

There was some evidences of psychopathic tendencies in the form of effeminateness. Patient was awakened from sleeping attacks by slight noises and he remembered having fallen asleep. There were no disturbances of intelligence nor symptoms of epileptic character. The narcolepsy was probably a neurosis sui generis, originating on a degenerative foundation. The second case was not one of genuine epilepsy, but rather an hysterical sleeping fit, presenting fundamental differences from genuine epilepsy—prolonged attacks, amnesia, difficulty in awakening, drowsiness after waking, and the conditions could not be distinguished from drowsy stupor. The author is of the opinion that the name narcolepsy should be reserved for cases of the first type, which in many respects reach an epileptic equivalent, though narcolepsy seems to present a separate clinical and nosological entity. The concept does not apply to sleeping states of other character, as drowsy stupor, attacks of unconsciousness, etc. [J.]

Heilig, G. EPILEPSY AND AFFECTIVE PSYCHOSES AFTER BRAIN INJURY. [Zeitschr. f. d. ges. Neurol. u. Psychiat., Vol. XXXVII, p. 92.]

The author reports a case of injury of the left brain hemisphere with hemiparesis on the right side. One half year later the first epileptic attack made its appearance, and was followed by others. Nine months after the injury the first psychic disturbances made their appearance following a renewed seizure, in the form of a severe anxiety psychosis. The excitement subsided gradually, but in place of it hallucinations of hearing set in, and at this time the patient was seized with renewed epileptiform attacks. These epileptic seizures are to be regarded as a result of the brain injury, and the spasms, corresponding to the localization of the brain lesion, had none of the characteristics of the Jacksonian type. The author is of the opinion that an epileptic diathesis in the patient is evidenced by a long-standing tendency to left-handedness, and under the irritation of the cicatrix of the wound the seizures made their appearance. The affective psychoses the author also traces to the brain injury; the hallucinations of hearing being referred to pathological stimulation in the acoustic sphere (from the injury of the temporal brain). The patient had a degree of insight into the cause of these hallucinations. Disturbances of circulation arising from the brain wound may have caused the depressive anxious excitements—a condition often met with by the author in patients suffering from brain wounds. [J.]

Siebert, H. CONCERNING EPILEPSY. [Deutsche Ztschr. f. Nervenhe., Vol. LX, p. 260.]

The author states that in the great majority of cases there is no evidence of an organic or material injury of the central nervous system in epilepsy. Discussing the relation of epilepsy to trauma and syphilis, he emphasizes that although the physician in the field hospital is in a

position to determine the nature and localization of the trauma after which the epileptic attacks made their appearance, he is not always in a position to know what other contributing factors were active in the nervous systems of those who develop epileptic seizures after injuries. In the author's opinion there can be no doubt that genuine epilepsy occurs in acquired and congenital syphilis, though it is very difficult to understand how periodic paroxysms can arise from localized lesions, and how, under these circumstances, there can be intervening periods with freedom from symptoms. A case is described of a girl, twenty years of age, in whom what seemed to be genuine epilepsy developed. When the disease had continued for two years a hemiplegia made its appearance after an epileptic seizure, which receded again in a year, leaving a spastic condition of the extremities, absence of abdominal reflexes, nystagmus, atrophy of tongue on the left, amaurosis of the right eye—results which justify the diagnosis of multiple sclerosis, and this disease must be assumed to have been the cause of the epileptic attacks. As the cause of each attack an acute swelling of the brain may be assumed, producing the paroxysms by general irritation. [J.]

Marsh, Chester A. PSYCHOLOGICAL THEORY OF EPILEPSY. [Am. J]. Med. Sc., 1920, 149, p. 450.]

Epilepsy should be looked upon as a mental disorder. Its complex phenomena of loss of consciousness and a convulsive reaction is an abnormal muscular expression of strong mental activity. It becomes the habitual abnormal outlet for pent-up mental energy in an individual, with a definitely peculiar mental make-up, who meets unsurmountable difficulties. These difficulties may be purely mental stress or the result of some process of disease which the individual suffers. It makes little difference what the attack happens to be. The body as a living organism resents any form of infringement upon its welfare, whether it be a mental or physical attack, or both. This is more readily understood when by careful analysis we study the mental characteristics of the epileptics, comparing it to normal mental activity. Mental life is primarily teleological. Our inner faculties, that is, our instinct and ways of thinking, feeling, or desiring, come to us when things interest or excite us, and they act as the motive power which, when directed in natural channels, serves to secure our common welfare and safety. These feelings may, however, when improperly directed, find expression in an abnormal manner, and if habitually exercised in this way, may lead to the possessor's destruction. With such motive force calling for expression, one or more of the following results may be expected: Wanting to do or get something, a person may, first, be successful in every undertaking; second, unsuccessful, he may think life is then not worth while, so commit suicide; third, unsuccessful, he may escape the intolerable situation to one made more tolerable in a state of insanity, where halluci-