her reason. It is a well-known fact that madness is of frequent occurrence at the turn of female life, frequently appearing almost simultaneously with the cessation of the menses. In this respect insanity bears a resemblance to many other diseases to which females are exposed at that period. The pregnant state, moreover, has also its connexions with this disorder. Monomania is especially the species noticed in this state, and what is very remarkable is, false pregnancies, moles, and hydatids, frequently give rise to the same complication. After accouchment, again, madness in a particular form is of such frequent occurrence, that under these circumstances it has been regarded as a distinct species, and termed *puerperal mania*. Insanity, too, has been repeatedly known to supervene on the suspension of suckling. It has appeared with abscesses of the breasts, and ceased when these have been dissipated. Under this head, too, I may properly allude to hereditary influence—a cause of madness, the operation of which is beyond dispute. It has been asserted even, and on very strong grounds, that vehement and peculiar emotions of the mother during her pregnancy, may, in some inscrutable manner, react so powerfully on the nervous system of the fœtus, and so derange the relations between the future development of intellect and organization, that insanity occurs as the child reaches puberty or adolescence.

To conclude this notice of the causes of insanity, a word is necessary with respect to the civil state. It has been everywhere remarked, that bachelors and maidens become mad in a much larger proportion than the married of either sex. Different ages, doubtless, operate here. Abstinence from sexual pleasures is evidently one, but generally the contrary excess is the most frequent. Moreover, the bachelor is exposed to a thousand contingent emotions, and dissipation, and irregularities, from which the married man is sheltered. However, that this is the fact, is at any rate proved by statistical computation of indisputable correctness.

BLISTERS IN ERYSIPELAS.

In an excellent article on this subject in the *Bulletin Général de Therapeutique*, M. Rigaud, late *interne* at the Hôpital St. Louis, advances a considerable number of facts, which prove the efficacy of blisters in phlegmonous erysipelas. The application should be made to the entire surface affected. Relief is usually obtained in twenty-four hours.

GENERAL PRINCIPLES OF THE SYMPTOMOLOGICAL EXPLORATION OF DISEASES OF THE EYES, BY PROFESSOR HIMLEY, OF GOTTINGEN.

(Concluded from page 425.)

XXIII. Besides the examination of the colour of the iris, we must attend to the *degree of dilatation* of the pupil, whether it be widely open, or strongly contracted; if its contour is circular, or angular, or rugged; if the angles are horizontal or vertical; if the inner edge of the iris is thin and cutting, or thick and much confounded with the deeper-seated parts; if, finally, this membrane is detached in any unusual point, thus forming an abnormal pupil.

XXIV. The *texture* of the iris must be equally examined, whether it is reticular or of unusual density, forming a contracted, almost homogeneous, membrane, or containing solid fibres in its reticular tissue.

XXV. As to the iris itself, as well as the parts which support it from behind, it is necessary to examine the *situation* of the membrane, whether plane, convex, or concave, at its anterior surface. Its convexity indicates excessive pressure from behind, which may be occasioned by an unusual increase of the vitreous humour, crystalline lens, the humour of Morgagni; by capsular excrescences, or a morbid accumulation of the aqueous humour in the *posterior chamber alone*. A concave disposition, on the other hand, indicates a diminished volume of these parts, a want of tension in the ciliary substance, very frequently a diminution, or complete absorption, or displacement, of the crystalline lens. But at the same time, we must not forget the natural position of the iris dependent on the age of the patient, since, in my opinion at least, in very young children, the anterior surface of this membrane presents an indisputable convexity. We must remark, too, if there exists in the iris an oscillation forwards and backwards, especially during the movements of the patient.

XXVI. Another point which should fix attention, is the *mobility of the iris*; it is that especially which determines the size of the pupil, which should be examined in different degrees of light, sometimes even with a taper, and its aptitude of motion increased accordingly. The slowness or celerity of the movements thus occasioned; whether they soon cease; or if the iris long

continues to modulate,—if the mobility of the pupil is more marked at one side than the other; all these should be carefully noted. *In some cases of amaurosis and amaurotic amblyopia, the phenomena which are induced in the iris by light and shade, appear to me completely reversed; for in suddenly separating the eyelids, previously well closed, the pupil first appears narrow, and then enlarges as the light increases. I have nowhere found this remark hitherto recorded. I attribute the phenomena to the excessive susceptibility of the eye, by which the ordinary daylight acts on this organ with a paralyzing power. At least in the patient I allude to, the affection under which he laboured had certainly this fundamental character. Again, with respect to the movements of the iris, we must observe if they are regular, or if some of its portions do not follow the general contraction or dilatation, as occurs in partial adhesions.*

In the cases in which the pupil always preserves the same width in different degrees of light, we must not hastily conclude that the iris itself is intimately altered. This circumstance often depends solely on an adhesion of the pupillary edge to the crystalline capsule, which hinders the interior excitability from displaying itself in changes in the state of the opening. *A more attentive examination shows interior motions of the iris, which become especially distinct in the cases where the structure of the membrane is reticular, or some change in the position of the surfaces will be seen. But frequently also the iris is actually paralytic, or so hypertrophied as to be incapable of motion.*

XXVII. The leading alterations in the crystalline lens and its appendages, are included in the special history of true and false cataract.

XXVIII. As to the anterior chamber and its contents, we must take care not to mistake thickening and loss of transparency of its anterior membranes for an opacity of the aqueous humour, produced by any morbid secretion or excretion. Puriform secretion into the anterior chamber is much more common than is generally believed, and may principally be dreaded in the cases where the iris becomes red, even at its internal edge alone. Again, we have seen repeatedly, and still continually see, accumulations of pus in the anterior chamber confounded with a milky opacity of the cornea, observed as the effect of some inflammations of this membrane, especially those denominated *metastatic*. This mistake is but too frequently the cause of the loss of an eye, the surgeon opening the cornea, supposing it to be an abscess. But we may always distinguish the two affections in the

following manner:—The opacity of the cornea, no matter from what cause it proceeds, whether a thickening of this membrane, which alters its transparency, or the presence of an opaque fluid contained in its substance, always preserves the same position, while, on the contrary, in cases of abscess of the anterior chamber, the moveable liquid always seeking the lowest level, occupies the triangular space which separates the cornea from the iris, and when we displace the head laterally, the motion of the fluid accompanies this change of attitude. It is at this same point that the *gerou toxou* is formed, and where the conjunction puts on the cushioned appearance. These cases are, nevertheless, readily distinguished. But a still more exact determination of this mobility becomes necessary, if it be imperative to avoid the slightest error. *I have very frequently found in the anterior chamber, opaque masses which preserved their original situation, although I moved the head to either side. This circumstance generally occurs when the mass is tenacious, and contains a large quantity of albumen; or, again, when the matter is only in very small quantity, in which circumstance it is lodged too fixedly in the place already mentioned, to be instantly displaced by its own weight. But still we can avoid the error, by placing the patient for some hours on his side, when the displacement will be found to have occurred.*

In some cases the aqueous humour appears reddish, and, nevertheless, it is the iris which is thus coloured; the cornea then presents a reflection of the tint (xxii—a), while, on the contrary, a blue iris changed to green, indicates an alteration of colour in the aqueous humour (xxii—c), &c.

XXIX. Lastly, in examining the bottom of the eye, we shall ascertain what is its exact colour; whether deep black, or grey, cloudy, or approaching to green, or if vessels can be distinguished upon it. It will be taken into consideration, at the same time, that the black tint of the pupil depends much on the light that falls on it, as well as the degree of its own dilatation. We must not too hastily conclude, that a very deep-coloured pupil is diseased. It is not rare to meet eyes in perfect health with pupils grey as in commencing cataract, or cloudy as in complete amaurosis. In the cases wherein the pupil presents a really morbid nebulosity, it becomes necessary to examine specially if the cause resides in the crystalline lens and capsule, or in the vitreous humour, or in the bottom of the eye; and whether, in fine, the case be cataract, glaucoma, or incipient amaurosis.

XXX. There still remains a point to be explored, to which even oculists have paid but little attention. I mean the condition of

the *lacrimal gland*. This organ is frequently the seat of certain affections, the true nature of which escapes the recognition of the surgeon, who, attending exclusively to the globe of the eye, neglects to notice morbid states of humidity, or dryness, or other lesions of the part in question. The observer, therefore, will devote especial attention to the region occupied by this gland, he will seek to ascertain if it be the seat of pain, if this be increased on pressure, if there exist any tumefaction beneath the upper eyelid, which pushes the globe of the eye downwards or to either side. He will observe the quantity of the tears, and judge also of their quality by the state of the parts they moisten, including the nasal fossæ, the affection of which in the ophthalmia denominated *humid*, arises, doubtless, in the first place, from the irritation of the acrid tears directed on them by the lacrimal passages.

XXXI. All the researches hitherto indicated, belong, properly, to the *inspection* of the eye (*Augenbesichtigung*. *Ophthalmoscopie*), but although the greater part of the examination of the eye is conducted by the eye also, there remain other modes of exploration, viz. the *touch*, and the study of the sensations of the patient.

XXXII. We have recourse to the touch, principally in order to judge of the tension of the membranes, to know if it be excessive—if the globe have a stony feeling under the finger. But an experienced glance may, in the majority of cases, anticipate the information thus obtained. The employment of the touch, however, becomes especially necessary in amaurosis and the affections which threaten to terminate in it, and also in occlusion of the pupil. Nodosities and encysted palpebral tumours also require examination by the touch.

XXXIII. With respect to the *sensations of the patient*, we must learn, precisely, if he suffers pain; when this is greatest, morning, evening, or night; if felt only in strong light, if experienced only when the eyelids are moved; the seat of the pain, and its nature, whether lancinating, burning, stretching, pulsating, itching. It is necessary at the same time to take into consideration the manner in which the patients relate their impressions, for in general they describe in an unusually animated and exaggerated manner, all the sensations they experience in the eye.

XXXIV. As to the state of *vision*, we must examine each eye separately. We must see if the exercise of this function is altered or lost—if the patient sees objects magnified, or diminished by halves, double, angular, moving while at rest, bordered by a kind of rainbow; and, in this case, if the areola exists constantly, or only in artificial

light, or when the eyes have been kept long open. Does the patient, especially when the objects are small, distinguish them well at the first glance, and then does he see them becoming mixed and confused; or, on the contrary, after a sustained effort to see correctly, do they then become more distinct? Is the duration of clear sight but short? What is the state of vision at different periods of the day? When is it better, in strong or feeble light; when the eye is placed opposite to the light, or when this is behind the organ? At what distance is vision most exact? Has the field of distinct vision of minute objects but a limited extent? Are colours seen correctly or altered? Do the colours in the latter case seem lighter than reality; for instance, is yellow taken for white, &c.? or, on the other hand, are the colours seen of a deeper shade, as dark red, or blue, or black? When examining cases of this confusion, we must not forget, that there exist occasional, though rare, idiosyncrasies, exemplifying the same phenomenon.

XXXV. We sometimes meet individuals who designedly *pretend* many affections of the sight, and even perfect blindness; as among military or hospital malingerers. In the cases where complete blindness is counterfeited, the truth will soon be discovered by our observing with caution the manner in which the individuals walk, especially in places to which they are strangers. The best test of the deception is to surprise them by some striking object, something very brilliant, such as the polished blade of a knife or a mirror. But often it is very difficult to arrive at the truth when the individuals only feign weakness of sight, especially that kind of weakness in which even small objects are at first distinctly seen, and then become obscure. In this case we must not give too hasty an opinion; we must scrutinize the patient's conduct with patience.

XXXVI. Still more frequently the patient makes false statements, through an error of self-deception; but the most frequent of all are those in which the patient affirms a blindness of years to have existed only but a short period. That is what occurs when, having long laboured under complete loss, or great weakness, of sight at one side only, the patient is ignorant of the circumstance, and only becomes acquainted with it by the casual shutting of the sound eye, or by this also becoming weak-sighted or blind.

XXXVII. In a great number of cases it is necessary to submit the patient to various trials or tests, as well for the purpose of obtaining exact knowledge of his state ourselves, and to make this known to the patient, as with the view of being able at a

later period to appreciate exactly the progressive or retrograde march of the disease. Such trials are made, for example, with printing types, or writings of various sizes, if the patient can read, or with points of various size, traced with ink on white paper, or with chalk on a black ground, and preserved for the repetition or comparison of future experiments. To test the vision of colours, we may use ribands or slips of paper of all varieties of tint, or even wafers, when the former cannot be conveniently procured. Brilliant and polished objects, such as those of steel, &c., give deceptive information; since while they are shining they frequently become too indistinct for a weak eye, and in the contrary case they are not sufficiently striking. Many experiments on persons operated on for cataract, have taught me this. We must equally make trials at various distances, and observe the length of time during which the patient sees distinctly while reading or otherwise exercising his sight. We must not place implicit reliance on the statement of the patients when they fancy they see distinctly their own hands or clothes, or other objects with which they are previously familiar.

XXXVIII. Lastly, in these trials we should in general not neglect to compare both eyes, one with the other, for which purpose one must be well covered with a bandage, while the opposite is examined. In conclusion I have only to remark, that my object in this article was not to trace the mode of diagnosis of single affections, but to advance the general precepts applicable to the examination of the alterations which the tissues of the eyes may present.

MONTHYON PRIZES.

The *Académie des Sciences* has decided in secret committee, that the following premiums should be awarded from the Monthyon funds. To M. Manec for his treatise on ligature of the arteries (analyzed in a late number of *THE LANCET*) 4000 fr. To M. DELEAU for his treatise on diseases of the ear, 4000. To M. Bennati, for his researches on the voice 2000. To M. Merat, for his treatise on tenia, 1500. To M. Lecanu, for his researches on the blood, 1500. To M. Parent du Chatelet, for his works on hygiene, 1500. To M. Villermé, for his statistical researches, 1500; and to M. Emmanuel Rousseau, for his researches on the employment of holly, 1500. In a subsequent meeting the academy also awarded 2000 to M. Leroux, for his discovery of Salicine, with the understanding that next year, if he produce further proofs of the febrifuge efficacy of this substance, he will receive the great prize of Monthyon, viz. 10,000 fr.

No. 433.

PHRENOLOGY.

To the Editor of *THE LANCET*.

SIR,—As a sincere lover of useful knowledge, it gave me great pleasure to hear at the last meeting of the Westminster Medical Society, that Dr. Epps was able to give the appropriate name and situation to any organ of the brain presented to him separately, from the peculiar disposition of its fibres. *This proved*, Sir, and the most obvious objection to the science of Phrenology is shaken, “the impossibility of determining where one organ ends and another begins.” Based upon anatomy, and supported by the success of its applications in the judgment of character, its destiny can no longer give any anxiety to its warmest admirers. The “*cui bono*” can never be urged against it until the mind ceases to be the subject of disease, and a knowledge, of its nature unnecessary in the framing or administering to all human institutions. Under these impressions, to see so vital an objection disposed of by the knife of the anatomist, must be a source of great delight to every candid inquirer, and to none more so, than to your obedient, humble servant,

A PHILO PHRENOLOGIST.

December 24, 1832.

SUPPLY OF SUBJECTS TO PRIVATE SCHOOLS.

To the Editor of *THE LANCET*.

SIR,—In accordance with the promise which the Right Hon. Lord Melbourne made to me, as stated in your journal of the 22d ult., I have the happiness to inform you, that, by his Lordship's interposition, the monopoly in the distribution of subjects is completely destroyed, that I have now a good supply, and that I am to be henceforth provided with them from the same source, and in the same degree, as those teachers who are the *would-be monopolists*.

His Lordship has thus, in the most prompt and honourable manner, fulfilled the very letter of his promise.

Yours, very obediently and truly,

G. W. DERMOIT.

30, Francis Street, Bedford Square,

January 1, 1833.

* * We are happy to find that the Home Secretary has been enabled to exert a sufficient *moral influence* over certain parties to empower, at least, one of the private schools to obtain a competent supply of subjects, but we should feel obliged if Mr. Dermott will state if the bodies are *purchased* from the parochial authorities. And at what price the subjects are placed before the students.