
Showing condition in left hemisphere.

Photograph No. III.

Showing the area in left frontal region occupied by cystic condition.



Photograph No. I.



Photograph No. II.

Photograph No. III.