

Original Articles.

TWO CASES OF CHRONIC ALCOHOLISM.¹

BY W. A. GORTON, M.D.,
Superintendent Danvers Lunatic Hospital.

OF the toxic neuroses, those produced by alcohol are probably among the most frequent, as they are certainly among the most interesting. So diverse have been the clinical phenomena attending their development, that until within a comparatively short period only a vague and general classification of them has been made, and it seems highly probable that many cases of nervous disorder have been erroneously attributed to other than alcoholic influences. The various forms of mental disorder produced by continued indulgence in the use of alcoholic drinks might be dwelt upon with some interest, and, perhaps, with profit, but the cases I have selected are chosen mainly to illustrate the complex character of what is generally called "Chronic Alcoholism."

A. H. J., male, aged thirty-four, married, native of United States, a milk-dealer by occupation, was admitted to the Danvers Lunatic Hospital, November 22, 1883. His friends stated that he had been a man of good bodily health and good mental capacity. Heredity good. For several years he had been very intemperate, and had indulged in venereal excesses. Seemed in perfect bodily health until August, 1882, or about fifteen months prior to admission, when he had what was called an attack of sciatica, which affected the right side principally, though pain was experienced on both sides, and which lasted about two months, confining him to bed most of this time. Experienced severe pain in his limbs during almost the whole period, but showed no mental symptoms. At the end of two months he had sufficiently recovered to resume his business and to renew his alcoholic and venereal indulgences. He continued in a condition which enabled him to attend to his work until July, 1883, although he suffered at times from neuralgic pains in his limbs. In July, 1883, or about three months before admission, he complained of being ill, suffered from the old pain in the limbs, but showed no special muscular weakness, although he fell from his wagon shortly before he gave up work. At this time he showed no mental symptoms that attracted the attention of his family, nor did he complain of any difficulty of hearing, vision or locomotion. He continued to drink to excess until August, when he began to show mental disturbance in the way of forgetfulness, incapacity for work and indifference to surroundings. At this time it was first noticed by the family that his gait was getting to be clumsy and unsteady. From this time until he entered the hospital he failed in all respects, becoming much demented and almost helpless from increasing feebleness of the lower limbs. He had no vesical or rectal paresis, and no fits. There was no direct history of syphilis. Examination on admission gave the following notes: man of medium height, well built but imperfectly nourished. Pupils are large in size, respond sluggishly. Tongue points to right and shows marked gross and fibrillary tremor. There is no appreciable lesion of heart or lungs, though the cardiac sounds are weak and the

pulse rapid, 144. Temperature normal. Is scarcely able to walk, gait showing extreme ataxia. Stands with eyes closed, but does so with extreme difficulty. Nutrition of limbs fair. The patellar reflex appears to be about normal on the left side, but is scarcely perceptible on the right. Cutaneous reflex apparently normal. Cutaneous sensibility apparently normal. Moves arms and uses hands without notable embarrassment. Speech incoherent, but articulation is not perceptibly impaired. Mentally is greatly confused, does not know where he is, cannot tell day of week or month. Seems greatly elated, but does not reveal delusions of grandeur. Mistakes identity of those about him. During the fortnight following his admission patient underwent no particular change. Was unable to walk without assistance, and passed much of the time in bed. Mental confusion persisted. Received no medicine. After this, patient began to improve, both mentally and physically, and two months after admission it is noted that he has become much clearer mentally, and is able to assist in ward work. Is childish in manner, memory is impaired and he has numerous delusions of identity. Says he feels well, has no pain, and thinks he ought to go home. Gait is slightly ataxic, but he gets about quite easily. In April, five months after admission, he had recovered almost completely from ataxic symptoms, and had gained greatly in general strength. Still showed delusions of identity, and thought he had discovered a new way to preserve meat and milk, which, when patented, would make his fortune. Improvement was progressive, and at the end of a year he had become able to do regular and hard work without fatigue, and had in great measure lost his delusions, though he was still uncertain about the identity of certain people about the hospital. Had had no neuralgic attack since admission. Fifteen months after admission he was discharged; has since remained well as far as is known, though I have not seen him for a year, but at that time he was in vigorous physical health and had no delusions.

The second case is that of a male, single, age thirty-five. A commercial traveler by occupation. Of good mental capacity and good physical health until he broke down from prolonged dissipation. Though very intemperate he had been able to support himself until the year preceding his admission, during which he was, for the most part, unable to work. In the spring of 1885 had reached such a state of mental, moral and physical degradation that he was placed in the Washingtonian Home for treatment, from which place he was transferred to the Danvers Lunatic Hospital, July 23, 1885, as a dipsomaniac. On admission he was found to be practically helpless from well-developed paresis of both lower extremities, and his condition indicated great physical prostration. Complete examination disclosed a large bed sore just above the left gluteal region, in the center of which was a large dark and offensive slough, and a smaller sore, apparently of more recent development, on the left knee. Was wholly unable to stand, but by great effort could partly flex the limbs. The cutaneous sensibility in both legs was found to be delayed but not markedly diminished. There was absence of the patellar reflex and of ankle clonus on both sides. Muscles of both limbs were flabby, and the general contour was indicative of atrophy. The respiration was accelerated and labored. Voice sounds weak and articulation difficult

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and explosive in character. Incomplete paralysis of bladder and rectum. Was mildly delirious. Talked in a calm, self-satisfied way, but had many delusions of identity, and did not know where he was. Thought he would be all right if allowed to get up and dress himself and take a little exercise. Said he had been paralyzed once before from syphilis, which he contracted at the age of eighteen, seventeen years before admission. Pulse 98, temperature 98°. For a week there was no perceptible change in his condition. Was mildly delirious, restless, and troublesome. Began to complain of pains in his limbs, which were partly due to the bed sore, which involved the greater portion of the left gluteus maximus muscle, and partly to some other cause, which was thought to be possibly syphilitic and he was given K. I. gr. xv. t. i. d., with hypnotics and anodynes at night. At the end of a month he had undergone slight improvement, but was still in a state of great exhaustion. Had acquired a certain amount of power in the lower limbs, the respiratory embarrassment had diminished, the vesical and rectal paresis had disappeared, the cutaneous sensibility was no longer delayed, and the bed sore had commenced to heal. Still showed loss of memory, with the same fleeting delusions of identity. Begged almost constantly for whiskey, which he thought would at once restore him to the full possession of all his faculties. Had taken it pretty freely with egg and milk, from the time he was admitted. At this time he was given hydrarg. protiod., grs. $\frac{1}{2}$ t. i. d. During the next month improvement was quite rapid, he had become able to walk, but his gait was unsteady, respiratory embarrassment had wholly abated, and he seemed rational and appreciative. Unfortunately no record of the condition of the patellar reflex was now made. On the 4th day of November, 1885, or nearly four months from the date of admission, he had apparently made a complete recovery. He declared that he felt as well as ever; and at any rate he was well enough to run away from the hospital and make good his way to Cambridge, since which time nothing has been heard from him. The decided paresis, the bad muscular nutrition, the acute bed sore, the delayed sensibility, and the rectal and vesical paresis, induced me to make the diagnosis of acute myelitis, but with the qualification that the case was one of chronic alcoholism, and that a long time must be allowed to elapse before a positive opinion could be given. I am aware that the syphilitic element of the case is not to be overlooked, but after a lapse of seventeen years, during which the patient declared he had taken mercury enough to sink him, it seemed a little less likely that syphilis was the cause of his trouble, than his continued indulgence in alcohol almost up to the commencement of the attack.

I am aware that the foregoing histories are incomplete in many respects, but they were made when the patient, owing to the great amount of mental disorder present, could give no assistance, and with no special reference to being used in subsequent reports. Similar cases have been numerous reported and diversely explained, but it seems to me that these two at least come within the descriptions of alcoholic neuritis and paralysis with which the German periodicals of the past year have been largely filled, a most excellent *résumé* of which, made by Dr. Knapp, may be found in the *Boston Medical and Surgical Journal* for September 16, 1886.

THE APPEARANCE OF INTERMITTENT FEVER NEAR THE NEPONSET RIVER.¹

BY J. S. GREENE, M.D., OF DORCHESTER, MASS.

WHEN the causes of disease are studied in the presence of a wide-spread epidemic, or where endemic phenomena prevail over a large territory, the abundance of material gives advantages too obvious to need particularising; yet this very abundance may prove a source of perplexity. It becomes necessary to recognize and estimate the power of counter-active or intensifying influences. Evidence collected from many and various sources has to be weighed and sifted. The value of the work depends much on the judgment as well as the industry of the worker; for he has both to collate and arrange facts and opinions, and to sum up his conclusions with judicial fairness.

Such, on intermittent fever, was preëminently the work of Holmes fifty years ago; and such are the quite recent papers on the same subject by the Drs. Adams. Far less ambitious is the mere reporter's work of describing those things only which his own eyes have seen; yet his few facts, in their very simplicity, may have some significance to justify their presentation. Such is my humble and easy task, and such my apology.

In a practice of twenty-three years I have not known a case of intermittent fever in Dorchester nor Milton, until within the last four years, *except such as have been imported* from malarial localities. Other physicians say that they have seen no indigenous cases. Dr. Benjamin Cushing remembers to have heard his uncle, Dr. Thaxter, say that he had one such case in Dorchester. Perhaps it would not be too sweeping a statement to say, that with barely an exception, the cases which I shall mention are the only instances of intermittent fever ever known to have had their origin on the soil of Dorchester or Milton. I have seen seven thorough-going cases in four different localities — two in Dorchester and two in Milton. Besides these I have seen two cases of uncertain etiology, which being each resident under one or other of the four roofs covering the undoubted cases, I suspect of partaking the infection. Dr. M. V. Pierce, of Milton, has lately seen a case.

I will now mention the several cases, and briefly describe the places where they occurred.

The first case was in September, 1882, in the person of a man whom I had known for years as a laborer in Milton, at the skin-shops, so called, where fleeces are washed. Here he had developed so characteristic a case of tertian intermittent that I formed a probable diagnosis from his aspect, as I saw him approaching my house. He was an Irishman, about thirty-five years of age, previously healthy and able-bodied. At the time of his attack he was living on the first floor of his house and his roof was leaky. Afterwards the roof was repaired, and he moved to the second floor.

This wool-yard forms part of a relatively low-lying level tract of seventy-five or a hundred acres extent, between Milton Hill and the elevated land to the westward, where stand the churches and public buildings of Milton. Through this intervalle flow the pure waters of Pine Tree Brook, which empties into the Neponset a short distance below the eastern bor-

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