effect to the shortening of the muscular portion of the tenotomised muscles so that their range of action is diminished. Both these theories, of course, refer to spasm in which the divided muscle is concerned and do not explain the diminution in spasm experienced elsewhere. We must, further, remember that the opponents of contracted muscles are always elongated and weak and that the rest afforded them by tenotomies by relieving them of strain helps to restore muscular equilibrium.

The practical deduction from these observations is that no opportunity should be lost of performing a tenotomy. Even in mild cases where a spastic tendon is to be felt we need have no hesitation in dividing it. If the surgeon has decided that a case of spastic paralysis is suitable for treatment a splint should be prepared so designed as to keep the limbs in pronounced abduction. The area over the hamstrings, the adductors at the groin, and the tendo Achillis should be suitably prepared for operation. The adductors should be first attacked. An incision an inch or two long should be made to the inside of the adductor longus. This muscle should be seized by a forceps and about three-quarters of an inch of it removed. The limb is then abducted and portions of the adductor brevis and gracilis are excised in similar fashion. The horizontal portion of the adductor magnus, and if necessary the pectineus, is divided and also any tissue, muscular or fibrous, obstructive to an absolutely free abduction of the femur. Experience has shown me that although the chief offenders are the adductors longus and brevis nevertheless the deeper muscles often require division. To anyone who has practised the operation the futility of attempts to divide the muscles effectively subcutaneously will be apparent. Division is followed with but little hæmorrhage and the wounds are closed without drainage. Having excised the pieces of the adductors each tendo Achillis is divided, or, better still, elongated, for we often note that after division of the tendon outright there is a tendency to walk too much on the heel. Rectangular splints are then applied to the foot. The limbs are then well abducted and the surgeon notes whether there is any obstacle to easy extension of the knees. If there should be (it is not often the case) an open incision must be made on each side of the popliteal space and the tense hamstrings are in turn divided. If these incisions are long enough the fascial contraction can be attacked on either side, for it is here that opposition is found. I would discourage the use of a transverse incision, as when adopted it often seriously hampers the surgeon's efforts to extend fully the knee by reason of the strain cast upon the sutures. Simple division, however, with fasciotomy usually suffices to allow of easy extension and excision of tendons could do no more. In 1885 when I was at the Liverpool Stanley Hospital there used to be an adult diplegic man always at the gates in a perambulator and on two or three occasions I took him in to try to straighten his contracted limbs. On one occasion I removed about an inch from each of the hamstrings, but he was mentally so deranged that we did not do each other any credit. I mention the fact, however, because Lorenz of Vienna has quite recently written on the advantage of excising portions of the hamstrings.

We have now presumably got our patient stretched comfortably upon an abduction frame and we must keep him there for three months. The wounds heal very rapidly and suppuration has occurred in the adductor cavity on three occasions only, despite the position of the wounds and the number of operations performed; for instance, in 1890 I operated on 27 patients and this may be taken as a fair index of my yearly return. At the end of three months the splint is taken off during the day and movements are sedulously practised. For some weeks stiffness exists and often the movements are at first painful, but after a time (always shortened by vigorous exercise) the pain disappears and the effort must be made to walk. The splints are of a simple kind designed to keep the knee from bending. The boots should be made of felt with substantial soles. The nurse should be instructed to keep both boots and splints upon the patient day and night, and for the first two weeks, frequently during the day, abduction, adduction, flexion, and extension of the hips should be practised. This should be done with and without resistance. At night-time the feet should be attached to the side of the bed in order to maintain abduction. After the first few days of this later stage of treatment the splints should be removed twice a day and the muscles well massaged and both active

and passive movements of ankles, toes, knees, and hips encouraged. Any movement executed in a jerky style should be practised until perfected.

The little patient may now try to walk. It will be noted that one of the difficulties of an untreated spastic child when he tries to walk is the narrowing of the pedestal upon which the trunk rests by reason of adducted limbs. Operation has now overcome this and with abducted limbs the body is poised upon a pedestal that is widened. During early training the nurse must see that while walking the limbs are not approximate and that from the first swinging aided by crutches must be prevented. Crutches should not be allowed until the patient has been taught to stand unsupported. I need not enter into any more detail regarding this most important stage of treatment, but would add that it affords an inexhaustible field for ingenuity and that upon the intelligence and industry of the nurse very much depends.

I cannot now deal with individual cases, but I may say that I have operated upon patients from 12 months to 20 years of age. A large number of these were so bad that they had never attempted to place one foot before the other. Some were structurally flexed (contractured) at ankle, knee, and hip. A most helpless youth, aged 20 years, with one limb across the other, was able in six months to stand erect and to walk with sticks, and 12 months later he was able to move his limbs north, south, east, and west with hardly an appreciable jerk. Success in an ancient case where so much has to be unlearned, and where the mechanical stage offers so much difficulty, proves the soundness of the principles I have endeavoured to expound. It is logical to infer that if old neglected cases are amenable to surgical education our prognosis should be very hopeful in the young.

With regard to the degree of benefit to be derived from treatment, the parents should be given to understand that under favourable conditions of nursing and tuition the child, aided by the hand or sticks, will be able to walk distances in from 12 months to two years, and that with perfectly straight limbs and heels on *terra firma*. A large proportion of cases will later manage aided by one stick. Even in the least successful cases parents, mostly having despaired, are full of gratitude. The mental condition of the children obviously improves when their physical defects are remedied and they are enabled to mix with their little friends. Complete recovery in spastic paraplegia is, of course, impossible.

It will be gathered from my remarks that the treatment of spastic paralysis should resolve itself into a system. That system involves operative, mechanical, and educational stages. The treatment cannot be separated into parts. If the surgeon is not satisfied that the case is to be under his control for 12 months he will consult his reputation best by leaving it alone. Operations not followed up by careful and prolonged after-care give rise to disappointment and discredit. Merely dividing tendons and trusting to massage and electricity is futile and dispiriting.

In conclusion, gentlemen, I would say that infantile paralysis offers an immense field for surgical enterprise and if I have succeeded in even suggesting to you some of the possibilities your time will not have been altogether wasted.

LUNACY AND LAW: THE CARE AND TREATMENT OF PERSONS OF UN- SOUND MIND IN PRIVATE HOUSES AND NURSING HOMES.¹

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My paper to-day is the natural outcome of the address by Sir William Gowers upon Lunacy and the Law,² the views of a London hospital physician, particularly in regard to private patients, given at our last general meeting in London. The discussion which followed was

¹ A paper read at the general meeting of the Medico-Psychological Association held at the County Asylum, Micklegate, near Derby, on Feb. 12th, 1903.

² THE LANCET, Nov. 22nd, 1902, p. 1369.

hardly worthy of the subject. Most of the earlier speakers, although eminent general physicians, had had little or no experience in the care and treatment of the insane; therefore when the turn came for those practically acquainted with mental diseases to speak the hour was advanced, the audience was weary, and an all-too-exacting brevity resulted. To-day the alienist's side of the question can be fairly stated. My wish is to deal with it as briefly and appositely as possible in order that the discussion may be as thorough as we can make it. I hope that all who have had practical experience of single care and of the treatment of mental cases in nursing homes will assist us in our search after truth, that the best results may accrue to those who suffer from this the saddest form of human ailments. I propose to treat the subject by a series of questions and answers, with illustrative cases here and there.

What is certified single care?—It is the care and treatment of a duly certified person of unsound mind in a private house. The forms for admission are identical with those for the admission of a private patient to a public or private asylum or registered hospital. There is a like order made by a judicial authority. The medical attendant takes the place of the medical officer in institutions, and must visit at stated intervals and make the customary reports to the Commissioners and Visitors in Lunacy. A registered practitioner with whom a single patient resides cannot act as medical attendant. The residence is approved by the Commissioners in Lunacy and the patient is visited periodically by them and the medical and other visitors for the county or borough. Chancery patients are visited by the Lord Chancellor's Visitors in Lunacy. Facilities of access are given to friends by statute. Thus abuses are guarded against and there is efficient official supervision.

What are the advantages of certified single care?—They seem to be (1) privacy; (2) domesticity; (3) secret visits of friends; and (4) the avoidance of the stigma of treatment in a lunatic asylum.

1. *Privacy.*—The rich and well-to-do try their utmost to keep secret the mental breakdown of any member of the family for well-known reasons, hence single care at a distance from home is the desideratum.

2. *Domesticity.*—The upper classes often dread the contact of their relatives with other insane patients and complain of the lack of the comforts of home life in public and private institutions. These objections are now removed by the villa residences attached to public and private asylums and hospitals for the insane.

3. *Secret visits of friends.*—In single care the relatives, if so disposed, can visit unobserved and much more frequently than they can in an asylum or hospital.

4. *Avoidance of stigma of insanity.*—The sting of certification is in the magisterial inquiry. Young and inexperienced justices often investigate the cases more fully than is necessary. They place too little reliance upon the facts contained in the medical certificates. The terrors of certification are thereby increased. The form of the medical certificate needs revision. The term "alleged lunatic" should be removed. The word "asylum" should be applied only to an institution for "the chronic and incurable insane." "Hospital for mental diseases" should be used for an "institution for acute and curable cases." The terms "lunatic" and "lunacy" should be removed from the statutes, "person of unsound mind" and "insanity" taking their places. For years past the terms "lunatic," "lunacy," and "pauper" have been forbidden at the City of London Asylum and the word "asylum" has only been used for statutory purposes.

What are the disadvantages of certified single care?—(1) The absence of skilled medical treatment; (2) unskilled nursing; (3) monotony; (4) insufficient moral control; (5) interference of friends; (6) limited supervision; and (7) want of tact and business capacity on the part of the custodian.

1. *The absence of skilled medical treatment.*—The general practitioner, as a rule, knows but little of the treatment of mental disease. Psychological medicine has only recently become compulsory in the medical curriculum. Moreover, I am sure that you will all agree with me when I state that the knowledge of the proper treatment of mental diseases is not to be acquired in the rounds of general practice, or in the consulting-room, or even, at present, within the wards of a general hospital.

2. *Unskilled nursing.*—The nurses (male and female)

having charge of single patients have had no special training, as a rule, in the management of mental cases and, although, perhaps, hospital trained, are quite unqualified for the work. No nurse is qualified to undertake a mental case in single care unless possessed of the nursing certificate of the Medico-Psychological Association, which is a recognised guarantee of efficiency. The responsibility with single patients is the greater because the nurse from want of skilled supervision is so frequently thrown upon her own resources.

3. *Monotony.*—We all know of the many associated amusements and means of recreation provided in institutions for the insane. How dull must be the life of the patient in single care in this respect.

4. *Insufficient moral control.*—The moral decadence of the upper and upper-middle classes when insane is far greater than of the agricultural and industrial populations. Sedentary life, luxury, and high living tend to bad habits. Self-abuse is far more common amongst private patients than amongst the rate-paid. The moral control—I would rather term it "school discipline"—of our institutions is one of the most potent means we possess for successful treatment. The day is apportioned out to meals, employment, recreation, and amusements. The will is made subordinate to others, bad habits are corrected, and in many instances our patient is thereby conducted back to rational health. [Here Dr. White gave details of an illustrative case.]

5. *Interference of friends.*—With single patients the friends either get them removed as far from home as possible, satisfy themselves that they are well housed, well clothed, well fed, and kindly treated, and visit them only when obliged, for sympathy for the insane relative generally quickly dies, or the patient may be visited much too often, the treatment of the medical attendant and management by the nurse being interfered with to the great detriment of the chances of recovery.

6. *Limited supervision.*—Certified single patients are taken for profit by needy practitioners, decayed ladies, and others. The official supervision of these custodians is limited. How can we guarantee in all cases humane treatment by nurses, also proper food and environment at all times? We must remember that the best mental-trained nurses remain in the asylum service or become attached to the better-class nursing institutes of the metropolis. Therefore we have not always the most trustworthy people in charge of the patients under consideration. On the contrary, it is an absolute fact that in a great number of cases the nurses in charge have not had any mental training whatever, frequently they are hospital-trained nurses who are sent out by institutions to whatever case may turn up. I have heard also of asylum laundry-maids posing as mental nurses on the books of such institutions.

7. *Want of tact and business capacity in the caretaker.*—Decayed ladies and retired nurses are not possessed of much business capacity, tact, or energy in the duties of the house.

What is uncertified single care?—It is the taking charge of a person of unsound mind (not under certificates) in a private house or nursing home. I believe that hundreds of insane patients of the upper and upper-middle classes are at the present time under care and treatment without being certified in the various counties of England and Wales, not to say the Channel Isles and the near continent. What happens is this. A member of a family, probably with neurotic inheritance, develops mental symptoms. The parents dread certification and because of the so-called "stigma of insanity" avoid as long as possible the alienist physician being called in but consent to a "nerve specialist" being consulted. To the neurologist the patient is taken; he duly prescribes and advises. After a short time the symptoms become more pronounced and home treatment is impossible; the patient must go away. Then the assistance of the decayed gentlewoman is sought, that she may undertake the remunerative care of the insane person, or a nursing home is selected with which some practitioner in a suburban or rural district is connected. The neurologist sees the case from time to time in consultation. He considers himself to be well qualified to treat this form of disease and in the interests of humanity (as Sir William Gowers tells us) is accessory to an evasion of the law. Ultimately in many instances, owing to an exacerbation of the symptoms (some attempt at suicide or homicide, &c.), certification becomes imperative and the patient is sent to a recognised institution for mental diseases. It is from these cases many of us have to glean our recoveries and a difficult task it is at so late an

hour in the day of disease. Let us consider two or three cases to illustrate uncertified single care. [Dr. White here gave a detailed account of some illustrative cases.]

What are the advantages of uncertified single care?—

(1) The avoidance of the so-called "stigma of insanity"; (2) secrecy; (3) the so-called continuity of medical treatment (doubtful if unskilled); (4) freedom from contact with other persons of unsound mind; and (5) domesticity.

What are the disadvantages of uncertified single care?—(1) Insufficient general and moral control of the patient (there is no legal power of detention, for the patient is in full possession of civil rights); (2) the patient's property is not safeguarded from unworthy relatives, solicitors, medical men, caretakers, and nurses; (3) frequently there is unskilled medical treatment, or none at all; (4) unskilled nursing as a rule; (5) monotony in some out-of-the-world place; (6) interference of friends; (7) want of official supervision; and (8) incapacity of caretaker.

The want of official supervision is, perhaps, the most serious of these disadvantages, for I have heard of inhumane and cruel forms of personal restraint which have been used upon these unfortunate patients even since the passing of the Lunacy Acts 1890-91, and is not this what we should expect with no official supervision?

[Here Dr. White gave an account of cruel treatment which had come under his notice.]

What is the suggested notification of mental cases?—It is that in all cases of mental unsoundness in which certification and compulsory detention seem needless, and in border-line cases, there shall be a system of notification to the Commissioners in Lunacy by anyone receiving payment to the effect that "A. B. is a person of unsound mind and is not a proper person to be detained." It has been also suggested that this notification shall be to the local authority. It is presumed in the first instance it will be followed by the visit of a Commissioner in Lunacy or someone deputed by the Commissioners, and in the second by a medical officer appointed by the local authority.

What would be the advantages of such notification?—They would be the same as those given under the heading uncertified single care (*vide* above).

What would be the disadvantages?—These again would be identical with those given under uncertified single care (*vide* above) with in addition increased official expenditure from the necessary appointment of deputy or district commissioners to inquire into the numerous class of cases which would rapidly crop up. In an article on Lunacy Law Reform in THE LANCET of Dec. 27th, 1884, I suggested the appointment of deputy commissioners in the following terms: "District experts as medical officers of insanity, occupying analogous posts with that of coroner or medical officer of health, with fixed salaries, these officers to be elected from their experience in the speciality, and to be allowed to practise as pure physicians. Their duties would be to examine all supposed lunatics in consultation with the medical man in attendance, to sign all necessary certificates, to visit all single patients, and patients in private asylums in their districts, to report thereon from time to time to the Commissioners in Lunacy, and so act as district agents for the Commissioners or Deputy Commissioners. They would have power to order the discharge of any single patient, or any patient from any private asylum in the district, should such a course be desirable on account of recovery or otherwise. They would also have authority to prevent the removal of any patient by his or her friends when such removal was calculated to be fraught with danger to the patient or others." Many of the suggested reforms in that article were adopted in the Lunacy Acts, 1890-91. This one was not, for the obvious reason—expense.

I am afraid that notification, unless under the most efficient official supervision, would encourage a continuance of the evasion of the law, or at least would delay proper remedial treatment in consequence of the patient not being under proper moral control.

What cases are suitable for cure and treatment as certified single patients?—(1) Quiet and harmless tractable imbeciles; (2) quiet and harmless chronic demented; (3) certain general paralytics in the last stage; and (4) hypersensitive patients convalescing from melancholia.

What cases are unsuitable?—All others.

What cases are suitable for care and treatment uncertified?—(1) Transient cases of mania and melancholia dependent upon drink and abuse of drugs; (2) certain

borderland cases where the symptoms are undeveloped; and (3) other cases in which the symptoms are not severe and which have a definite exciting cause not likely to be long operative.

How should they be protected against abuses?—By proper and complete official supervision. I have been for years past, and am still, in favour of the appointment of deputy commissioners for districts as defined above, such appointments to be made from those skilled in the treatment of mental diseases.

What is the suggested temporary care and treatment of the incipient insane?—In 1899 the joint committee of the British Medical and Medico-Psychological Associations, of which I have been a member by your courtesy since its formation, waited upon the Lord Chancellor at the House of Lords. The committee urged the necessity of early legislation for the incipient insane. It told the Lord Chancellor how numberless borderland cases were smuggled away in the country, the Channel Isles, and on the continent, to avoid legal certification, how their chances of recovery were imperilled thereby, and how the possibilities of inhumane care existed. As a consequence he introduced into the Lunacy Bill of 1900 the following clause, adapted from the existing clause in Scottish Lunacy Law:—

1. If a medical practitioner certifies that a person is suffering from mental disease, but that the disease is not confirmed, and that it is expedient with a view to his recovery that he be placed under the care of a person whose name and address are stated in the certificate, for a period therein stated, not exceeding six months, then during that period, the provisions of Section 315 of the principal Act shall not apply.

2. The certificate must not be signed by the person under whose care the patient is placed.

3. Where a medical practitioner signs any such certificate he shall within one clear day after signing it send a copy of it to the Commissioners, and the Commissioners may visit the patient to whom the certificate refers.

I believe that this clause with its three sections will meet all the requirements of the case for the insane of the upper and upper-middle classes provided that the deputy commissioners above named be appointed.

As several of the county and borough asylums are at the present time admitting private patients in large numbers would it not be well that the voluntary boarder system appertaining to the registered hospitals and private asylums should be extended to public asylums? There are many patients—incipient and border-line melancholic cases—who lack self confidence and who, if they can place themselves under the sheltering wing of an institution giving them medical and general supervision will rapidly regain their mental balance and thus escape certification. Those who have had ample experience of the voluntary boarder consider the legislation regarding him has been productive of much benefit.

Having surveyed the subject in detail we must now consider the various points, not already discussed, to which allusion was made by Sir William Gowers. The contemplation from the train of the wall of Hanwell Asylum, we are told, prompted him to lead a crusade against the existing Lunacy Laws. He thought of those the wall excluded and those it included. Now the wall of Hanwell (the oldest of our London county asylums) is an anachronism. The asylums of to-day have no walls and while the buildings include those committed to the humane and skilled care of the medical officers for treatment, they do not exclude those who desire to gain knowledge regarding mental diseases. The lovelorn Kentish cavalier when he wrote in his prison in Westminster the lines the first of which Sir William Gowers quotes little thought they would be applied to an asylum for the insane some 250 years later. Let us contemplate these lines:—

"Stone walls do not a prison make,
Nor iron bars a cage;
Minds innocent and quiet take
That for an hermitage;
If I have freedom in my love,
And in my soul am free,
Angels alone that soar above
Enjoy such liberty."

We do not acknowledge the walls as part of our treatment to-day, nor are iron bars necessary in institutions for the insane; they appear (as we have seen) to be only required for uncertified patients in single care. Our cavalier, although imprisoned, was happy withal in the freedom of his thoughts.

Sir William Gowers tells us that in many cases certification is harmful and unnecessary. Many of us differ from him upon this point. We recognise in certification the

means of placing the patient under proper control for treatment, and we are satisfied that the chances of recovery are in many instances greatly increased thereby. The cases quoted by him as suitable for treatment without being duly certified were peculiarly unfortunate. They all had delusions of persecution, and these patients, as we alienists know, may at any time become actively homicidal or suicidal by impulse. They should certainly all have been under certificates, both in the interest of the public and of themselves. Sir William Gowers states that every patient received for payment and uncertified is a free agent, can leave or be removed at any time. Such is not my experience with uncertified insane patients in single care. Furthermore, I do not admit that certification is in any way disastrous to the patient or the painful distress to friends it is stated to be.

Sir William Gowers speaks of the "divorce of psychological medicine from general medicine." There is no divorce. They have always been separate and distinct and must remain so from the very nature of mental disease and the treatment demanded. The moral side of this treatment is all-important, the medicinal only accessory and that in quite a minor degree. The days of chemical restraint and of the exhibition of medicinal nostrums for insanity are past and gone. We have too many proofs of the value of our more enlightened system to wish to revert to them. Let the general body of our profession make themselves thoroughly acquainted with this system; they will then recognise the vital importance of the daily contact of the mental physician with his patient to control the management and moral treatment of the case, the necessities of which are ever varying.

We are told that the "master of method" is necessary for the full and proper development of the normal mind of youth, that a scholar who has not had training as a school-master is unequal to perfecting a student's education in classics, mathematics, or the higher sciences, how much more then must the "physician of method," trained by long experience and daily contact with the insane, be essential for the re-education of the abnormal mind, for the replacing of the unhinged mind upon its hinges, for the dispelling of the hypochondriacal delusions of the melancholiac, and for the calling back to mental life again of the quasi-demented patient in mental stupor? Speaking after 30 years' experience as a public asylum physician, and 13 as a lecturer on mental diseases, I would state unhesitatingly that to comprehend the vagaries of the mind diseased, to lead that errant mind back to health, and to recognise the means by which this end can be attained, are problems only to be solved by those who have made the insane their intimate and lifelong study.

Note appended Feb. 7th.—Sir William Gowers has just published in pamphlet form his address of Nov. 20th, 1902, with a Note. I observe that the title is altered. It now reads, "An Address on the Prevention of Insanity." Would not "on the Evasion of Insanity" be more appropriate? In the note he draws attention approvingly to Sir William S. Church's suggestion that notification should be to the local authority, the facts of each case to be subsequently investigated by the medical officer of health or some other official appointed by the local authority. What does the medical officer of health know of mental diseases? Is he qualified to decide such a case? and who is the other official suggested? Who but one skilled in the treatment of insanity is qualified to decide whether the conditions under which the patient is placed are such as are likely to promote recovery or whether certification is necessary in his or her own interest? Sir William Gowers is in error when he states that provision is already made for the reception of border-line patients as voluntary inmates of public asylums. At present voluntary boarders cannot be taken in county or borough asylums, but only in registered hospitals and private asylums. He tells us, moreover, that it is a sarcasm to suggest that patients on the verge of mental derangement would place themselves in lunatic asylums. Is he not conversant with that large class of cases of incipient melancholia in which the patient lacks self-confidence and self-reliance, is imbued with a sense of impending trouble, and consequently eagerly seeks admission within the walls of a private asylum as a voluntary boarder and expresses a feeling of relief when under the sheltering wing of the institution? The limitation which Sir William Gowers takes objection to in connexion with the clause for the treatment of incipient insanity, "that no person under this section shall receive more than one patient at the same time," is in accordance with the principle of the Lunacy Acts, 1890-1891, that

private asylums are to die out by gradual extinction, for no new licence can be granted. To receive more than one patient would constitute a private asylum. Sir William Gowers objects also to the sanction of the justice of the peace being necessary and adds that "such a sanction could only be a useless formality." He forgets that it is right that the liberty of the subject should be taken away only by some mode of judicial procedure.

NOTES UPON A CASE WHERE SYMPTOMS OF EARLY GENERAL PARALYSIS OF THE INSANE FOLLOWED A HEAD INJURY;

TREPHEINING; REMOVAL OF DEPRESSED BONE;
DISAPPEARANCE OF THE SYMPTOMS.

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ON Dec. 16th, 1902, was seen for the second time a patient, aged 30 years, who exhibited a remarkable group of symptoms. About three months previously he had been thrown out of a dogcart and had sustained a scalp wound in the left frontal region, below the frontal eminence. He was also somewhat "concussed," but his symptoms were not considered bad enough to confine him to bed except for a short time. The bone was carefully examined and found to be uninjured. All went well for some weeks, but in about a month's time the patient commenced to suffer from pains in the head, loss of memory, and a vague feeling of "not knowing what he was about." His wife and friends noticed an alteration in his manner and temper. He exhibited sudden and violent outbursts of passion and was unfit to carry on the ordinary business and duties of life. I was at that time anxious for him to remain in London, but he returned to the country, and under medical advice rested in bed for some weeks and took the iodides. At the same time all alcohol was interdicted. He got much better, but on resuming a more active life all his old symptoms returned with increased violence. Getting alarmed his friends again brought him to London. His mental condition being very peculiar Dr. T. Claye Shaw saw him on Dec. 18th, and the following is a summary of his remarks:—

The patient wore a confused and demented facial expression and had a considerable amount of both facial and general tremor. He complained of pressure-feeling over the scalp and declared his inability to perform any sustained mental work. There was no disease of the fundus oculi, but the pupils were slightly non-symmetrical, the left being the smaller; they reacted to light and accommodation. He could not stand firmly when his feet were placed together, nor could he walk along a line when told to plant one foot directly in advance of the other. The knee-jerks were present but weak. There was some tremor of speech, but the tongue was fairly steady and there was no prominent complementary spasm of the muscles around the orbit. When asked to read the paper he misplaced and mispronounced words and altered the spacing. The handwriting was to be deciphered with difficulty owing to the crowding of the letters and shakiness of the upstrokes.

The prominent mental condition was one of dementia, an apathy and slowness of comprehension in answering ordinary questions. There was an unwarranted sense of bien-être but no illusions could be elicited. The friends said that he had become subject to impulsive outbursts and was considerably changed in general disposition. He suffered from insomnia and spoke of loss of sexual appetite.

As to diagnosis there was no history of alcoholic excess or of syphilis and the symptoms appeared to be directly traceable to the injury to the head. It was probable that they were due to pressure and the only remedy seemed to be to resort to trephining as soon as possible. The temperature under the tongue was 100° F.

The operation was done on Dec. 19th. On reflecting a semilunar flap including the area of the old injury, and examining the bone critically, a faint crack was distinctly seen. Upwards of three months having elapsed since the injury union had occurred, and without a close inspection the lesion would have been undetected. A trephine with the diameter of a shilling was here applied; the bone was very thick and hard. On removal of the disc a fracture of the inner table of the skull was evident and two small pieces of bone were depressed deeply upon the dura mater, which