

tion of the head and eyes and allied phenomena, there was invariably a lesion of the vestibular nerve, the vestibular nuclei or posterior longitudinal bundle.

He had not made microscopic studies of the lesions. He could observe, however, that in small lesions the animal fell to one side, or turned its head to one side whereas in large lesions they turned around. He was convinced that the position in the case was due to some pressure on the left side. He thought the diminution of the reflexes was best explained by the theory that the cerebellum functionates as a checking organ on the motor centers of the cerebrum.

DR. PETER BASOE asked if the cranial nerve symptoms were not very frequently due to hydrocephalus. In many cases of cerebellar tumor there had been so much hydrocephalus that it was easy to explain the involvement of the cranial nerve by the stretching of the nerves from the downward pressure.

DR. HUGH T. PATRICK was of the opinion that cranial nerve involvement in tumors and cysts of the cerebellum was to be accounted for on mechanical grounds.

DR. GEORGE B. HASSIN, in closing, said he wished to point out the regularity with which the cranial nerves were involved in cysts of the cerebellum, especially in cases not advanced. He did not agree with the explanation given by Dr. Meyers regarding the abnormal position of the body. The forced position of a patient with a cerebellar cyst was not the result of a disturbed cerebellar function, being rather a matter of comfort for the patient. He feels less distressed when lying on the diseased side, as a position on the healthy side causes increased pressure on the aqueduct of sylvius and greater distress.

The hydrocephalus could not be considered the cause of the multiple nerve involvement, because out of the three cases demonstrated only one showed a hydrocephalus which was unilateral and very slight. On the other hand, a regular cranial nerve involvement did not occur in hydrocephalus associated with other brain lesions.

As cerebellar cysts usually bring about an extensive and even complete destruction of whole lobes of the cerebellum, they could be utilized for the purpose of studying the clinical symptoms resulting from such a destruction. Solid tumors were less adapted, as they usually leave a larger portion of the cerebellar tissue comparatively intact.

BOSTON SOCIETY OF PSYCHIATRY AND NEUROLOGY

Regular Meeting, March 20, 1919

GEORGE A. WATERMAN, M.D., *President*

A NOTE ON DR. SOUTHARD'S ORDER OF EXCLUSION IN DIAGNOSIS. Presented by DR. LAWSON G. LOWREY.

DR. LOWREY stated that in mental diseases there is no definite system of presenting symptoms, but in considering any one case it is possible to narrow the possible diagnoses down to two or three groups. Dr. Southard has presented a scheme of diagnoses that contains eleven groups. Another possible order of grouping is one based on statistical frequency. This method would

result in different orders in different institutions, and is therefore objectionable. A better basis is one founded on etiologic factors.

Dr. Lowrey agreed with Dr. Southard as to the first four groups: the syphilopsychoses, the hypophrenoses, the epileptoses, and the pharmacopsychoses. In the last five groups, he also agreed: the geriopsychoses, the schizophrenoses, the cyclothymoses, the psychoneuroses, and the psychopathoses. As a fifth group, Dr. Southard has the encephalopsychoses, and as a sixth group the somatopsychoses. Dr. Lowrey thought that a reversal of this order is clearer, more logical, and simpler for teaching. He therefore suggested that the fifth group should be the somatopsychoses, and the sixth group the encephalopsychoses.

DISCUSSION

Dr. ELMER E. SOUTHARD stated that the grouping that he had made was not based on a teaching consideration, but on reliability of tests of differentiation. The first four groups are social groups, the fifth concerns the neurologists, the sixth the problems of internal medicine. Such a grouping has the disadvantage of bringing into juxtaposition certain cases that might better be more widely separated. He had considered the order that Dr. Lowrey suggested and recognized the arguments for the transposition. The exact sequence of the grouping he thought less important than the acceptance of a definite classification.

A CASE OF ENCEPHALITIS LETHARGICA. Presented by Dr. CHARLES A. McDONALD.

A case reported in brief and diagnosed as encephalitis lethargica, showing signs characteristic of this disease as described by Von Economo, Netter and Smith. The patient had cranial nerve involvement as shown by ptosis and diplopia. The lethargy was the initial and presenting symptom—mild at first—increasing in severity until she was comatose before death. Until the last two days of her illness she could be roused when she would be found to be oriented. In addition she had absent deeper reflexes. No Babinski sign. No bladder disturbance. White blood cell count a little less than 10,000 and spinal fluid within variation. Necropsy showed a general increased vascularity with no evidence of meningitis.

THE QUESTIONS OF DURATION OF ATTACK AND RECURRENCE IN MANIC-DEPRESSIVE INSANITY. Presented by Dr. JOHN B. MACDONALD.

The problems of prognosis, duration of phase, length of interval, and recurrence in manic-depressive insanity were considered; also the light thrown on these problems by a study of 450 cases of this disease at the Danvers State Hospital. As to age periods, thirty-six males and eighty females, totaling 116, or 25.7 per cent., were 25 years or younger in age. Forty-four males and 132 females, totaling 176, or 39.1 per cent., were mature, namely, 25 to 40 years old. Forty-seven males and 100 females, totaling 147, or 32.5 per cent., were climacteric, that is, 40 to 60 years old. And four males, and eight females, totaling twelve, or 2.3 per cent., were postclimacteric, that is, 60 or more years old. Depression was the most frequent initial phase, being nearly twice as

common as manic or mixed types. When the initial attack was depression the second attack recurred with men in about 10.6 years, and with women in 10.9 years, but with an initial manic or mixed attack the average interval of recurrence in men was 6.1 years and in women 6.5 years.

On the other hand, the average duration of attack was considerably longer in the depressed cases. Only 62 per cent. of the depressed cases discharged recovered in six months, while 79 per cent. of the manic cases were so discharged. The recovery curve for manics reached its height between the fifth and sixth month; for depressions, between the seventh and eighth, when the initial attack occurred below the age of 40.

Beyond the age of 40 permanent recoveries were rare from first attacks.

Apparently it is most difficult for the manic-depressive case occurring after 40 to realize that he has passed the zenith of his powers, and that his plane of accomplishment is on a lower level.

In 295 of the 450 cases recurrences occurred. In 100 cases all the attacks were of the depressed type; in 128 all were manic.

To gain an idea of the tendency toward establishment of the complete manic-depressive cycle, a review was made of 100 cases in which the completed life history was known. Of these, seventy-eight showed in one or more attacks a variation of type, namely, a completion of cycle; twenty-two presented attacks of one general type throughout, but differing in duration and intensity. Of those showing uniformity of phase in all attacks almost two thirds were depressions.

In the case of depression, the extremes of duration of free intervals after first attacks varied from forty-four to two years for females and twenty-eight to two years for males. Following initial manic attacks, the extremes for females were twenty-eight and two years, and for males thirty-nine and one years.

Between the extremes mentioned, individual cases presented a bewildering variation of interval durations. Given certain antecedents, certain consequences do not uniformly follow in manic-depressive disease.

DISCUSSION

DR. H. R. STEDMAN asked the reader as to how many cases of recurrent paranoid conditions he had seen. He also asked regarding seasonal variations, and the possible influence of the season as a factor governing the recurrence.

DR. E. B. LANE stated that he had seen cases that completed a double cycle in a year. Environment played little part in the production of the condition. He thought that some somatic factor played a decisive part.

DR. E. E. SOUTHARD asked whether the analysis shed light on the problem as to whether manic-depressive insanity is a psychosis or a group of psychoses. Is Kraepelin to be credited for a new disease or merely a synthesis of disease? Would a study of heredity help?

DR. MACDONALD (closing the discussion) said that many of the cases did not seem to be distinct entities. He thought that the condition was probably a group of conditions. Completion of cycle was shown in seventy-eight out of 100 cases.