Society Proceedings

NEW YORK PSYCHIATRICAL SOCIETY

NOVEMBER 3, 1909

The Vice-President, DR. HIRSCH, in the Chair

THE CURE OF PRE-PARETIC STATES

By C. L. Dana, M.D.

A report was given of the later history of seven cases, which Dr. Dana had presented to the society in 1905. Of the seven cases, five had continued well; one had developed melancholia and killed himself; the other had had a renewal of his primary symptoms and died from true paresis, after a remission of complete health, lasting for seven years.

Dr. Dana reported four other cases, in which the patients had shown distinct symptoms of paresis, but which had all recovered and remained well for several years.

His conclusions were that paresis was simply another phase in the life history of syphilis, and that there was no reason why it should not be arrested by proper treatment in the earlier stages, just as occurs in locomotor ataxia.

He thought that symptoms of true paresis often appear long before the characteristic lesions of the cerebral cortex occur, and cited a case in illustration in which a patient had developed noticeable changes in mentality five years before any organic symptoms appeared.

Dr. Meyer said it would be very desirable at the outset of the discussion of such an important topic to eliminate any unwarranted contrasts between neurologists and alienists, and the time when the one or the other would be able to make his diagnosis of general paralysis. The present conceptions of general paralysis held by most men are identical with those held by men like Krafft-Ebing and Oppenheim whose qualifications as neurologists as well as alienists stand above question. There is no doubt about the recurrence of far-reaching remissions in general paralysis, but also no doubt about the difficulty of definition of what should pass as general paralysis. We know with what hesitancy we approach at the present time the differential diagnosis of syphilitic vascular lesions and of various diffuse or more localized syphilitic processes, and how reluctant we must be in many cases about making a diagnosis of general paralysis. The only safe and final discrimination to-day is the anatomical differentiation. He remembered most clearly a case of tabes at the Worcester Insane Hospital, committed on account of incompatibility and flighty business ventures, for years a slightly hypochondriacal but capable worker at the institution, retained on account of epileptic attacks, and finally a decline within a few months with marked tremor, difficulty of speech, but always remarkably good insight. The autopsy showed only tabes, no cerebral infiltrations

of the general paralysis type. In all honesty we have to define this as a condition which we have no right to specify as general paralysis and which we are forced to designate as a condition of uncertain character.

In none of the cases that Dr. Dana has specified did Dr. Meyer find those symptoms which he would demand for a diagnosis of general paralysis in his hospital service. Most of them are undoubtedly cases in which he would have felt that we had no right to certainty and in which we would have to give nature and the patient the benefit of the doubt. We have, however, to-day methods of differentiation which should be made available. He only referred to the differences established between the Wassermann reaction of the blood serum and that of the cerebrospinal fluid. Where we do not get the reaction with the cerebrospinal fluid, but only with the serum, we have reasons to think of cerebral syphilis only.

In regard to the depressions and neurasthenic states, Dr. Meyer should be extremely guarded even in the presence of pleocytosis unless he should find discrepancies of judgment, even of a slight character, speech and writing disorder, tremor and reflex anomalies. With all these strictures, he nevertheless would want to express his appreciation of Dr. Dana's bringing this type of cases to discussion. We have to face them for action; whether Dr. Dana calls them pre-paretic states or Dr. Meyer preferred the term pre-diagnostic states, is a difference in nomenclature and in definition.

Dr. Carlos F. MacDonald said Dr. Dana is certainly to be commended for his optimism and for the very careful study he has made of the subject, as well as for his able presentation of it; and while Dr. MacDonald is not yet prepared to accept his view of the matter, he must say that if Dr. Dana succeeds in establishing it to the satisfaction of alienists generally, he will have made a very great step in advance in respect of our knowledge of this most formidable, most fatal and, heretofore, most hopeless of all forms of mental disease—a form of mental disorder from which there has never been an authenticated recovery.

It seems to Dr. MacDonald the whole matter hinges upon the question of diagnosis, and he confessed that it is difficult for him to realize how we can determine in a given case that it is true paresis so far in advance of the onset of the disease; that is, before there are any appreciable symptoms by which we can recognize it, or at the period which Dr. Dana characterizes as the "pre-paretic state." In other words, in cases where we may suspect the approach of paresis he failed to see how a diagnosis can be made before the disease has developed to an appreciable degree, or, if a provisional diagnosis be made, and there are no further developments, how are we to determine definitely that the case was one of true paresis or that it would have developed into that disease had no preventive measures been adopted. Alienists have long been accustomed to look upon true paresis, when the diagnosis is definitely established, as an absolutely hopeless form of disease, as regards recovery. We have also frequently observed in these cases remissions covering long periods of time, and it has occasionally occurred that such cases have been pronounced recovered, but experience has shown that they never fully recover, but that, eventually, they invariably relapse, even though they may have remained apparently well for months, or even years; so well, in fact, that they are able to live at home, under ordinary circumstances, but rarely are they able to fully resume their former relations in life, especially in a business or other capacity which involves mental strain. He recalled a case of a man, prominent in public life, which occurred early in his experience as an alienist,

in which he made a diagnosis of paresis, having found the characteristic mental and motor symptoms of the disease. He announced his diagnosis to the family and also, unfortunately, gave a positively unfavorable prognosis. Within a period of less than a year a remission occurred which lasted altogether about seven years. The friends of the patient regarded him as recovered and felt that Dr. MacDonald had made a mistake in diagnosis and, of course, in prognosis. The patient eventually relapsed and died of paresis. At that time it seemed a very exceptional case, but later experience and the observation of a large number of cases have led him to take a different view of it and he now knows that cases in which the remission is prolonged to a period of many months, or even years, are not infrequent. But these cases never fully recover. On the contrary, they invariably relapse and terminate fatally unless sooner carried off by some undercurrent disease or by an accident. We, of course, all see cases of pseudo-paresis, either of the alcoholic or luetic variety, which resemble true paresis so closely, for a time at least, that it is difficult to differentiate them from the latter disease. A certain proportion of these cases yield to treatment and make a perfect recovery, the outcome of the case oftentimes determining the diagnosis; so that, where cases of paresis are said to have been arrested or to have terminated in recovery he had regarded them as instances of mistaken diagnosis; that is, that they were either cases of pseudo-paresis or some condition other than true paresis, for he has a pretty firm conviction that no case of true paresis ever recovers.

The cases cited by Dr. Dana are certainly interesting, and the subject as presented by him is well worthy of being followed up, and it would be well if it could be established to the satisfaction of alienists that there is a "pre-paretic" stage in which the disease is recognizable and that such cases can be arrested or cured. But, as before remarked, the difficulty lies in our inability to recognize the disease before the development of any of its characteristic symptoms and to determine that it is a case of true paresis while it is yet in what Dr. Dana designates the "pre-paretic" stage.

As regards the statistics of institutions for the insane, many of them are of very little value, especially those respecting the etiology of insanity.

Dr. Campbell said he felt it a little difficult to discuss the subject of the paper without at times using words which perhaps beg the question, but he thought that in discussing this question of general paralysis in the incipient stages, one has first of all to be somewhat clear as to what one means by general paralysis. If one uses the term pre-paretic, without having shown what general paralysis means, we shall be talking at cross purposes. It is not only in the initial stages of this disorder that difficulty arises; even in the very advanced stages there are cases where one has difficulty with the diagnosis.

If one start from Alzheimer's point of view, one is on fairly solid ground; he separated a large number of cases which were clear clinically, and found in all these cases that there was a uniform anatomical finding. Therefore, in the typical cases of general paralysis which come to autopsy one expects to find anatomical changes. If in one hundred and seventy clear cases one has always found this anatomical picture, what is one going to do when in doubtful clinical cases one does not find this picture? Are we still entitled to call it general paralysis, owing to the nature of the clinical picture, or is it not better to hold the case simply in suspense unless the anatomical finding shows that the case obviously belongs to some other clinical group? If there are a certain number of cases which

go as far as autopsy, but yield anatomical findings upon which we still cannot make a diagnosis, and where the case rests in suspense, upon what ground are we to accept these cases clinically doubtful, where we have no confirmation of diagnosis by anatomical examination, to call these cases pre-paretic and to assume them to belong to the same disease, to general paralysis? To do so is to a certain extent to beg the question. If one takes the anatomical findings in general paralysis, there are in the picture the two elements, the degenerative and the inflammatory changes, and in each of these one finds variations in the different cases. In some cases the details of the picture remind us of what is found in certain cases of brain syphilis where there has not been a question of general paralysis. Therefore, even in fairly uncomplicated cases of general paralysis, the microscopical examination may point to elements in the picture itself which suggest that besides the ordinary changes of general paralysis, there is a secondary element present, or at least the whole process may be found on analysis to consist of two processes.

The earmarks which Alzheimer found always present in one hundred and seventy cases, we are entitled to use in our judgment of doubtful cases. In doubtful cases of general paralysis which come to autopsy, we often find in addition to the changes of general paralysis factors present, such as processes depending upon what we are accustomed to call definite syphilitic changes, such as Heubner's endarteritis. Therefore, one may find in cases of general paralysis syphilitic changes simultaneously present; and in that element of the anatomical picture which is termed the general paralytic element, there is frequently evidence which suggests that the process is a complicated one. Clinically we find that a patient may have had a variety of neurological incidents preceding by a very long time the development of what we consider the clinical picture of general paralysis, and at autopsy we may find that there is evidence of syphilitic changes besides the process of general paralysis. The whole clinical course, therefore, must not be looked upon simply as the progression of a unitary disease, but as a rather complicated history. Different cases may run a very similar course, but the outcome may be different, because the process of only one disease has been there, and there has been no development of the specific general paralytic process. The close similarity of the earlier stages of such divergent cases does not enable us to conclude that they should be put in the same category.

With regard to the question of the duration of the disorder, and of the value of institution statistics, Dr. Campbell did not exactly see why institution statistics should be disqualified, because after all they are the only complete statistics; the duration of the disease until death can only be determined after the day of death. Institution statistics used in the cases in which anamneses are complete are as a rule the most reliable statistics on which to estimate the duration of the disease.

Dr. Dana said he did not mean to speak disrespectfully of institutional statistics. He was speaking of this single group of very carefully worked out statistics by Dr. Green which appeared in the *Journal of Mental Science*. He is a physician in one of the Scotch asylums and these were statistics from an asylum. He published a table showing that in the young and in tabetic cases and in women, the duration of paresis is four or five years. In other cases it is shorter. Dr. Dana only meant that that kind of statistics should be supplemented by others, as Dr. Diefendorf has himself suggested.

He has much the same point of view with regard to cerebral syphilis as Dr. Hirsch. He has a conviction that we will reach a conclusion finally that cerebral syphilis is always a potential paresis and that cerebral syphilis and paresis are not very fundamentally different.

JANUARY 5, 1910

The President, DR. WILLIAM MABON, in the Chair

THE ALLEGED INCREASE OF INSANITY

By H. R. Stedman, M.D.

In a paper on this subject Dr. Stedman showed the loose and unwarranted conclusions which have led to the popular belief that insanity is increasing and emphasized the vital importance of utilizing exclusively the number of freshly occurring cases and comparing them with the size of the population at different periods in any attempt to ascertain whether or not a disease is on the increase. The most careful research by competent investigators from data at present available shows *no increase in insanity* above that which is due to the natural growth of the population.

Dr. Russell believed that Dr. Stedman was correct in saying that the data on which to form an opinion on this subject are very incomplete. The speaker endorsed what he has said, at least to the extent of saying that we are hardly justified in taking very strong ground that there has been a real increase in insanity.

We are trying to improve our methods of collecting data in this state and hope in time to be able to furnish better information than we can now.

The importance of the subject to the lay mind must be very great, for there is hardly any question asked more frequently, and the public has a right to expect a conclusive answer. It is very difficult to compare the statistics in one place with those of another. In the last report of the State Commission in Lunacy in this state, there is a comparison between New York and England. One point brought out in regard to first admissions in this study is that in this state the cases admitted for the first time to a state hospital have much less frequently had previous attacks than in the cases of English admissions. In the case of those admitted to English hospitals for the first time, there is more frequently a history of previous attacks for which they were not admitted.

Another study that might be referred to was one made by Dr. Salmon some time ago. It was an article he read at the State Conference of Charities. In this he showed that the increase in the insane in institutions in this state pertained only to foreign-born residents of the state. For the native population the increase in the number of the insane in the institutions corresponded almost exactly to the increase in the native-born population. With the foreign-born it is quite different. The proportion of foreign-born in the institutions is almost double the proportion of foreign-born in the population.

There are some facts which would indicate the increase of insanity; one is the increase of suicide. We know that quite a large proportion of suicides have some morbid mental condition and that insanity and the prevalence of suicide may be said to go hand in hand.