REFLEX NEUROSES AND THE NEUROPATH.*

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Mr. President and Gentlemen:—It is with great diffidence, not to say trepidation, that I appear before you. When your honorable vice president came to me at the eleventh hour and asked me to say something to this polysyllabic aggregation of brains and erudition, I was decidedly panic stricken but, appreciating the compliment, accepted with pleasure. I shall detain you but a very few minutes.

The kinship of Neurology to ophthalmology, otology, laryngology and rhinology, is exceedingly close. The retina, as you all know, is simply a bit of elaborated cerebral cortex on a long pedicle, and almost the same may be said of the internal ear. The hypophysis, snugly ensconced in the sella turcica, is a sort of cerebral tonsil—partly nasal epithelium, partly gray matter of the brain. The ophthalmologist must know the optic atrophy and nystagmus of multiple sclerosis, and the neurologist the nystagmus of leucoma and the central scotoma of toxic amblyopia. How nearly a cerebellar tumor pressing on the restiform body may simulate aural vertigo with tinnitus and deafness, most of us have had occasion to observe, and disease of the frontal sinus may be hard to differentiate from abscess of the frontal lobes of the brain. The ataxia of erroneous visual projection, the dizziness of middle ear disease and the pavor nocturnus caused by adenoids must be known to the neurologist. Hysterical amaurosis, auditory atrophy, from tabes and the laryngeal crises of the same disease.

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are familiar to his confrères, of the eye, the ear and the throat. In anatomical study, in pathological research and at the bedside, we have much in common and we may often extend each to the other a helping hand. I am sure I never get into serious conversation with an eye or ear man without learning something I am glad to know. But occasionally there are encounters, when belligerency must be recognized. Of late years these have had to do largely with so-called reflex disturbances. That is, with rather definite nervous disorders, such as chorea and epilepsy, or isolated symptoms, such as localized pain or twitching, or general nervousness and the like, said to arise from local abnormality of the eye, ear or nose, without marked symptoms referred by the patient's sensations to these organs. My own experience is that the better neurologists and the better eye, ear and throat specialists really differ very little on the subject, but, in a general way, neurologists are reproached with not recognizing the importance of these local diseases in the etiology of the functional nervous affections, and in return the nerve men are apt to accuse oculists of narrow vision; of not knowing, and sometimes not trying to know much about the nervous affections they treat through the eye. I hope I may be pardoned if, in this question, my leaning is rather toward the position of the neurologists, but I beg of you to believe that the few words following are not uttered in any spirit of criticism but simply in the way of a friendly chat on a subject of importance to us all.

It would seem reasonable to assume, as a premise, that if the oculist is to attempt to relieve certain nervous manifestations by eye treatment, he should have a good understanding of these symptoms in all their relations. For instance, it is manifestly not sufficient for him to know that headache is caused by astigmatism. He must also know that astigmatism may cause no headache, and that similar head-pain may be due to other causes. More than this, he should know what these other causes are, how to detect them and *how to estimate their importance*. Otherwise, he puts himself upon the plane of the apothecary who knows that phenacetin will alleviate pain and promptly serves it to every customer who complains of cephalalgia.

That might be an easy plan upon which to practice ophthalmology but it is unworthy of the medicine of this end of the nineteenth century.

In handling functional nervous trouble, for instance, it is now incumbent upon the ophthalmologist to recognize the "neuropath", or neurotic individual. How shall he be known? First of all by the ancestors and relatives he keeps. Heredity may put altogether another face upon an apparently simple disorder. I have at present under my care a nervous and migrainous lady whose family history reveals migraine in father, mother, the only brother, the only sister, and in her own two children, the youngest of whom is only 6 years of age. Obviously the congenital twist of the central nervous system in such a case cannot be ignored. But with the single exception of migraine, nervous diseases are rarely inherited in kind; that is, the particular affection of the parent transmitted to the child. The influence of inheritance is none the less paramount, and it is the inalienable right of every nervous patient to be kindly but closely questioned as to the occurrence in the immediate or collateral relatives of insanity, eccentricity, epilepsy, migraine, paralysis, inebriety, hysteria and nervous prostration or simply the nervous temperament. And please allow a practical physician to add that general inquiries are notoriously inadequate and that "nervous prostration" covers a multitude of neuropathic sins. Time and again have categorical questions brought a neurotic taint to light after distinct negation of nervous kinship and "nervous prostration" has turned out to be anything from innocuous nervousness to paranoia and general paralysis of the insane.

Even more important than the genealogical bough is, of course, the bent of the individual twig. This is nearly always clearly revealed by the life history if biographical details are carefully elicited. These, when obtainable, should begin with birth. Parturient asphyxiation or post-natal convulsions may mark the occurrence of cerebral injury which is later voiced in somatic or psychic imperfections. Infantile convulsions, prolonged enuresis of childhood, delayed teething, walking and talking, unsatisfactory or spasmodic progress at school, accesses of easily

provoked passion, and lack of harmony with other children—these are all indices of more or less importance. A slowness in comprehending and accepting the ordinary moral obligations of civilized life is never to be passed over lightly. The boy who, in spite of good influences, is an incorrigible liar or thief, may not develop into a criminal, but he is liable in later life to be the prey of functional nervous troubles.

Particularly must the physician be on the lookout for the self-centered individual who seems ordained to be possessed by a conviction, but by a conviction born of emotional impressibility rather than of mature reflection and consecutive reasoning. This is the possibly brilliant person, ever in unstable equilibrium, who is the victim of his cerebrum. The history of such a patient may exhibit a kaleidoscopic succession of illnesses and recoveries; of apparently causeless prostrations and sudden cures; a motley mixture of symptoms referable to all organs and a queer combination of uselessness and admirable capacity, that stamp him with the die of psychic susceptibility. He is the pathologic weathercock, the constant sport of changing imperative conceptions. He is doomed to feel and suffer much, to indulge liberally in introspection and personal comparisons.

Finally, the neuropath is brought to light by the examination of himself. The ordinary marks of the imperfect man—often called stigmata of degeneracy—are to be noted. Among them, asymmetrical cranium or face, microcephaly, deformed dental and palatal arches, abnormal teeth and misshapen ears, are of the more important and easily detected. It has seemed to me that excessive associated movements should be classed with these. Neurotics are more apt than others to make grimaces when they talk. No one stigma is of much importance, several of them together always are. The deep reflexes are generally very brisk and I believe an increase of the wrist-tap and jaw-jerk to be the most indicative of these, unless there be an indication of ankle-clonus, which is very positive evidence indeed. Fine vibratory tremor is frequent and a difficulty in shutting the eyes very tight, far from rare. In the essentially nervous person, pain is seldom unique.

If he have frontal headache, there will also be backache, or occipital discomfort, or distress in the epigastrium. In women, inframammary pain on the left side is almost the rule. If there be tenderness of the supra orbital nerve (which is never exquisite except in typical neuralgia) it will also be found over the suboccipital, and if the cervical spine be sensitive to pressure, the lumbar region will not be exempt.

To the rapid shifting of tender points I have often called attention. I think it of importance. Such points are frequent in nervous people and the rapid shifting illuminates not only the character of the tenderness but also the general condition and tendency of the patient. Given a patient with a tender point, or a number of them, along the spine on the vertex, in the temple, or elsewhere, the sensitive point is first to be definitely located, and this can ordinarily be done with the exercise of a little care. By pressure with the rubber tip of a pencil, the tenderest spot is found and then compared with the surrounding area, to determine positively that it is more sensitive than the adjoining surface. As this procedure is carried out it is not rarely observed that the hypersensitive point becomes more tender and the surrounding territory less so. The exact location where pressure is very painful having been settled, it is lightly marked with a pencil and the physician directs his attention to other parts; to the eyes, the heart, the throat—where you will. After a few moments he returns to the region of the tender point and examines for it again, taking care *not* to press upon the marked place first, but upon points more or less adjacent to it. He will now find a tender point half an inch to four inches distant from the original tender place, and in definitely locating this second sore spot as he did the first one, the latter will be found to have disappeared. That is, the place previously marked is no more tender than its surrounding area. In other words, the tender point that was so exceedingly hyperalgesic has shifted half an inch to four inches. Such shifting eliminates at once not only organic disease but a *local* neurosis. It could be due only to abnormal action of the highest sensory centres of the cerebral cortex, or rather to a perverted psychic reaction to sensory stimulus, a state

of affairs that could not possibly be caused alone by local disease of the eye or nose.

Possibly you may ask, "what is the use of all this to the eye or throat man?" A great deal of use. First, the imperfect and neurotic individual is naturally and actually the one who most frequently exhibits imperfections in the eye and nose. Second, these may be, and frequently are, simply coincidences and have no more etiologic relation to existing nervous symptoms than have the supernumerary teeth or crooked ears. Third, supposing that a low degree of refractive error or a sensitive turbinate acts as an irritant on an abnormally sensitive nervous system, correction of the local abnormality is only the least part in the treatment of such a patient. Fourth, because such a patient has this or that discomfort in eye or nose, it does not follow that there is local disease. That a person has periodical headache with scintillating scotomata, or even the scotomata without cephalagia, is no proof at all that the eyes are at fault. Fifth, as a matter of fact, the neuro-path is the person *par excellence* who wishes local treatment and who is not benefited thereby. When I say not benefited, I mean permanently; for he frequently experiences some temporary relief. Indeed, if treatment does not immediately make him worse, he is sure to say that it does him good. But the inborn instability and impressibility is bound to assert itself to the confusion of the doctor and the despair of the patient. The latter is fertile in suggestion and facile in change; as inconstant in results of treatment as he is in medical allegiance. In deciding on operative measures and in formulating a prognosis, I beg of you to beware of the patient who has passed through the hands of the ophthalmologist, the otologist, the laryngologist, the rhinologist, the gastrologist, the proctologist and the neurologist.

Venetian Building.