never absent, extending from the right to the left hypochondrium. About the sixth day jaundice makes its appearance, but gradually disappears, and is nearly gone at the end of the fifteenth day. Pain in the left side came on about the twenty-fourth day, after a severe chill; fluid was present so as to cause dyspnoea and require aspiration in seven days, a permanent opening about the forty-third. Sweating was marked during the fourth and fifth weeks with a temperature, as indicated by the thermometer, from one half to one and a half degrees below normal considerable of the time. The last two weeks there were chilly sensations most of the day, but not a distinct chill.

The autopsy showed no trouble in the abdominal cavity which could have been the starting-point of the inflammation in the portal veins. The use of quinine had no effect in controlling the chills.

Urine. The urine was examined several times by Professor Wood, each time with nearly the same result. It always contained some albumen, a few granular and blood casts, urates in great quantity, its color was of a deep red, evidently concentrated, and generally had a peculiar odor, perhaps it might be called strongly urinous. I thought the fetid pus from the side resembled it somewhat. Professor Wood suggested acute parenchymatous nephritis similar to that dependent upon blood-poisoning.

RECENT PROGRESS IN MENTAL DISEASE.

BY CHARLES F. FOLSOM, M. D.

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In the pathology of mental disease, although careful investigations are yearly adding new facts and confirming previous observations that there are always well-marked and definite changes in the brain in insanity of which paralysis is one of the symptoms and in chronic dementia, and that generally mental disease is associated with recognizable morbid conditions, which become more manifest the longer the duration of the disease, it must still be said that, except in dementia and paralysis, we know very little of the pathological conditions of the brain *giving rise to* insanity beyond the fact that they probably are chiefly cortical and diffuse rather than local.¹ In doubtful cases, therefore, there are no purely physical symptoms (pulse, temperature, etc.), which furnish strong presumptive proof of that loss of self-control which constitutes the chief distinguishing feature of insanity.

In the classification of mental diseases, the disposition to place ætiology, symptomatology, and metaphysical distinctions on a lower footing than pathology and clinical history is more and more manifest — a subject which is considered at some length, with a comparison of the systems of classification, in the JOURNAL of July 22, 1880.

In the medical jurisprudence of insanity recent cases indicate that the strictly medical-expert theory is gaining strength, especially in this country, to the manifest benefit of the criminal class, but with a more than possible danger to society, whose interest naturally lies in the direction of maintaining the highest standard of responsibility consistent with justice, safety, and humanity.

¹ For a fuller discussion of this point see the JOURNAL, July 15, 1880.

The chief advances of late years have been due primarily to efforts for better treatment — in this country directed toward following the Scotch and English methods of less restriction, and in acceding to the popular demand for more elegant hospitals, and to the wishes of the superintendents for greater ease in administration. If we may judge by the last edition of Dr. Kirkbride's book,² our changes in asylum construction during the last twenty-five years, from the patients' point of view, consist in better ventilation, heating, and opportunity for classification, and more room, air, light, cheerfulness, and means for amusement. The same statements hold good, to a less degree, however, of France.

There is great misapprehension in the United States as to what has actually been done elsewhere in giving excessive liberty to the insane, arising from the fact that people who have had very few opportunities for observation and experience, and who generalize somewhat hastily from scanty knowledge, give their conclusions to the public through the daily press with a self-confidence that begets in the minds of the community unjust condemnation of institutions, in regard to which they hear little but disparagement, and because exceptional authorities, somewhat dogmatic even if of advanced views, who advise very wide departures from the common practice, are quoted (not always correctly) as if they so fully represented all the intelligent medical opinion on insanity that those disagreeing with them were simply ignorant or knaves. As a matter of course the friends of other asylums, here and abroad, in self-defense, go to the opposite extreme and exaggerate correspondingly the comparative merits of their own systems, while the community, having no government lunacy commission to which it can refer for impartial information, being naturally distrustful of public officers, and having no means of testing for itself the truth or falsity of charges against them, believes what is asserted the most loudly.

After some careful study of this matter in Europe in 1873, 1874, 1875, 1878, and 1880, I think I am safe in saying that the public asylums of Massachusetts, with which I am most familiar in this country, are in all ways superior to the vast majority of those in France except in the matter of scientific study and experiment, while mechanical restraint is so generally adhered to throughout the new republic by the best authorities, with only here and there a rare exception, that at a recent meeting of the leading psychological society in Paris, after full discussion of the subject during four sessions, all but one of the members present were strongly in favor of mechanical restraint in the treatment of the insane. The Germans do not provide their patients so many personal comforts nor such pleasant hospitals as we give ours, but surpass all other nations in scientific research, while they are rapidly developing the non-restraint system, in some places even more absolutely than is done anywhere in England or Scotland.

The readers of the JOURNAL are already, in a general way, acquainted with the vast advances which have been made in some European asylums, more particularly in Scotland, but it is only fair to say that our attention has been drawn chiefly to hospitals which are landmarks even in their own country, and that it

² On the Construction, Organization, and Management of Hospitals for the Insane. By Thomas S. Kirkbride, M. D., LL. D. Philadelphia. 1880.

is still possible to pass a long time visiting many asylums, even in much-praised England, without any feeling but disappointment that they are not better than they are, nor so good as ours,—for our patients at least. I feel quite sure, as did Griesinger, after a most painstaking investigation, personally, in various countries, that there are decided peculiarities of climate and race, and social differences that will always prevent the adoption of any universal plan of treating insanity everywhere by a uniform rule, although I believe that Americans, Germans, Irish, French, Scotch, and English are none so perfect in this matter that they cannot study to advantage the work of the others.

In Germany an asylum for two hundred patients was finished a few years ago at Marburg in accordance with Dr. Meyer's plan¹ of several (eight in this case) entirely disconnected buildings, containing from ten to forty patients each, with open grounds, out-of-door occupation, no high-fenced airing courts nor mechanical restraint, and with the light portion of the window-sashes made of wrought iron in all but the quiet wards so as to avoid the appearance of bars. At my latest information two other asylums were building upon the same plan, and in about a dozen there was absolute disuse of mechanical restraint, Professor Westphal's wards in Berlin, with which ours have been invidiously compared, having one attendant to each three patients, or about three times as many as in our State institutions. In Belgium the vast majority of the insane are treated in asylums similar to those of other countries with a rather liberal use of restraint, several hundred being let out to peasants in Gheel to work about the farms, with now and then an ankle-chain, until very lately at least, to prevent running away or active violence, and being sent to an ordinary asylum so soon as they become unmanageable under the peasant's discipline, a method not yet followed in any other country.

Recent Scotch and English advances have been so fully described in the JOURNAL² and in the Seventh³ and Tenth⁴ Annual Reports of the State Board of Health of Massachusetts, that it is not necessary to more than briefly allude to them here. Conolly never took the position that mechanical restraint should *never* be used in the treatment of the insane, but maintained that the very rare cases where its use is desirable occur so seldom that it is possible to manage large asylums for years without once resorting to it. With very few exceptions, this was the position of English superintendents twenty-five years ago⁵ and remains the same now, as it is also in Scotland, the only real change that has taken place being, according to my observation, the abandonment on both sides of the extreme views that were advocated by a few persons in the heat of the debate on Conolly's reform, and a gradual decrease in practice of the cases in which mechanical restraint would be considered the best means of treatment. Neither Dr. Bucknill's utter discarding of mechanical

restraint under all circumstances nor, at the other extreme, Dr. Shepard's use of it in eight individuals at Colney Hatch in the course of a year, with an average daily number of a little over one thousand patients, represents any considerable body of English or Scotch medical superintendents. In the best asylums in England and Scotland not far from three fourths of the inmates are occupied, many of them profitably, some hardly being able to do more than trundle a wheel-barrow under direction; in others very few patients work, and there are all possible intermediate degrees of practice. Those amusements are encouraged, and to a greater or less extent carried out, in which the insane can themselves take part. Mechanical restraint is so rarely resorted to that it has been said, and I have no doubt with truth, that it is possible to go the whole round of English or Scotch asylums without seeing any more of it than occasionally soft mittens, or long sleeves closed at the ends which simply prevent the free use of the fingers, leaving the arms free. I have never seen any other forms in frequent visits to many of their institutions. The large panes of plate glass, and the unbarred wooden sashes first used at Rainhill, now not uncommon in England and Scotland, have the great advantage that each ward, or even room, can be managed to suit the needs of its occupants, the windows may be precisely like those of an ordinary house, they may be arranged so as to open just wide enough not to allow the passage out of the human body, or they may be protected in cases of violence by a shutter which is so concealed as ordinarily to hardly indicate its presence. It is seldom used, however, and I found on the day of my visit to Woodilee, last year, that with about five hundred patients, only sixteen had their windows protected during the previous night, and none at the time of my inspection. These shutters, although so little used, are less unsightly and prison-like than those, some of which are quite generally found closed even in the daytime, in our own State. Dr. Tuke's open-door system⁶ has been maintained at Cupar by his successors, Dr. Fraser and Dr. Brown; it has been adopted in his own private asylum, and Dr. Rutherford has extended it to every ward in his new asylum for the insane of one half the City of Glasgow, the following description of which, in his own words, seems to me quite just. Some of the attendants even have no keys, but the doors of course are always locked at night.

"A year has again passed without the occurrence of any serious accident to patients or attendants; indeed, no untoward event of any kind has occurred to disturb the harmony of the institution. . . . With three hundred and eighty-two acres of land surrounding the asylum, there can be no lack of means of employment for the patients, and of such a kind as cannot fail to still further develop those principles of treatment in which this asylum has taken a decided lead. . . .

"The nature of the work necessarily varies with the season of the year. It consists of the cultivation of the farm and garden, together with ordinary estate work, such as road-making, planting, fencing, draining, quarrying, building, etc. In quarrying, building, and conveying the materials, about forty men and their attendants have been regularly employed during the past two years. . . .

"Besides the one hundred and fifty men who work out of doors under the care of ordinary attendants, and the twelve able-bodied men who act as house cleaners

¹ A full description is given, with a sketch of the hospital and grounds, in the Archiv für Psychiatrie und Nervenkrankheiten, vii., 224.

² August 12, 1875. August 26, 1875. September 9, 1875. October 14, 1875. December 9, 1875. April 13, 1876.

³ Disease of the Mind (169 pages), by C. F. Folsom, M. D.

⁴ An Asylum or Hospital Home (29 pages), by T. S. Clouston, M. D.

⁵ Eighth Annual Report of the Lunacy Commission of England, pages 123 to 209, in which the opinions of one hundred and eighty-one medical officers, in charge of public and private asylums, are given on this point. See also the president's address before the British Medico-Psychological Association by Dr. T. L. Rogers in the Journal of Mental Science, October, 1874.

⁶ See the JOURNAL, August 12, 1875.

about thirty are employed as tailors, upholsterers, store-keepers, shoemakers, bakers, plumbers, blacksmiths, painters, joiners, engineers, and stokers, under skilled artisans, who are required primarily for necessary tradesmen's work in connection with the institution, and are attendants only in the sense that they employ the patients of their respective trades. . . .

"This full employment of the patients renders it possible to give greatly extended liberty, and to do away with all remaining forms of mechanical or chemical restraint, such as walled courts, locked doors, stimulants, narcotics, and sedatives. No airing court or inclosed space of a like nature has ever existed at this asylum. The doors of the wards open directly into the grounds, and the whole estate is the patients' exercising ground. From fuller employment and increased liberty, with their accompanying diminished manifestation of insane acts, there proceeds a greater capacity for self-control. On this principle, all the doors of this asylum were originally constructed to open with ordinary handles and without a key. An unfortunate accident occurred shortly after the opening, due to a patient escaping, not through a door, but through a window, and it was considered prudent to alter those doors opening to the grounds by removing the inside handle. Two years ago these locks were restored to their original condition, and the asylum has, as your committee are aware, since been conducted with open doors, with fewer accidents, a smaller proportion of attendants, and with fewer attempts at escape than formerly. It is with pleasure that I am able to say, that many Scotch asylums are now conducted largely on the open-door system, and some of them very largely; but Woodilee is, so far as I am aware, the only public asylum which is conducted *entirely* on the open-door system, for in it there is not even a closed ward, where so-called refractory patients are confined."

Of course it is necessary, under Dr. Rutherford's method, to have the patients kept — in herds, I was inclined to say — under the direct eye and control of the attendants, perhaps more than would be generally tolerated among Americans, who, sane or insane, are so sensitive to constant supervision as to be almost intolerant of it, and who have not all yet fully learned the difference between self-will and independence or license and liberty. As a matter of fact, the open doors of the "open-door system" mean freedom to go in and out to one fourth, or at most one third, of the patients. The others are under such close watch and direction of attendants that even in Scotland most of the superintendents consider their liberty to be quite as much restricted as by the locked doors, and regard the open doors as more useful for certain selected patients than as a system for all. The enlarged liberty now given to the insane in many asylums of Great Britain consists in substituting the watchfulness of trained attendants, with the educated self-control of the patients, for high fences and indoor seclusion, and contrary to what seems the prevalent opinion here, not in allowing irresponsible lunatics to wander about the country on parole. Dr. Sibbald's abandonment of high-fenced airing courts has been followed in Scotland universally, and to a less extent in England. In both countries fences five or six feet high are usually considered quite necessary. The fifteen hundred pauper insane boarded out in families¹ under the Lunacy Commission are

¹ See the recent Annual Reports of the Lunacy Commission of Scotland, especially Dr. Fraser's and Dr. Lawson's Reports.

in the main well cared for, and with constant supervision the plan is a thorough success, now that the difficulties of securing good attention and of preventing a certain amount of illegitimate births have been obviated. Under the advice of Mr. Mould,² of Cheadle, the medical superintendent of one of the asylums near Birmingham, the trustees have recently purchased or hired several dwelling-houses within an area of two miles of the main building, by which means it is practicable to classify and treat the patients under much more favorable conditions than formerly. To a less degree also elsewhere in England and in Scotland, pleasant houses are used, especially in the summer, for the entertainment, or as a seaside resort, of parties of patients one after another.

That an enormous improvement has taken place in the condition and behavior of the insane from these steps goes without saying. The change from 1874 to 1880 in Dr. Clouston's wards at Morningside, for example, would have seemed to me almost incredible if I had not myself seen it. The great change in Scotland is due largely to the wisdom of Sir James Cox and Dr. Arthur Mitchell, as shown in the policy³ they inaugurated in the lunacy commission of working with the utmost harmony and courtesy *with* the asylum officers rather than against them; but I fancy that still more has come from the genius of such medical superintendents as Clouston, Sibbald, Tuke, and Rutherford, even if their example has not always been followed, from the wide experience of the medical staff generally, and from the confidence of the community that the asylums will keep ahead of its just demands rather than behind them.

As already intimated, the men whose asylums are held up to us for immediate imitation are leaders in their own countries, and it is still doubtful how far their examples will be followed even at home, but Marburg, Gheel, Raiuhill, Morningside, Cupar, Woodilee, and Cheadle have important lessons, that the usual restrictions upon the lives of the insane can be very much reduced to their great benefit and with perfect safety, — a matter which is of no small importance to those who have known the misery of needlessly rigid confinement. In our country, where employment is as a rule abundant, attendants leave the asylums and seek less confining work if required to give as close attention to patients as the open system demands, and still it is almost impossible in most of our asylums to secure attendants enough, even without raising our standard of requirements. Where, too, patients require so many attentions in the way of serving food, care of clothing, etc., as ours, we need a larger proportion of attendants than in European pauper asylums, where a shirt is a shirt if only of the right size. Our rigid winters and intensely hot summers absolutely forbid for a considerable portion of the year that out-door exercise and employment which are thought in England essential to the success of the non-restraint system, and the demoralization created by confinement in-doors during January, February, and March is not easily counteracted before the burning heat of July and August excites it again. Our patients are of so many social grades

² See the Presidential Address delivered at the annual meeting of the British Medico-Psychological Society, by George W. Mould, M. R. C. S., in the Journal of Medical Sciences, October, 1880.

³ There is no better description of the workings of the Scotch Lunacy Commission than Dr. Arthur Mitchell's testimony, pages 461-490 of the Report from the Select Committee on Lunacy Law, London, 1877.

that classification to avoid want of harmony is extremely difficult; they demand more than in Great Britain that the noisy and violent be secured from annoying or injuring the quiet; they are far less willing to be obedient to authority of physicians, and especially of attendants; they require better food, nicer clothing, more little attentions; fewer of them are accustomed to manual labor or willing to "lower themselves" to it, or to "work for the State," to which their relatives and friends also often object, and a *larger proportion* of them are of the worst type of insanity, although our worst type is no worse than the worst of Scotland and England.

When I first visited Europe, in 1873, I had seen in this country from six to eight per cent. of patients in mechanical restraint; I knew cases where the camisole had been continued months or even years after its use had ceased to be necessary or best, even on the ground of its original adoption. In Professor Westphal's wards in Berlin, where mechanical restraint is never used, I saw a vigorous, well-developed young girl of about twenty held in bed by three strong young students, during a maniacal paroxysm, in a manner which seemed to me indelicate and on other grounds objectionable, but with the merit that it was discontinued immediately it was not needed. Coming back to the United States I found in one hospital six women wearing strong camisoles and bound in chairs, the feet of three not resting upon the floor or anything else; in another, out of three hundred patients, six were in iron handcuffs, and three were fastened by a few iron links to the wall or to chairs in which they were put. Visiting England again, I found that what seemed to me dangerous doses of morphine, hyoscyamine, and digitalis were not seldom used in place of mechanical restraint, although with many of their best men that I could mention such was not the case, less drugs, if anything, being used than here. I thought there was in some asylums indication of violence which might have been easily prevented by mechanical restraint. Certainly, an occasional patient running about half-naked and shivering in a temperature of 60° F., or exhausted to the point of inability to fairly stand, or clothed by day and covered at night with thick duck quilted almost to virtual indestructibility, or kept several hours together in a cold bath, would suggest to advocates of the judicious use of mechanical restraint some justification of their method of treatment. After my return I found an insane man who had worn iron handcuffs day and night for several years, and another with iron handcuffs fastened to an iron chain around his waist, which were removed twice a week for a change of the clothing that he wore day and night. All these cases of exercise of mechanical restraint which I have mentioned are, in my experience, common enough in the treatment of the troublesome insane in almshouses, and very exceptional in the asylums of this country, as extreme drugging is said to be in England; but still it seemed to me that a system capable of such abuse, and indicating what, from my stand-point, was an entirely wrong conception of insanity, to say nothing of those institutions where mechanical restraint is habitually used by the attendants and not by the medical officers, should be abandoned; and yet I remember that when in Germany and England there appeared to be so many serious objections to the dogmatic adherence to "non-restraint" that the *judicious use* as a *medical prescription* in rare cases of the least objec-

tionable forms of mechanical restraint seemed on the whole best. After all, such matters depend more upon the manner of the observance of the rule than upon the rule itself to an extent which is not always indicated in printed reports or revealed to any other than expert visitors. The advocates of non-restraint admit that there are cases where individual patients might have been better treated with mechanical restraint, but maintain that the moral effect on the others is better for its absolute, or nearly absolute, disuse. They show, too, that the system of non-restraint has been an educational one upon the medical staff and attendants, by requiring them to devise substitutes for mechanical restraint in occupation, diversion, and careful medical treatment. So far they are certainly right, and with all the faults of their system it seems to me clearly better than that generally, but not universally, practiced in the United States.

We have passed the time when theory and speculation are most useful in treating this whole question, and must now await the teachings of experience. The asylums of this country and France and, to a less extent, those of Germany and parts of England can do much more than they are now doing in enlarging the freedom of the insane; we all can add to their means of comfort and happiness, and possibly raise the percentage of recoveries. In such climates as ours we should be obliged to exercise our utmost ingenuity to devise in-door occupation for the worst parts of the year, and with our people we would require more attendants. Those of our hospitals needing more and better-trained physicians will supply that want with the general elevation of the standard of medical education in our colleges and universities.

Whether or not we go as far as Dr. Clouston or Dr. Rutherford would advise, we cannot proceed far in increasing the liberties of our insane without educating the community to look upon mental disorder as a disease which is to be treated upon the principles of medical science and common sense, and to regard insane persons as pretty much like other people, with narrower powers of self-guidance and self-control, as they now persistently refuse to do. People must learn that it is wrong, as well as unwise, to lie to them, and the abominably wicked deception pretty uniformly practiced towards them outside of asylums must be given up for fair dealing. The insane must believe that they will be treated at least honestly, and when sent to an asylum committed in an honorable, straightforward manner, and not entrapped by underhand devices. Attendants must become accustomed to the new order of things. The doctors have before them the long, tedious work of overcoming the natural suspicion of those patients who feel that they have been cheated by their friends and caught in the hospital trap, of organizing a vast work with insufficient means in the face of unjust popular distrust, and of attempting to educate into some sort of habits of self-help the old asylum boarders, in whom years of mental and physical inactivity have produced corresponding helplessness and loss of power of self-restraint, to the demoralization of those newly committed, — all this, beside living and working among people many of whom have lost comparatively little in intellectual capacity while so given over to the violence of evil passions and impulses as to make them, not seldom, in the highest degree dangerous and even homicidal unless under proper control, and all of whom have been sent to the

asylum because they were beyond the capacity of treatment outside. It lies in the power of the community and of the State to either help or hinder the solution of this difficult problem.

The duty of the State in this matter is one which is engaging more and more the public attention each year, and the more any country has already done for the protection of its insane, the higher is its standard raised for future work. In England, during the past few years, there has been a strong movement for better safeguards against improper commitments to insane asylums, and for "an efficient and sufficient inspection of asylums such as this country has never yet enjoyed."¹ An intense opposition has arisen, too, in the medical profession and outside of it, to the asylums which are not directly controlled by the State, on the ground that "the business of the boarding-house" conflicts with the best interests of the patients,² a danger far less in the United States than in Europe, but one which can be fully provided for in either country by efficient State inspection. The feeling in this country, at least, is very decided that private asylums are not only useful but very much needed, and certainly there is no more danger that the superintendents of them will not adopt the best methods for the early cure of their patients than that other professional men will fail to see that their true interest lies in doing well and speedily whatever they undertake to do.

Hospital Practice and Clinical Memoranda.

BOSTON CITY HOSPITAL.

CASES UNDER THE CARE OF DR. R. T. EDES.

PROBABLE SECONDARY DEGENERATION OF LATERAL COLUMNS OF CORD. EXAGGERATED REFLEXES.

CASE I. Alexander D., aged sixty-one, laborer. During the last year has had pain in left hip, knee, and outer side of foot. Slight headache referred to right frontal and right occipital region.

Refers to some previous occasion when he had a sudden attack of pain but says he was not paralyzed. (It is difficult to disentangle this story from that about the cataracts which were operated upon four years ago.) The want of clearness is, however, so far as one can judge from continued conversation, rather a congenital trait than a symptom connected with his present trouble.

Patella reflex is exaggerated on both sides, but rather more upon the left. The ankle clonus is very well marked; ordinary reflex is exaggerated; he walks with the assistance of a cane, but with the "clinging" gait of spastic paralysis; the left leg weaker than the right; a very distinct reflex can be obtained from the tendon of the triceps extensor cubiti. Discharged relieved.

SUDDEN ATTACK OF HEMIANÆSTHESIA WITH SLIGHT MOTOR PARALYSIS; INCREASED TENDON REFLEX ON THE AFFECTED SIDE; DIMINISHED SWEATING ON THE AFFECTED SIDE; IMPROVEMENT WITHOUT ACTIVE TREATMENT.

CASE II. Peter O., aged forty-one. March 17th. Ten years ago had a chancre. Is a drinking man. Last January, the next day after shoveling snow, when he

¹ The Lancet, December 4, 1880.

² Ibid.

was exposed to cold, began to notice numbness in right arm and leg, which has continued to the present time; diminution of power in same limbs; no pain.

March 18th. Tactile anæsthesia in right hand is very decided, two points being felt as one at one and one half inches apart; sensibility in right foot is diminished; ordinary sensation seems the same on both sides of the face, but says he does not feel any sensation in shaving on right side of face; sensibility to pain diminished on that side; the same condition of hemianæsthesia exists on the trunk; power of coördination diminished in right hand.

On the anæsthetic side, patella tendon reflex is much increased and ankle clonus is very decided; sensibility to Faradism not materially changed.

March 19th. Says he has more pain on right side than on left, and has a pricking sensation like pins and needles.

March 21st. Temperature of surface on both sides is the same as measured on thorax and on face.

Says that he does not sweat on paralyzed side; one quarter of a grain of pilocarpin was given subcutaneously causing profuse sweating; there was, however, a decided difference between the two sides, the anæsthetic (right) being very moist, while on the other the perspiration ran off in drops and streams; the temperature was at this time a little higher on the left side of thorax.

March 28th. Thinks he uses his leg better and that it has more feeling in it; the hand is also better; sensation, however, is still obscure.

April 11th. Discharged relieved, thinking that he is able to go to work.

Returned to the hospital about October 1st. Has been at work as a gardener through the summer. Now has a return of about the same symptoms.

GENERAL PARALYSIS; HEMIPARESIS; TENDON REFLEX NORMAL ON THE PARETIC SIDE, ABSENT UPON THE (COMPARATIVELY) NORMAL SIDE.

CASE III. Eben R., aged forty-six, was "dumped" at the hospital without a history. He answers questions well enough but it is difficult to get a very connected story from him. He has been employed in a hotel, but it is not clear in what capacity, whether as engineer or cook.

He complains only of weakness; says he was well up to a few days ago when he vomited, which he attributes to the irregular habits and abundant opportunities for eating incident to his occupation.

His manner is peculiar; expresses himself as satisfied with everything about him, including his own condition, although he is weak and passes his urine in bed; is at times delirious; a little slurring of some of his words.

A few days after entering there was apparent a decided weakness of the right hand, which he could not put on top of his head, and the movement of the facial muscles about the mouth was a little less marked on the right side.

In the absence of history of previous disease it was remarked at a clinical lecture that although it was possible that his mental and bodily condition might be the result of a slight hemiplegia, or rather a localized lesion giving rise to a hemiplegia, yet the probability was strongly in favor of "general paralysis." It was then found that friends had recently visited him who stated that he had not been in his right mind for some years,