Society Proceedings

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DR. P. C. KNAPP in the Chair.

A Case of Brain Tumor.—This was reported by Dr. Walton. The case was of interest through its atypical course, and the presence of symptoms suggesting local encephalitis.

Mrs. G., aged 63, seen in consultation with Drs. Griffin and Ryder, of nervous disposition and inclined to worry, but with no prior mental disease, appeared well up to June, 1904, though is said to have talked and acted strangely at times for some months before, apparently sometimes appearing not quite oriented. There was no history of gripe or other known infection, no abdominal, pulmonary, cardiac or renal complication. Prior to the attack in June she had had considerable trouble and worry over household affairs. She became restless, would roam about and talk at random; complained of severe headache. Is said also to have been aphasic. After about a week, went to bed semi-comatose. From this time the temperature was elevated, twice reaching 103.5 F. with chill. Catheterization was necessary. Some improvement in mental condition followed. Mental torpor ensued and tenderness on turning head; no retraction. About September 1st hemiplegia appeared. Examination one week later showed optic neuritis. Blood count: whites, 12,500.

When Dr. Walton saw her September 19th she lay quietly on her back without appearance of discomfort. The pupils were alike and reacted to light. On being addressed, she would look quietly at the speaker without responding. On being urged to answer, would sometimes make an irrelevant reply; for example, when asked what she had in her hand, finally said, "Your voice is very much like Mrs. X's." Did not recognize objects in right hand, evidently recognized them in the left. Apparent loss of temperature sense in right arm and leg. Movements of right arm and leg restricted; left, normal. Could not name handkerchief, but says it is something to wipe nose with. Did not protrude tongue or touch nose with finger upon order, but could imitate these movements. Knee-jerks absent on both sides. No clonus. Tendency to Babinski on the left.

Condition remained practically the same except with deepening torpor and more marked hemiplegia, but without sign of headache, until a few days before her death, which occurred Oct. 15th.

Dr. McGrath, who performed the autopsy, reports a glioma in the following situation: "The mass extends anteriorly to within 2.5 cm. of the surface of the frontal lobe; inwards to the median line; outwards nearly to the surface of the frontal lobe, just anterior to the fissure of Sylvius, the cortex at this point showing some softening; downwards to within about 1 cm. of the surface of the base; and backwards to a point which externally is 2.5 cm. posterior to the tip of the temporal lobe, and internally corresponds with the front of the optic thalamus. This mass occupies the greater part of the corpus striatum, replacing the body of the caudate nucleus, the most of the lenticular nucleus, and the anterior portion of the internal capsule. Its peripheral parts infiltrate the white matter contiguous, and externally the gray, within the limits above specified."

Dr. Knapp said that the history given him differed somewhat from that obtained by Dr. Walton. When Dr. Knapp saw her in the middle of September he was told that she had been dyspeptic in the spring, with some cardiac weakness, that she had been much quieter than usual, and that her memory had failed. She had had considerable headache, but not severe in character, so that her attention could readily be diverted from it. In June she could not remember words, often used the wrong word, and then realized her mistake. Her eyes looked wild and unnatural. About the first of July she went to bed, was unable to help herself, passed urine and feces in bed, but moaned when wet. There was no somnolence. For ten days she had helped herself a little. Her husband said that she understood all that he said to her and answered him properly. Her attendant physician stated that she rarely answered him at all, or else made some irrelevant remark. While Dr. Knapp was there she answered no question, executed no command, and paid no attention to a written command. She uttered one sentence, well articulated and properly arranged, relating to the general situation, but having no relevance to what was said or done at the time. The blood count showed 6,800,000 reds and 12,500 whites. There had been occasional chills and elevations of temperature. There was tenderness and rigidity of the muscles on the left side of the neck. She had old catarrhal otitis with labyrinthine trouble, but no source for a cerebral abscess could be elicited. There was well-marked right hemianesthesia without any hemiplegia. This had existed for some weeks. Dr. Jones reported optic neuritis, greater in the left eye. The pupils and visual fields were apparently normal. The reflexes were lost. There was no vertigo or vomiting. The chills and tenderness of the neck suggested abscess, but as no source could be found, the diagnosis of tumor seemed most probable. Dr. Knapp believed the tumor to be deeply seated, involving the insula and thalamus, but it proved farther forward than he had thought.

A Case of Tumor of the Frontal Lobe.—This was reported by Dr. Brownrigg, illustrating anew the rather remarkable absence of crippling symptoms during the prolonged growth and softening of a large tumor mass in the frontal lobe. A man of 51 became semi-comatose from the effects of intracranial pressure. Severe headaches recurred periodically for over five years, but had never incapacitated him for active work. He had been in the habit of taking morphine and headache powders for his head pains, and was thought by his physician to be suffering from the withdrawal of the former drug when first seen. He could be roused and would talk connectedly and enunciate well, though he was apathetic and tended to sleep. He still complained of generalized headaches. His superficial reflexes were abolished, knee-jerks diminished, and ankle clonus absent. He was removed to the Highland Spring Sanatorium, and gradually became continuously comatose and died, after having been acutely sick and prostrated only two weeks. Towards the end the muscles of the left side, especially of the arm and leg, became more spastic than those of the other side; the left knee-jerk increased, and the increase of the plantar reflex became especially noticeable. Throughout his semi-comatose condition he frequently put his right hand over the right frontal region, though he would never say that the pain was greater there. The diagnosis of tumor of the right frontal lobe region was confirmed at autopsy. The brain showed great increase in size externally to correspond to the cavity apparent to all, approximately the size of a hen's egg. The cavity was filled with soft degenerated brain tissue and partly absorbed blood clot, and was probably due mostly to vascular changes and slow softening. There was no history of shock. There was reason to believe that syphilis existed and was partially treated ten years ago. Without much doubt, this man had been carrying this mass of dead tissue for months, and it is especially remarkable that he was able to be about to so

late a date. In fact, he drove trotting horses for exercise each day up to two weeks before death with apparently perfect control of himself and the animals.

Dr. Walton said that these tumors add to the numerous instances indicating that diminution may result from cerebral disease. The fact that in the second case the reflexes returned and became exaggerated only tends to show that the spinal reflex centers were not the original sufferers and were able to take on their function after an interval, as happens in certain cases of cerebral hemorrhage and cerebral trauma in which the reflexes disappear for a number of days, but return and become over-active. It is true that in slowly progressive cerebral lesion, exaggeration rather than diminution of reflex is the rule, but the first case reported tends to show that cerebral lesion alone may cause even persistent loss. The best explanation of the various phenomena seems to be the assumption in the human mechanism of multiple centers for the reflexes, of which the cerebral are those of primary control.

Dr. Knapp said that as the cord was not examined in either of these cases, it seems hardly fair to cite them in support of any theory as to the location of the reflexes. Absence of the reflexes is not very common in cases of tumor, while changes in the cord are often found, which may be enough to explain such absence.

A Case of Cholesterine Stones in the Brain of a Man of Fifty-six, Dead of Heart Disease.—This case was reported by Dr. E. E. Southard. The brain showed extensive arteriosclerosis, with microscopic signs in the secondary distributing system. There were infarctions of lung and kidney, besides a small fresh area of softening in the cerebrum. The largest mass of cholesterin crystals weighed 2.25 grams, and measured 2 cm. in diameter. The mass occupied the middle of the left lenticular nucleus, and was surrounded by a thin neuroglia capsule. Two smaller masses lay in the cortical gray matter.

Both gray and white matter of the spinal cord at various levels showed miliary gliosis about masses of cholesterin crystals. The patient had been under observation three weeks and had shown no nerve symptoms. A frost-bite on the right foot had failed to heal in a period of some months.

A Medico-Legal Study of Some Noted Criminal Cases.—This was read by Dr. Folsom.

Dr. Stedman was glad that the reader had brought to light the old case of Marie Jeanneret, because of its resemblance to that of Jane Toppan. Both were nurses, and both poisoned without adequate motive a large number of patients. Dr. Stedman had been inclined to make use of this parallelism by coupling the two cases in his account of the mental condition of Jane Toppan, but selected instead that of Christiana Edmonds, which was better reported and in important respects more striking in its similarity. There is little doubt that, with the light that has been thrown on this class of cases in the last half century or so, and since Marie Jeanneret flourished, she would have been held to be, as were the Edmonds and Toppan poisoners, insane and irresponsible. In fact, Lombroso, who, when there is a question between criminality and insanity in a given case, is especially prone to consider the person simply a criminal, classes Marie Jeanneret (in an abstract of her case) among the criminal insane of the hysterical type. Jesse Pomcroy is, in Dr. Stedman's opinion, a typical and extreme case of normal insanity, utterly irresponsible and unpunishable, and would be so classified nowadays by most authorities on a full examination of his history and mental condition.

Insane murderers of this degenerate class do not, in his opinion, deserve the extreme penalty of execution or imprisonment for life, nor would such a penalty have any deterrent effect on other lunatics. It would also tend to revive the old retaliative idea of punishment, and was neither good law nor good medicine. He regretted the advocacy of such a measure by Dr. Folsom, as he believed it to be retrograde in its tendency.

Life confinement in an asylum for the criminal insane, on the other hand, meets all the requirements in the way of justice, humanity, medical care, and, if you will, punishment.

He was inclined to agree with Prof. Hyslop of Columbia that the only way to make any headway against murders by anarchists was to instill into the minds of the public the fact that anarchism is a stamp of insanity, and that public and continual expression of anarchistic sentiments should be the signal for the commitment to the insane asylum of those who are guilty of it, just as we endeavor to protect society from the delusionally insane when they show signs of endangering the lives of others.

Mr. Koren said that his interest in the subject under discussion extends beyond capital cases; and he wished, therefore, to make a plea for the wider application of the science for which this society stands in the treatment of criminals.

The whole modern penal system rests upon the assumption that the criminal is, generally speaking, a normal being. The criminal codes, therefore, virtually declare the insane criminals, because not normal, to be outside of the pale of the law, and do not permit their punishment. In other words, the sole distinction made is between responsible and irresponsible criminals. To him this classification seems not only unscientific, but one leading to the most deplorable results in practice. Clearly, there is between the two groups distinguished in the law a third, consisting of persons who lack the ordinary moral perceptions and are thus only partially responsible, without it being possible to declare them insane in the usual meaning of the term.

It does not make any difference how one views the doctrine of "moral insanity," or how one theorizes about the "born criminal" as an anthropological variety of the human species, the fact remains—and we have to thank Lombroso for emphasizing the need of dealing practically with the matter—that many men and women again and again come into conflict with the law because they in some respects are abnormal. To put it differently, there are in our penitentiaries and houses of correction large percentages of incorrigible habitual offenders who have become such chiefly because their individuality deviates from the normal type. He supposed the explanation lies in some congenital or acquired abnormal condition of the brain.

How are we dealing with the members of this group? As a rule, in the application of penalties the law makes no distinction between them and the normal individuals. In exceptional cases in which indubitable evidence of insanity exists, they are declared irresponsible and treated as sick persons, not as criminals. Most of them are sentenced according to a more or less fanciful scale of penalties which presumes to fit the crime, but pays little or no heed to the mental traits and peculiarities which have tended to make the individual in question a criminal.

The result is that we fail both in just dealing with many criminals and in affording society adequate protection against them.

The point he wished to make is that our criminal codes must bear the opprobrium of being antiquated, unscientific, and even barbarous, until they distinguish between three groups of criminals: First, those who are wholly responsible for their acts; second, those who are only partially responsible; and third, those who are wholly irresponsible, that is, insane.

Self-evidently, no innovations are necessary for dealing with the first and third groups. The second he would distribute according to the needs of individuals among institutions other than those of a penal character; for instance, the epileptics, certain alcoholics, the feeble-minded, etc. For a number of incorrigible habitual offenders it might be necessary to establish separate institutions in order to secure their permanent segregation.

He was not dismayed by the thought that he had hinted at measures which may seem to some too ideal, and therefore impossible in practice.

We have begun to move out of the old ruts. There is a growing movement for a more rational treatment of criminals, based on a scientific classification in the courts. It remains for a body like this to give this movement a safe direction.

Dr. Copp said that the practical side of this matter relates to the public safety. There is no doubt that such persons are abnormal, being either mentally deficient or mentally diseased. The question is one of degree of responsibility. Should such persons be dealt with as responsible or irresponsible persons? The right principle should be applicable in dealing with lesser as well as capital offenders.

The present penalty for a capital offense is death or confinement in an insane asylum for life. Therefore, the proposed change to life imprisonment would not affect the public safety in this class of cases. It would allow the doubtful case of insanity to be confined in a prison for life; in other words, it might substitute prison methods for hospital methods. But in dealing with minor offenses the principle of responsibility affords distinctly less protection than that of irresponsibility. If a mentally abnormal person is regarded as responsible he is arrested, imprisoned for a short time and discharged into society. The process is repeated indefinitely, perhaps until he has committed a capital offense. On the other hand, if he were regarded as irresponsible he would be committed at once to an insane hospital or the school for the feeble-minded, and would be permanently secluded from the community. Public safety would be efficiently guarded, and the commission of a capital crime might be prevented.

Dr. Mitchell thought it was desirable to give all men accused of crime the benefit of any doubt that might arise as to their responsibility, on account of mental defect or disease.

The question of responsibility was usually carefully determined in the more serious offences, but he knew of many cases where men had been convicted of minor offenses and misdemeanors committed subsequently to the onset of a psychosis.

This was a hardship that rested fully as heavily upon the family of the accused as upon the individual.

He felt that society should be carefully protected from the possibility of further offenses in the case of persons acquitted of serious crimes against the person, on the ground of irresponsibility, due to chronic or congenital causes, and that such persons should be held under order of the courts, their liberty being granted only after most careful consideration of the individual case and the nature of the offense.

He spoke of cases where this caution had seemingly been disregarded.

Dr. Knapp saw no necessity for any change in the present law. The jury now have it in their power to accomplish the result aimed at by bringing in a verdict of murder in the first or second degree, a privilege which they did not have under the United States law in the *Bram* trial. If the jury prove too severe, there is plenty of opportunity for the judge or the governor to alter the verdict. The tendency to insist upon the complete responsibility of insane and defectives was hardly to be commended, and adherence to judicial decisions as to the prisoner's ability to distinguish between right and wrong or to the older legal opinions had only too often led to the judicial murder of the insane and irresponsible, as in the *Guiteau* case. The whole doctrine of human responsibility, and even the freedom of the human will, were to-day in dispute. No one who had to do with the criminal classes could doubt that many of them were at least defective and with limited responsibility, and it was improper to judge them by the standards of the normal man. Some day it might be possible to make the diagnosis of criminality before the subject had committed any overt act and put him under restraint, as we do the homicidal paranoiac.

It might be well to get rid of the term "moral insanity," but it would be better, if we could, by abolishing the term, to get rid of the morally insane.