of sensation and judgment ; and in melancholia without delusions there is disorder of judgment and feelings. So that psychia means disorder of the basis, just as psychoses signifies morbid forms.

As we cannot conceive the possibility of *increase* or exaggeration of judgment in insanity, and as in the case of the memory, emotions, and the will, exaggeration is accompanied with perversion, we need only consider as disorders of the fundamental faculties—diminution and perversion ; that is, the psychia may present itself as intellectual weakness (*menipsychia*) or simple disorder (*dyspsychia*). This determination must be made in moments of calm or semi-lucidity.

The morbid forms may be divided by two principal characters, according to the emotional tone prevailing (expansion or depression), or according to the degree of cohesion of ideas (coherence and incoherence). The more important, or more fixed of these characters—the emotional state—is selected for the first division of psychoses ; the second character (coherence) is used in the subdivision.

Although the fundamental morbid species of this classification in some instances do not correspond to well-defined clinical types, they constitute provisional symptomatic groupings, useful for purposes of study, and they offer this advantage that they do not prejudge the real nature of the diseases, which will some day be more clearly understood. The classification is also simple and logical.

H. J. MACEVOY.

Transitory Mental Disorder in Hemicrania. (Alien. and Neur., Jan., 1900.) V. Krafft Ebing (translated by McCorn).

The author gives a detailed account of the cases, previously recorded, which bear on this subject, and in addition a description of cases he has personally observed. His aim is to determine the actual relationship between the psychical disorders which accompany hemicrania and the hemicrania itself ; whether it can be said that these manifestations are the outcome or allied to the hemicrania ; or whether the whole condition is an epileptic manifestation. There is no case quoted where an inference could be drawn that would give actual proof that the mental disorder and the hemicrania were the outcome of the same condition. On the other hand, there is abundant proof, in the minority of cases not so clear, in the majority of the cases quite decided, that the ophthalmic migraine and the various psychical states are manifestations of epilepsy, or hysteria and epilepsy combined. In some of the recorded cases the actual diagnosis was not made for some years, the condition originally looked like an attack of migraine with ophthalmic accompaniments, but as it developed stigmata of epilepsy showed themselves. These were distinct loss of consciousness, and the classic attacks of *petit* or *haut mal* with pre- or post-epileptic excitement.

Viewing the clinical evidence as a whole, most of it is unmistakably against the existence of such a condition as the title of the paper ; only 3 cases are quoted out of 21 where there is any real connection between the mental symptoms and migraine, particularly ophthalmic. In these cases there are phenomena closely associated with an epileptic state, and in the author's opinion they are psychico-epileptic

types. He is inclined to agree with Féré that ophthalmic migraine is an epileptic manifestation.

G. A. WELSH.

Narcolepsy: a Contribution to the Pathology of Sleep. (Amer. Journ. Med. Sc., Feb., 1900.) *McCarthy, D. J.*

This is a critical examination of the term "Narcolepsy" to determine how far it can be called a distinctive neurosis, and how far it ranks only as a symptom of an existing pathological state. The author, while stating that the published work of Dana points to its existing as a distinct neurosis, from his own experience negatives such a theory, and states that if a careful examination of each case be made, the clinician always finds proof of an already existing definite lesion. He says that the chief causes are hysteria, epilepsy, and toxæmic states, and to exemplify these he quotes several cases of great interest. They give abundant proof that a diagnosis cannot be made till the fullest inquiry and examination has been made into the history and morbid phenomena of the case. Altogether he brings forward strong negative evidence to support his views. The first case mentioned seemed, on primary examination, to be an example of the idiopathic state, till subsequent examination revealed hysterical hypæsthesia.

In his differential diagnosis no new points are brought forward, his one aim being to teach that an exhaustive examination of every suspected case is necessary. He quotes no case where, in his experience, one of the above causes was not made out, but mentions that Dr. Weir Mitchell had such a case where post mortem, no change was found.

G. A. WELSH.

Diseases of the Optic Nerve in the Early Stage of Multiple Sclerosis [*Ueber Erkrankungen der Sehnerven im Frühstadium der multiplen Sklerose*]. (Monats. f. Psych. u. Neur., Feb., 1900.) *Bruns and Stölting.*

The writers look first at the history of the eye symptoms of the above disease. Their diagnostic value was partly recognised in the sixties. Oppenheim, in 1887, emphasised the fact that optic neuritis, accompanying a spastic spinal paralysis, was frequently a sign of multiple sclerosis. He pointed out, in 1894, that optic neuritis was occasionally the first sign of multiple sclerosis. A series of cases are given to illustrate this point. In the first case, headache, giddiness, vomiting, and fainting occurred, but no certain signs of multiple sclerosis, then a double optic neuritis and papillitis arose with marked amblyopia; this disappeared and the visual acuity returned to normal in one eye and to four sixths in the other; the neuritis was followed by definite signs of the essential disease. The second case showed as a first sign a unilateral papillitis with almost total blindness, followed by normal visual acuity and normal appearance of the fundus; other symptoms did not arise for two years. This case showed later Brown-Séquard's symptoms. The third case was a retro-bulbar neuritis without papillitis; the dimness of vision came on gradually and was attended with dyschromatopsia. The visual acuity subsequently returned to normal almost. Years intervened before other symptoms