

suppurative action which is artificially set up, in addition to those morbid eliminative manifestations on the skin and mucous membranes which belong to the natural evolution of the disease.

The lapse of time in itself, as Dr. Gardiner has remarked, implies a source of fallacy. The influence of time seems to be the explanation underlying the statement (if true) that it is necessary not to make the inoculations too numerous or too frequent, lest immunity be reached before the cure of the patient is established. M. Diday, in his "Histoire Naturelle de la Syphilis," has laboured to demonstrate the doctrine, that in the majority of cases, even in the absence of treatment, syphilis tends to self-limitation, and that its symptoms ultimately cease to appear, leaving the patient in a fair state of health. The evolution of diseased manifestations is not continuous, but successive,—one set of symptoms tending spontaneously to disappear, and to be replaced by another and another; the number and severity of these different outbreaks differing in different cases, but still tending to become less severe, and with longer periods intervening between them, until they finally disappear altogether. So completely may this be the case that the patient may be susceptible of contracting the primary disease *de novo*, either without any glandular enlargement or general infection, or even in the form in which it originally appeared.

Out of 43 cases treated by M. Diday on the non-mercurial plan, in 26 the general symptoms never assumed a serious character, and the general health was finally re-established. In 18 of these cases, sufficient time had elapsed to render the permanence of the cure almost certain. The remaining 17 of the 43 cases treated non-mercurially were of a more serious nature. Some of them might have terminated in spontaneous cures; but M. Diday did not consider himself justified in any longer withholding mercury for their treatment. (M. Diday's work contains tables of all these cases, showing the number of outbreaks and the date of the last manifestations, &c.) There can be no doubt, also, that, in many cases treated non-mercurially, the earlier successive stages of constitutional manifestation spontaneously disappear. The health may be *apparently* completely re-established; yet, after very considerable intervals of time, the virus sometimes no longer remains latent, but—called into action by some change of climate, life, or defective general health—syphilitic manifestations again exhibit themselves. Of this fact we have had abundant evidence. Our observations are, therefore, beset with many difficulties. Some of the patients treated by syphilization have exhibited tertiary symptoms; and, considering the very long interval of time at which these symptoms may appear, others may yet occur. The best test, perhaps, although an imperfect one, which we possess of the eradication of the virus from the system, is the non-hereditary transmission of the disease—the procreation of healthy children; and it still remains to be seen whether any remedy, or any combination of remedies, be as efficacious as mercury when tested in this way.

Secondly. The next point is the influence which external suppurations, ulcerations, &c., exert upon the course and character of the syphilitic manifestations. Some evidence on this subject has been already advanced.

In common with many other observers, I have been forcibly struck with the bearing of this fact—viz., that so long as a suppurating or phagedenic ulceration exists in a syphilitic subject, the more general manifestations may not appear, or fail to advance when present. And these slow chronic ulcerations are amongst the most intractable forms of the disease. The syphilitic taint may be evidenced in this way only, to the exclusion of other and more general symptoms, and the health of the patient may not be notably affected, the action of the virus appearing to be localised and confined within the narrow limits of an open sore—a phagedenic or a serpiginous ulceration. In a case recently under observation, the appearance of a syphilitic exanthem was witnessed contemporaneously with the healing up of some ulcerated, suppurating lesions.

In former lectures I have observed that "fresh inoculations from suppurating sores, during the time of their development, check the activity of the other lesions of the skin;" and there would seem to be good grounds for believing that they exercise the same influence over other lesions elsewhere seated. Thus Dr. Steenberg says (as quoted in Dr. Aitken's "Science and Practice of Medicine," vol. i., p. 716) that he has seen the existence of an ulcer of a tertiary kind act as a natural issue in subduing the irritation of syphilitic cerebral disease; an entire remission of the nervous symptoms having occurred while the ulcer remained open.

"In my opinion," says Dr. Boeck, "it matters little whether

the treatment requires some days more or less; it also matters little whether a new rash appears. The more important point is whether the relapse is connected with serious injuries of parts—for example, with loss of the nose. But the principal thing is, that the interior organs—the nervous system, the liver, the kidneys, &c., are not affected." The study of these internal syphilitic diseases is only now beginning; but in several hospitals of London I have seen such diseases, which have been shown to me as of syphilitic origin.

It is highly probable that syphilization, like tartar-emetic ointment, but in a far superior degree, may exert a very powerful influence in preventing the syphilitic diseases of internal organs by diverting the *materies morbi* to the external covering of the body, and by depurating the system through this part. We cannot, however, speak as yet of this with any certainty, because we lack the necessary number of observations as to the pathological state of the internal organs of persons treated by syphilization.

The study of this branch of the subject of syphilis mainly depends upon our advanced pathology; for since the observations of morbid anatomists have pointed out the frequency of internal syphilitic lesions, the history and symptoms which may attend these lesions have been more largely sought for and investigated. The publications of Dr. Wilks and Prof. Aitken will, however, corroborate the statement that syphilitic lesions of bone, muscle, nervous tissue and glands, have been frequently traced on the dead bodies of patients, whose symptoms during life afforded no suspicion of their existence.

The next lecture will be principally devoted to the treatment of syphilis, and to a comparison of its treatment by syphilization and by the calomel vapour bath respectively.

PRACTICAL OBSERVATIONS

ON

CERTAIN VARIETIES OF INSANITY THAT ARE FREQUENTLY CONFOUNDED.

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I.—MELANCHOLIA WITH STUPOR, AND DEMENTIA.

It is not common in practice to find the different kinds of insanity, which are so precisely described in books, nearly so definitely marked and so broadly distinct as they are usually supposed to be. One form is very apt to run insensibly into or to take the place of another, and between the typical forms all sorts of hybrid varieties are met with. Mania, melancholia, and dementia are not, as one so easily glides into the habit of thinking they are, definite pathological entities; they are truly different degrees or sorts of degeneration of the mental organization, or of deviation from healthy mental life; and they are consequently sometimes found intermixed, or replacing one another, or manifested in successive order in the same individual. General paralysis is that form of insanity which is perhaps most characteristically defined, and least liable to be confounded with any other form; and yet it is scarcely possible for an experienced physician, when brought face to face with certain exceptional cases of general paralysis, to say positively whether the disease is general paralysis or some form of secondary dementia complicated with paralysis. This difficulty, arising directly from the manifold varieties of its features, has its deeper origin in the very nature of mental disease. The character of the person afflicted is an essential element in the determination of the particular symptoms of his mental degeneration; and as no two characters, like no two faces or no two voices, are exactly alike, the symptoms of mental degeneration are infinite in variety.

Two sorts of insanity, which are very like one another and are not seldom confounded, but which are really different, are a form of melancholy known as "melancholia attonita," or melancholy with stupor, and the stupor of actual dementia. It is certainly a very hard matter to distinguish them, and yet

it may be of great consequence to do so correctly. Recently, I was asked to see a gentleman having all the appearance of a demented person, and supposed to be hopelessly demented, for the purpose of a Commission in Lunacy. But on seeing the patient, and being made acquainted with his previous history, it appeared more probable that he was not actually demented, and that, as there was some hope of recovery, it would not be well to take out a commission. And the event happily proved the wisdom of the caution; for the man entirely recovered before the expiration of a year. I shall strive now, therefore, to point out how forms of disease so like in appearance, but so different in reality, may be distinguished.

In melancholia attonita, or melancholia cum stupore, as it is sometimes called (melancholie avec stupeur, or stupidité, by the French; Melancolie mit Stumpfsinn, by the Germans), the patient has certainly the appearance of one demented. He moves sluggishly to and fro, or stands statue-like in one place, or sits quite impassive; and where he stands or sits, there he must be fed, and there he passes his motions; for bodily wants and necessities are alike unheeded. The expression of the face is that of vacant, self-absorbed amazement, the patient being as one astonished; or it takes the fixed form of some painful passion; as if in a trance, he scarce seems to see or hear; there is partial or general insensibility of the skin, and consciousness of time, place, and persons is lost. The muscles of the body are generally lax, or some of them may be fixed in a cataleptic rigidity. Extinct as all intelligence, feeling, and volition seem to be, the patient's mind is still not a blank, for it is possessed by one great and terrible delusion—as, for example, that the world is come to an end; that he is in hell; that he is standing on the edge of a volcano or of a sea of blood, and must not move a step for fear of his life: and when he recovers, he is as one awakened out of a frightful dream which he remembers. How is such stupor to be distinguished from the stupor of actual dementia? To an on-looker the patient is to all intents and purposes demented; for as to live in one sensation would be equivalent to having no sensation at all, so for a mind to be entirely absorbed in one terrible delusion—to be fixed, as it were cataleptically, in one persistent state of morbid consciousness—is equivalent for the time being to there being no mind at all.

This condition may sometimes be distinguished from the ordinary form of chronic secondary dementia by the gradual supervention of the latter on some other form of mental disease, when the history of the disease can be traced. Not always so, however; for although melancholia with stupor is sometimes primary and of sudden origin, it occurs at other times after epileptic attacks, and after acute mania, with which last it may even alternate. Moreover, there is an acute dementia of sudden origin, scarcely noticed in books, which has the closest resemblance to melancholia with stupor, and which there is the greatest difficulty in distinguishing from it. It is important, then, to recognise the usual conditions of the occurrence of acute dementia, more especially as they have not hitherto received due attention.

Acute dementia sometimes follows a serious attempt at strangulation, or a series of epileptic fits, and lasts for a few hours or days; and, in one case which came under my observation, there was strong reason to believe that a masked epilepsy appeared in that guise. A man of epileptic visage, and said to have had "fits" occasionally, was suddenly, after some faintness, affected with a blank confusion of mind, and complete inability to recognise anybody or anything—to remember the past or appreciate the present; he was, in fact, completely demented. So he remained for a few days, and then got quite well. It is well known to those who are familiar with the manifold varieties of insanity that are met with in connexion with epilepsy, that there may occur, in place of the usual epileptic fits, an attack of acute mania, or of dangerous moral insanity, the insanity really being a masked epilepsy. This vicarious manifestation of convulsion was noticed long ago by Dr. Darwin in his "Zoonomia," and has recently been insisted upon by M. Morel. The case above mentioned may, I think, be held to establish the probability that acute dementia sometimes occurs as a masked epilepsy.

Again, after certain acute diseases, as typhoid and typhus fevers, pneumonia, acute rheumatism, insanity sometimes follows, taking usually in such case the form either of delirium or of acute dementia, according seemingly to the degree of shock which the nervous system has undergone. So occurring, acute dementia may easily be recognised. But it is sometimes brought on suddenly by a great moral shock, and it now and then undoubtedly occurs in young men and women as a primary disease, of unknown causation, though apparently con-

nected in some way with disturbed sexual functions. It is not unknown how great a revolution takes place in the mind at puberty when the sexual life awakens into activity; how intimate is that connexion whereby, as Goethe aptly expresses it, "There is an awakening of sensual impulses which clothe themselves in mental forms, of mental necessities which clothe themselves in sensual images;" and it may well be, therefore, that in after-life a great moral commotion, issuing in the destruction of the mental equilibrium, may have its real origin in some abnormal condition of the sexual functions. At any rate, such cases of sudden acute dementia do occur in practice, whatever be their origin. For example: a pale, delicate, fragile, blue-eyed young lady, aged twenty-five, came under my care after being ill for a week. She had not taken food, and was much exhausted. Her vacant, wandering eyes were devoid of all intelligent perception, and her countenance was blank and expressionless. There was a restless, agitating movement to and fro of the body generally, and of the head in particular, with a low monotonous moaning. She was speechless, and it was impossible to elicit any kind of response, or to fix her attention. She took no food, save what was forced into her mouth, and was inattentive to the calls of nature. Before three months were over she completely recovered under the appropriate treatment. She had suffered some disappointment of her affections; menstruation had ceased, and acute dementia followed.

Another somewhat similar case was that of a young gentleman, aged nineteen, of pale, delicate appearance, with large prominent grey eyes. He had for some time been employed rather hard in an office, and had not quite satisfied his friends with his conduct out of it, when one day he was suddenly seized with a quasi-hysterical attack of incoherency. There was blank confusion of mind; he neither uttered nor expressed otherwise anything indicating ideas in his own mind, and he was unconscious of what was said by others and of what was going on around. There were occasional periods of confused excitement. He took no food except it was forced upon him, and was inattentive to the calls of nature. His head had been leeches in order to subdue the supposed excitement, and he had in vain taken the most drastic purgatives in order to remove an obstinate constipation. Brandy, eggs, and beef-tea, removing the exhaustion, soon subdued all excitement; a simple enema of castor oil produced full action of the bowels, and within a month he quite recovered his senses.

I could bring forward other examples of acute primary dementia; but the foregoing will suffice here to establish the reality of the disease, its general character, and its curability. The prognosis in acute dementia, properly treated, is indeed, on the whole, exceedingly good—better even than the commonly favourable prognosis in melancholia with stupor. When patients recover they do not remember anything of their state; the mental functions having been suspended or paralysed, themselves have been as if they were not. In truth, we might not unjustly say that while melancholia attonita represents a sort of convulsion of the mind, acute dementia represents a paralysis thereof.

What are their differential features, so far as recognisable? As a matter of fact, an instinct, which cannot be analysed and plainly expounded in words, commonly guides the decision in a particular case. The historical development of the disease should be carefully weighed, and close attention given to its outward and visible characters, and especially to any variations in its course. The expression of the melancholic is that of one astonished, or as if fixed in a painful trance,—the mind veiled, as it were, by a great cloud let down between it and the external world; the patient stands or sits in one place, or moves slowly to and fro; he often offers a passive resistance to being moved from one place to another, or to being fed; sometimes he exhibits a strong tendency to suicide, and at times a temporary excitement; on recovery he remembers his suffering as a painful dream, and that he was dimly conscious perhaps during it of what was going on around, but could not speak nor make known his state, so completely was he cut off from the external world. In dementia the countenance is expressionless; there is no resistance offered to being moved; the patient passively takes food when it is given to him; he is not suicidal; any excitement which occurs is of a very confused and aimless character; and on recovery there is no remembrance of what has happened during the attack.

The prognosis in melancholia attonita is favourable; but it becomes very unfavourable if recovery does not take place within a few months, the disease then passing into chronic incurable dementia.

Queen Anne-street, March, 1866.