

I have no doubt that sex as well as habits of diet have something to say in the production of these hypertrophies, and especially with their location. In several instances in the human subject I have witnessed definite subsidence of the tumours as the result of abstinence, and conversely a few weeks of beer-drinking will cause the tumours very perceptibly to increase.

In the ass I have not as yet met with them in the female subject, and, curiously, those in which I have seen the tumours were castrated males. They were both well-conditioned animals and had been well fed and not overworked.

Anyone specially interested in this subject can have an opportunity for examining the asses I have mentioned by a visit to Haslemere (after due notice and by appointment).

Chenies-street, W.C.

CLINICAL ASPECTS OF SOME VARIETIES OF EXCITEMENT.

By W. T. MUNRO, M.B., CH.B. ST. AND.,

ASSISTANT MEDICAL OFFICER, ARGYLL AND BUTE DISTRICT ASYLUM, LOCHGILPHEAD.

THERE are numerous conditions of acute mania, or of delirium, with which one comes in contact in the work of a mental hospital, and many of these cases can be separated and differentiated and referred to a particular form of insanity. Perhaps most patients with any maniacal or excited condition (with the exception of acute alcoholic excitement), when certified, are looked on by the medical man as cases of mania. The object of this short paper is to try to give some points in the diagnosis which will help the general practitioner to form an accurate diagnosis and place his maniacal patients in the correct group of cases.

We have states of (1) mental exaltation or mania proper; (2) alcoholic excitement or delirium tremens; (3) excitement in general paralysis; (4) katatonic excitement; (5) semi-conscious epileptic states; and (6) excitement in dementia præcox. Let us look at such patients, and I will try to illustrate cases to give the differential points for an accurate diagnosis.

Perhaps the most common are those who suffer from acute alcoholic excitement. The general symptoms may be well known, but I give a case.

CASE 1.—Man, aged 42 years, admitted Jan. 17th, 1911. He was very restless and excited, but one could retain his attention for a minute or two, and on asking him where he came from he could tell us. He could also tell us what he did, and admitted that he had been drinking very heavily since the new year. He did not know where he was, and although he had been admitted only half an hour before examination he thought he had been here for a few days. Restlessness was extreme. He would lie still for perhaps two minutes, then would suddenly jump up as if he feared something. Again on lying quiet he would follow with his finger all round the walls and ceiling again to jump up suddenly. On asking him what he saw he described them as devils and dragons, and said he could not catch them. He was also very incoherent in his speech. He seemed to be apprehensive and to fear something. If shown anything such as a thread on his bed he lay and looked at it for a minute or two and then made a grab at it. He would also suddenly grab at the blankets as if he wanted to catch something. He was very tremulous, and his outspread fingers showed strong jerky tremors. His tongue was thickly furred and tremulous. His temperature was 100° F. and his pulse rapid. Knee-jerks were exaggerated; pupils were normal. There was a slightly dilated heart.

Now to examine the case. The patient is collected to a certain extent, but he has no idea of place or time. He can tell us what he does and where he comes from, but he does not know where he is or how long he has been here. Again, there are most vivid hallucinations of sight and continued restlessness, and the physical examination. The diagnostic features are the following: The tremor, the restlessness, the vivid character of the hallucinations of sight, the want of clearness of ideas of time and place with other signs of collectedness; and the physical features, such as temperature, pulse, slight enlargement of the heart, and exaggerated knee-jerks, are very common.

After an interval of four days the patient has recovered; he has lost 6 lb. in that time, but has gained 12 lb. since.

The next delirious condition which I wish to mention is the following:—

CASE 2.—A man, aged 39 years, was admitted on Nov. 2nd, 1910. When admitted he greeted me as an old friend and at once asked me to go to London with him. The history previous to admission was that the night before he had suddenly become unmanageable, threatening to kill his wife and children. He denuded himself, declaring that the voice of God had come to him telling him to remain nude till the Day of Judgment, and he threatened to kill anyone who came near him. Previous to that he had been perfectly well and working every day. He was put to bed but was very restless, tossing about in bed, wanting to get up, throwing the bed-clothes about him, while his movements were very tremulous. Then he would sit up and talk to himself in a most silly manner. On being spoken to he would be roused to attention for about a minute, and he told us where he came from, that he was a grand singer, and that when he sang the whole world heard him. He was very divertible; jumped from one subject to another at once. He was only to be here for a night, when Lady — was coming for him in a flying ship. The night after admission he became violent, jumped up suddenly, attempted to jump out by the window, and cut himself slightly; then he said he was very foolish to have done so. Like Case 1, he seemed to be very apprehensive. He is also very tremulous. He tells us he sees a motor-car coming for him, then he sees Lady —'s flying machine.

Now there are certain features which are much like Case 1. There is the tremor, the uncertainty of movement, the continued restlessness, the apprehension, and the hallucinations. Now with only the above features, and if these were not carefully noted, one might go wrong, but there are certain deviations from the picture of Case 1. Our patient is more confused and he has the most impossible delusions, while he has not the exceedingly vivid hallucinations of vision. To examine our patient further, one would notice at once that his speech was slow, syllabic, and slurring. His pupils were unequal, but reacted to accommodation, and, slightly, to light. There is no expression in his face. His tongue is tremulous, the knee-jerks are markedly exaggerated, no ankle clonus. Babinski positive, and he has a psoriasis all over his body. It is a case of general paralysis, and now we see there was nothing remarkable in his delusion that when he sang the whole world heard him. Question him further he tells us the church he sings in is his own and is painted in all the colours known. Moreover, he is very wealthy. As to causation, he has been a sailor, sailed to St. Malo and Dunkirk, but there is no evidence of specific infection.

What are the diagnostic features? We have the delusions of grandeur, the divertibility, the rapid change from one subject to another, the change of consciousness of personality, the motor symptoms, the tremor, the unequal pupils, and, on physical examination, the condition of the reflexes.

The third patient whose condition I wish to describe is, perhaps, more interesting than either of the two previous cases:—

CASE 3.—Woman, aged 27 years, a tinker. She also exhibits several features which might easily be spoken of as acute mania. Her excitement is only paroxysmal, but if seen during that stage, and only then, and not carefully examined a wrong diagnosis might easily be made.

Our patient's excitement is best seen just after meals. First, she will not start to eat anything whilst the others are at their food. Now try to take away her food—she resists. Trying to persuade her to take her food makes no difference. She will not even look up. Her face is expressionless; then try to remove her food, she resists and becomes very excited.

She calls out "Oh God! Oh God!" repeating herself several times, will clutch bread in her hands, and resist all effort to remove it. She now becomes abusive, swears at one badly, and will tear one with her fingers. You speak to her, she repeats what you say over and over again, to again become very abusive. During this stage she may attack the nurse, and does so with great cunning. Now leave her alone, she will lie back with her food, but still talks angrily, repeating herself again and again. In a short time she is quiet, and one would notice that she lies rigidly in one position. Now to note the condition as far as we have seen. There is excitement, but there is more. The perception of

the patient is perfect. Is not the condition negativism? There is first the attempt to persuade her to eat, and she never gives you any indication that she has heard you, but lies quiet; no words from her, but she will not eat. Now try to remove her food, again she is negative; and this time there is the excitement with also a repetition of phrases.

Further, a pin can be stuck into this patient's forehead and she will not wince, and if we lift an arm it remains in the position we put it into for about a minute, and gradually falls down. I have pointed out the negativism: Why is she negative? Is it from any delusion or apprehension? It cannot be from either. There is nothing in the behaviour of the patient to suggest that there is any apprehension or delusion. Again, why should she not wince when a needle is pushed into her forehead, and become excited when a gentle hand is put on her? Clearly we have to deal with a case of negativism, an instinctive opposition without foundation from delusion or apprehension.

My diagnosis is katatonic excitement. We have as diagnostic features the abrupt alternation between senseless excitement and rigid tension, the taking up of peculiar attitudes, the confusion of talk with complete comprehension, the meaningless repetition of the same words.

The next patient I wish to mention shows a condition of apprehension.

CASE 4.—Woman, aged 50 years, for the past fortnight has shown a condition of terrified apprehension. She is very excited, and every time one goes near her she calls out with a frightened look, "Oh God! Oh God! it was not me," repeating this over and over again. She varies her words "You won't do it," "I did not do it," "Why am I put here?" Then she will catch hold of you and implore you "Don't leave me," "I did not do it." Again, if I spoke to the nurse, she complained that we were speaking about her and making up our minds what we should do with her. She could easily hear what was said to the nurse, but she did not appear to understand what was said. Clearly, she is in a state of terrified apprehension. You speak to her and ask what is the matter; you cannot get any answer. She still continues in the same excited, apprehensive state, and she does not understand what is said to her. There is more or less stupor. There are features like Case 3. There is the meaningless repetition of words with excitement, but there is a great distinguishing feature in the fact that the patient is stupefied. Now again our patient is very restless, she is not in bed and she will not sit still any longer than a minute, but gets up and moves from one place to another. There is great uncertainty in her movements and she even hits out at times. This condition of seeming ignoring of questions is not negativism. She is stupefied. Again, she is quiet for, perhaps, a minute, and you can move her arms about without any hindrance from her own will. Her excitement is meaningless and her assaults are without the adroitness of Case 3. Her talk is very disconnected, but, unlike Case 3, it is comprehensive in that the whole talk is due to apprehension. The condition is a dream-like one, with changing incidents and fluctuations of emotions of an apprehensive nature and utterances in accord.

Consider the case. Here again we have excitement or delirium. What are we to eliminate? We may exclude the alcoholic form on account of the profound stupefaction, also from the want of tremor and the want of the vivid hallucinations of vision. Alcoholics are not nearly so stupefied. You can arouse them to answer you and even to give a correct answer. They are collected to a certain extent. The clouding of consciousness is too deep for ordinary fever delirium. Exclude katatonic excitement by the want of perception and hence no negativism. Again, we do not have the repetition of phrases and abuse of katatonia, nor do we have the alteration between senseless excitement and rigid tension. Our patient's excitement is continuous. Clearly we have a condition of delirium the result of an apprehensive state of mind. We have profound disturbance of comprehension, active delirium, extreme apprehension, an inclination to reckless acts of violence, and the condition of stupor along with excitement corresponds to certain epileptic semi-conscious states. The only thing else noteworthy is the condition of the pupils. They are dilated and react very feebly to light.

This patient has now recovered and does not remember anything at all about her condition, but says she must have been very ill. There is little doubt that the condition is an

epileptic one. In this patient we actually have a history of fits. But apart from fits we have irritability and real bad temper just before this semi-conscious epileptic state. A typical feature of epileptics is piety alternating with irritability. At the time of writing our patient is reading the Bible.

My next patient is more impulsive. Like all the previous cases, she is subject to outbursts of excitement, and she exhibits some features which are different from them all.

CASE 5.—Woman, aged 28 years, up to a few days ago had remained very quiet, but has now reached a state of excitement. She chatters in a confused way—really a senseless playing with words. She runs about the ward, moving from place to place, is very impulsive, apt to do most reckless things, will push her fist through the window, will smash dishes, and has attacked a nurse. She is very abusive, and grimaces, making most hideous faces.

As far as we have seen, the most outstanding features are the impulsiveness and the grimacing. She is quite collected. If you ask her questions she answers only in monosyllables, and very slowly. In a short time her outburst of excitement is over and she sits down, and the most significant feature which will be observed is a vacant, silly smile. There is difficulty in getting her to start to do any work, and when she does anything one would notice that her movements are languid and listless. There is a great want of initiative, but there is no hindrance of will to action, only there is the want of interest, everything is done in such a dull, listless manner. Another feature about our patient which is noteworthy is the loss of interest in her surroundings. She does not care where she is put or who looks after her. She has no emotions. She expresses no desire, has no hopes and no fears.

Now what is the diagnosis in such a patient? We have seen her excitement, which is only temporary, her recklessness and her restlessness, but these features have little to do with the diagnosis. To consider our patient. Her ability to understand what is said to her is unimpaired, but she only answers in monosyllables. Again, there is the great want of emotion, or, as it has been put by Kraepelin, a want of the strong feelings of the impressions of life. The diagnosis is dementia præcox.

The features of such a case are: the want of feeling of the impressions of life as seen in the want of the emotions. Her lack of interest in her surroundings with ability to understand and remember. Again, the vacant, silly smile and the grimacing are common, as is also the great want of initiative.

The five cases which I have ventured to describe all show varying features, and each of them is worth consideration. One might take exception to classifying katatonia and dementia præcox separately, as katatonic symptoms are common enough in dementia præcox, but my intention was to describe katatonic excitement separately, and its significant features will justify a special description.

CASE 6.—Alongside of these five cases, and for comparison I shall illustrate the special features of a married woman, aged 32 years, who exhibits great mental exaltation and can be called a true case of mania, properly so called. As soon as one enters the ward the following picture may be seen. She is very noisy and excited. She is walking about the ward; is attracted by the least thing, will pick up anything, remark upon it, and throw it away at once. Perhaps she is induced to sit down, but the moment you turn your back she is up again, attracted by something else. Now she will seize a chair, swing it round and sit down on it, to get up again immediately and go through some other movement. All this time she is talking, but one could not follow the purport of her talk as she changes so often from one thing to another.

She is very fond of dress, and perchance in her wandering round the ward she sees herself in a mirror and she will stand for a minute and admire herself. Her own image has attracted her attention. I once saw her steal a nurse's cuffs, put them on, and sit down as "my lady" quite quiet for about a minute. You speak to her, ask her name, and she will give a correct answer, but she answers so much more, and at once gets away from one subject to another—speaks and does just whatever comes to her mind. You cannot fix her attention on one subject; she cannot be led into any connected conversation, digresses immediately, and then jumps up and moves round the ward as previously described. She is very merry, she laughs throughout her talk, and when out for her walks goes round singing all sorts

of songs, and will sing during the whole time out. Our patient's merriment may very soon change to angry irritation. She becomes very abusive and, as the impulse moves her, will attack any one, and it requires considerable restraint to prevent her doing damage.

What are the significant features of our patient? The most prominent is the divertibility. Some accidental attraction at once arrests her attention, but this is immediately thrown out and some new attraction is forced into consciousness, to be at once departed from. This divertibility is shown equally in mood—merriment to anger; in thought—changing ideas; and in action—her continued changing of position and movements. The patient has not the ability to prevent herself being ruled in thought, mood, and action by the influences of the moment. Next one would note the "flight of ideas." Her thoughts are to no purpose. The train of thought is broken at once by one idea being driven out by another. Again we would note the impulsiveness, in the fact that she will attack any one. Here we note the same thing: there is no check on the transposition of impulses of the will into action. We would also note the deficient attention. We cannot retain our patient's attention on any subject. The rapid change of the sensations which are forced into consciousness, and each in turn receiving attention, makes it impossible for her to concentrate her mind on any subject.

The whole condition may be summed up thus:—There is no check on the number of ideas which force themselves into consciousness; no check on the sensations received, and each in turn may show itself in mood, action, or speech.

Looking at all those cases, what have we? There are certain features different in them all. First take attention. Case 1 can attend and can comprehend what is said to him to a certain extent, but is soon taken up with his hallucinations of sight. Case 2 can be aroused to attention, but is more confused than Case 1, and soon mentions his delusions of grandeur. Case 3 understands what is said to her, can attend, but will not let you see she does attend, except in the fact that she is negative. Case 4 is stupefied and cannot attend. Case 5 can attend, but she has no interest in what is said to her; she is languid and listless, and would rather not be troubled. Case 6 cannot attend on account of the divertibility; the rapid change of the sensations forced into consciousness and then put into action.

All our cases showed excitement, but all have showed some points of distinction. It would only be taking up space were I to add a note about each, as to which had delusions, hallucinations, or as to the condition of the memory, &c. Enough will be got in the short commentary at the end of each case for an accurate diagnosis. My paper is only clinical, but it may serve a useful purpose if it stimulates a proper investigation into all cases of "Mania."

Lochgilphead.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

HYSTERECTOMY FOLLOWED BY DOUBLE PHLEBITIS.

BY H. MACNAUGHTON-JONES, M.D. R.U.I.,
F.R.C.S. IREL. & EDIN.,

PRESIDENT OF THE OBSTETRICAL AND GYNÆCOLOGICAL SECTION OF
THE ROYAL SOCIETY OF MEDICINE.

THE patient, aged 48 years, a nullipara, had suffered for some years from severe hæmorrhages, for which she had been curetted a few years previously. At the time of operation for tumour of the uterus she was greatly emaciated and extremely anæmic, and altogether in a most unfavourable condition for operation. The tumour was delivered with great difficulty, being firmly wedged in the pelvic cavity. It was a multinucleated myoma, one mass of isolated nodules from cervix to fundus. On the fifth day after operation proctoclysis was commenced, and as there was some distension of the abdomen the wound was opened and a suprapubic drain inserted. Exploration revealed nothing, and only some serous fluid escaped. The proctoclysis was continued on and off for five days, but the suprapubic opening

was not closed for ten days. The first symptoms of phlebitis appeared in the left femoral region on the thirteenth day after operation, and the swelling extended to the entire limb. It had returned to its normal size by the twenty-fifth day. On the thirtieth day the right thigh commenced to swell, and it followed the same course as the left, becoming the more swollen of the two. The swelling subsided completely in about ten days, and from that time there were no untoward symptoms. The patient has since done well.

This is the only instance of phlebitis in both legs as a post-operative complication that I have been confronted with. The important lesson to be learnt from the case—and one that is often overlooked—is the increased risk run from grave anæmia, the result of bleeding from fibroids, and also the unfavourable conditions consequent upon this complication which increase the operative mortality. Whatever be the precise physiological cause or causes, there is no doubt that the condition of the blood in such cases tends to thrombosis; also the possible effect of traumatism in the forcible delivery of these tightly wedged pelvic tumours has to be remembered.

As generally occurs, the left leg was the one first affected, and it was rather remarkable that the attack in the right did not begin until the thirtieth day after operation. In Kelly's "Operative Gynæcology" (1898 edition) it is stated that out of some 1100 operations he had had phlebitis in both legs in only one instance, and in his last classical work on medical gynæcology, written with Noble, the authors state that out of 7130 women operated upon thrombosis occurred in 48. Of these, 727 had fibroid tumours, and 19 of the 48 cases resulted from operations on fibroid, a relation regarding the greater risk of thrombosis from fibroids which is in accord with the experience of other surgeons.

The therapeutic points of interest in the case were the good results following the proctoclysis with suprapubic drainage, as recommended by Dr. J. B. Murphy, and the benefit obtained on two occasions when the bowel was obstinate from subcutaneous injections of infundibulin—"pituitary extract." It may also be interesting to note that in this, as in other cases in which I have had to deal with extreme anæmia, the patient was kept on "carnine," in the present instance for 17 days, in addition to other nourishment.

Harley-street, W.

NOTE ON A CASE OF PANCREATIC CYST IN A CHILD AGED 14 MONTHS.

BY D. I. CONNOLLY, M.B., CH.B. VICT.,

ASSISTANT RESIDENT MEDICAL OFFICER, CRUMPSALL WORKHOUSE,
MANCHESTER; LATE ASSISTANT HOUSE SURGEON, STAFFORDSHIRE
GENERAL INFIRMARY, STAFFORD; LATE HOUSE SURGEON, ST.
MARY'S HOSPITALS FOR WOMEN AND CHILDREN,
MANCHESTER.

THE patient was admitted into the Staffordshire General Infirmary on Jan. 29th, 1910. The history, as given by the mother, was as follows. The child had been breast-fed up to about the age of 10 months, when she was weaned. She had not had a day's illness up to three or four days before admission to hospital. The mother then noticed that the child became listless and refused food, also that diarrhoea set in. At the same time the little one developed difficulty in swallowing, apparently having a "sore-throat." The mother became alarmed at the child's condition, because, as she said, "she was always so lively and full of play," and brought her to hospital.

On admission the child looked fairly well-nourished, but wore an anxious expression, and was quite listless. The tongue was furred, the papillæ were prominent, and there was some injection of the fauces. Nothing was to be made out in the chest. On examining the abdomen, it was found to be distended and tympanitic all over. Palpation elicited a feeling of resistance in the right hypochondrium. The movements of the intestine were audible on auscultation. The pulse was rapid, reaching from 160 to 180 per minute, and the temperature at first was about 99° F. In the nervous system there was nothing of note except the general languor previously noticed. It was not found practicable to obtain a specimen of urine. There were no signs of rickets or any deformity.

Treatment consisted of milk only. The diarrhoea not improving, albumin water was substituted. Of drugs, grey