

Critical Digest.

NEURASTHENIA.

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LIKE hysteria, with which indeed it has many points of relationship, neurasthenia adds to its domain from day to day. Is it that these limits are still undefined, and that a certain number of cases of obscure and doubtful nature are often attributed to it? Or does this increase come rather from the fact that physicians better understand this new disease and recognise its presence in cases where formerly nothing but the appearance, not to say simulation, of disease was believed to exist? Finally, is this neurosis actually more widely distributed as a result of the rapid strides of our civilization? for this advance entails a certain degree of overstrain, and of this, neurasthenia may reasonably be considered the expression.

All these reasons may be appealed to with more or less justice; but whatever be the value of the explanation neurasthenia is none the less tending to occupy a predominant place in neuropathology. This position it owes to the almost unlimited number of its manifestations, to the protean diversity of its appearances, to the complications of its relationships, and finally, to the troublesome tendency recognised in it of "regenerating degenerescence" if such an expression may be allowed: this we shall have to explain later on.

History.—The literature of neurasthenia, however, is relatively poor; not so much because the disease which it represents is, up to the present, wanting in an anatomical substratum proper to it, but because it is destitute of the objective signs which experimental medicine of our times more particularly affects.

In 1869, Beard¹ gave the name of neurasthenia to a nervous state hitherto described under various designations. Among the many names which have been used, we shall mention among others the spinal irritation of Frank,² the neurospasmia of Brachet,³ the general neuralgia of Valleix,⁴ the protean neurosis of Cerise,⁵ the general hyperæsthesia of Monneret,⁶ the nervous state of M. Sandras,⁷ and the nervosism of M. Bouchut.⁸ The new teaching of Beard was not, however, at once accepted; for Krishaber⁹ presented his cerebro-cardiac neuropathy as a separate disease, and yet its history clearly corresponds to neurasthenia. In reality it is only from the latest and more complete memoirs of Beard¹⁰ that the real differentiation of neurasthenia from the numerous, more or less similar nervous conditions hitherto confounded with it, and its promotion to the rank of a separate morbid entity, date.

Among the later works exclusively occupied with this morbid condition there is, first of all, a short memoir by Jewell,¹¹ who scarcely does more than comment on the work of his fellow-countryman. On the contrary, the article entitled *Neurasthenia*, written almost entirely by M. Huchard,¹² in the *Traité des névroses* by Axenfeld, constituted, at least in France the first complete didactic work upon this subject. Weir Mitchell¹³ next described a particular form of neurasthenia in women, and he insisted especially on the value of

¹ BEARD. *Boston Med. and Surg.*, 30 Avril, 1869.

² FRANK. *De Neuralgia et Neuritide. Univers. praxeos medic. præcipit.* Leips., 1821.

³ BRACHET. *Recherches sur la nature et le siège de l'hystérie et de l'hypochondrie et sur l'analogie et la différence de ces maladies*, Paris, 1832.

⁴ VALLEIX. *Traité des névralgies et affections des nerfs*, Paris, 1841.

⁵ CERISE. *Des fonctions et des maladies nerveuses*, Paris, 1842.

⁶ MONNERET. *Traité de pathologie générale*, Paris, 1857, t. I., p. 420.

⁷ SANDRAS. *Traité pratique des maladies nerveuses*, Paris, 1860, t. I.

⁸ BOUCHUT. *De l'état nerveux aigu et chronique ou nervosisme*, Paris, 1860.

⁹ KRISHABER. *De la névropathie cérébro-cardiaque*, Paris, 1873.

¹⁰ BEARD. *Neurasthenia (nervous exhaustion). Its nature, symptoms, and treatment*, New York, 1880.—Its causes and consequences, *American Nervousness*, New York, 1881.

¹¹ JEWELL. The varieties and cause of Neurasthenia, *The Jour. on nerv. and ment. dis.*, Chichago, janvier, 1880.

¹² AXENFELD et HUCHARD. *Traité des névroses*, Paris, 1883.

¹³ WEIR MITCHELL. *Du traitement de la neurasthénie*, trad., franc., Paris, 1881.

certain physical agents in its treatment. Arndt¹ devoted almost at the same time a very important memoir to neurasthenia. He did not consider it a disease, but "a symptom or group of symptoms representing morbid processes or states, or definite sensations of discomfort," for which he invented a long terminology. But the question presented itself under a totally new aspect in the important publication of M. Glénard.² This author described a new morbid condition for which he proposed the name of enteroptosis. He believed that most cases of gastric neurasthenia might be attributed to it. The symptoms of neurasthenia arise, according to this author, from trouble in the abdominal part of the alimentary canal. It is characterised by the prolapse of various organs (liver and kidney), and of the intestines. Particular objective signs are, in such instances, constantly observed. In the treatise of M. Grasset,³ not less than in the work of Erb,⁴ one finds no further mention of the original idea of M. Glénard, of which M. Launois⁵ gave a very interesting critical review in the *Revue de Médecine*.

We shall next mention without further comment a publication by Giovanni.⁶

M. Glénard⁷ returned to the same subject confirming his former ideas in a communication to the *Société des hôpitaux*, which provided to M. Féréol⁸ the opportunity of making a very remarkable communication. This observer does not pronounce categorically upon the reality of enteroptosis, in the sense of a special disease; but insists upon it as a clinical fact deserving attention, as it may be the source of therapeutical indications. The same year Ziemssen⁹ published an article of some importance on neurasthenia.

¹ ARNDT. *Die Neurasthenie (nervenschwache) ihre Wesen, ihre Bedeutung und Behandlung*, Leipzig, 1885.

² GLÉNARD. *Application de la méthode naturelle à l'analyse de la dyspepsie nerveuse. Détermination d'une espèce. De l'entéroptose*, Lyon, 1885.

³ GRASSET. *Traité pratique des maladies du système nerveux*, Montpellier, 1886.

⁴ ERB. *Ziemssen Handbuch*, t. XII., art. NEURASTHÉNIE.

⁵ LAUNOIS. *Revue de médecine*, 1887, t. VII. p. 64.

⁶ GIOVANNI. *Sulla neurasthenia*, Cremona, 1885.

⁷ GLÉNARD. *Société médicale des hôpitaux*, 15 mai, 1886.

⁸ FÉREOL. *Bulletins et Mémoires de la Société médicale des hôpitaux*, 5 janvier, 1887, pp. 499, 509.

⁹ ZIEMSEN. *Die Neurasthenie and ihre Behandlung*, Leipzig, 1887.

Later, M. Glénard¹ put forward some new considerations upon the diagnosis of enteroptosis.

We ought also to refer to the excellent thesis of M. Lafosse² upon *Neurasthenic Headache*, as well as, to a review by M. Lemoine,³ and to a work by Glatz⁴ on *Neurasthenic Dyspepsia*.

The most important publications of the last years are unquestionably the *Leçons du Mardi*, by Professor Charcot,⁵ and the monograph of M. Bouveret.⁶ M. Charcot has had on several occasions, both in the first and second years of these lectures, the opportunity of expounding his ideas on neurasthenia. The professor specially considers the frequent combination of neurasthenia with hysteria, and the exclusive part these two affections play in the constitution of the so-called traumatic neurosis.

These views have quite recently been developed with much skill by M. Pitres.⁷ The volume just published by M. Bouveret is an excellent and comprehensive work upon the question, and we shall frequently borrow from it. M. Levillain⁸ has also produced an important monograph upon neurasthenia, but his work hardly represents anything more than a *résumé* of previous publications, for he adds but very few original remarks to what others have said. The long notice written by M. Vigouroux upon the treatment of neurasthenia by static electricity ought, at any rate, to be referred to here.

Finally, we shall allude to a short monograph upon *Psychical Neurasthenia* by M. Régis.⁹ Under this title, (and thus assigning them to neurasthenia), the author describes

¹ GLÉNARD. *A propos d'un cas de neurasthénie gastrique*, Paris, 1886.

² LAFOSSE. *La céphalée neurasthénique*, Thèse de Paris, 1887.

³ LEMOINE. Pathogénie et traitement de la neurasthénie, *Annales médico-psychologiques*, septembre, 1888.

⁴ GLATZ. *Des dyspepsies ... et plus particulièrement de la dyspepsie neurasthénique*, Genève, 1888.

⁵ CHARCOT. *Leçons du mardi*, t. I., 1888-1889; t. II., 1888-1889. Voir plus spécialement: 2e, 12e et 13e leçons, 1888-1889.

⁶ BOUVERET. *La neurasthénie (épuisement nerveux)*, Paris, 1890.

⁷ PITRES. De la neurasthénie et de l'hystero-neurasthénie traumatique, *Progrès médical*, 6 décembre, 1889, n° 49, p. 448.

⁸ LEVILLAIN. *De la Neurasthénie*, Paris, 1891.

⁹ RÉGIS. Les Neurasthénies psychiques. *Journal de méd., &c.*, Bordeaux, 1891, Nos. 36, 37 et 38.

most of those emotional "obsessions" (*obsessions émotives*) studied particularly by Charcot and Magnan, and attributed by them to hereditary degeneracy, of which these symptoms are the incidental manifestations.

These mental symptoms would have, it is true, according to this doctrine close relations with degeneracy, but only indirectly through their connection with neurasthenia when this latter is degenerative in character. This conception of M. Régis is not supported by any argument of a psychological or clinical order, and appears to us to throw confusion into the question of neurasthenia rather than to enlighten it. At any rate it is a fact that many such "obsessed" individuals present no sign of neurasthenia, and inversely that the great majority of neurasthenics do not suffer from such "obsessions." Finally, the symptoms in question are found associated with degenerative neuropathies such as hysteria, tabes, epilepsy, &c., upon which it does not seem to us any more legitimate to make them depend. Association then, is the only reason which M. Régis has invoked in aid of his theory. M. Grasset,¹ has just traced in the *Montpellier Medical* the history of many cases of neurasthenia, appending some interesting considerations.

Lastly, we may mention that we ourselves have quite recently differentiated, under the name of topoalgia,² a certain kind of neurasthenia which is monosymptomatic in character, and which we shall return to in the course of this review.

Ætiology.—Neurasthenia is a widely distributed affection. A rough calculation may be made from the fact that patients suffering from it represent a twelfth part of those presenting themselves at the out-patient department of the Salpêtrière.³ If one considers moreover, that this neurosis is, as a rule, more common among the well-to-do classes than among

¹ GRASSET. Quelques cas d'hystérie male et de neurasthénie. *Montpellier Medical*.—Mai et juin, 1891. Nos. 9, 10, 11, 12.

² PAUL BLOCQ. Sur un syndrome caractérisé par de la "topoalgie" (Neurasthénie Monosymptomatique, forme douloureuse).—*Gazette hebdomadaire de médecine et de chirurgie*.—Mai et juin, 1891, No. 22, p. 287 et No. 23, p. 268.

³ According to an abstract made from the lists of diseases diagnosed during my year of office, 1887-1888.

hospital patients, an approximate idea may be formed as to the average proportion of cases of neurasthenia. Although this disease, especially in its serious forms, is most often of hereditary origin, it is admitted that in certain cases it may develop in a soil hitherto intact from all nervous taint. When heredity constitutes the predisposition, it is rarely the heredity of the same affection, but most often it is the heredity of transformation; and there may be found among its antecedents, insanity, tabes, hysteria, epilepsy.

Cases of neurasthenia have been recorded at the early age of 11 to 20, but this is very exceptional. The disease generally makes its appearance between the ages of 25 and 55, the maximum being between 35 and 45. Men are more often affected than women. If the female sex, owing to uterine disorders, offers greater opportunity for the development of this neurosis, men, on the other hand, are more exposed to injury and over-pressure. Certain occupations predispose to neurasthenia, because they demand sustained and considerable intellectual efforts, or because they entail excessive and permanent emotional activity. Thus doctors, whose occupation combines these two troublesome conditions, speculators, engineers, literary men, contribute a striking contingent to the neurasthenical class. Very likely it is because the Americans find themselves in this situation rather than owing to any meteorological conditions that they are affected in relatively larger proportions. The Jewish and Slav races seem to be predisposed to this malady, as they are in fact to most of the neuropathies, without any known reason being assigned for this peculiarity. Gout and rheumatism form a soil most favourable to the development of neurasthenia. In most cases, says M. Huchard, neurasthenia is an "arthritic" neurosis.

The determining causes of neurasthenia are of more importance than in the case of other neuropathies, for the reason that hereditary predisposition may here be absent. They all realise this one condition, cerebral over-pressure, be it brought about directly by excessive activity of the organ, or indirectly in consequence of a debility affecting the individual generally and the nervous system in particular.

In the latter case we may assume a predisposition in the form of a "*locus minoris resistentiæ*."

Let us now examine the various causes determining the overstrain we have alluded to as the chief cause of neurasthenia. Both fundamental modes of reaction of the nervous system (*viz.* sensory and motor) may have been overworked. In the first instance, all the passions or excessive feelings may call forth neurasthenia; whether it be love, ambition, filial affection, cupidity, any impediment to their development may set up a consecutive neurasthenia. In the intellectual order, all excess of work may have the same result. The combination of these two sets of causes, intellectual and emotional, will bring about the disease even more easily. This happens particularly in the preparation for competitive examinations.

Traumatism, the preponderating pathogenic influence of which M. Charcot has shown, may in our opinion be compared to a kind of overstrain, its extreme intensity compensating for the shortness of its duration, hence hardly any but severe injuries, and especially those accompanied by shock or violent emotion, are ever followed by neurasthenia. The extreme worldliness of life in large cities, the abuse of pleasures, certain intoxications (as by morphia, ether, cocaine) act in like manner. Among the causes operating through the agency of the general enfeeblement of the individual which they bring about, the majority of the infectious diseases, such as enteric fever, influenza, must first be referred to, and then disorders of the chief systems, and in particular the digestive, genito-urinary, and nervous. As regards gastric disturbance, it seems incontestable that the affection of the general nutrition observed as a result of dilatation of the stomach or the auto-intoxication arising from it, can produce neurasthenia. As to enteroptosis, we shall have to enquire later whether it does not bring with it analogous secondary consequences (a diminution in the lumen of the alimentary canal, and consecutive nutritive disturbances).

Sexual excesses, masturbation, diseases of the sexual organs are also frequent causes of neurasthenia. As to

nervous diseases it is difficult to know in the cases in which they precede the appearance of neurasthenia, whether they have played the rôle of exciting cause as happens in hysteria developed under the influences of neuropathies, or whether they exist only in the condition of simple morbid associations. However this may be, it is especially in the course of tabes, hysteria, and cerebral syphilis that neurasthenia appears.

Clinical Study.—On account of the many signs, varied forms, and numerous morbid associations of neurasthenia, we have thought it necessary, for the sake of greater clearness of exposition to approach the clinical description in the following order, proceeding to some extent from the simple to the complex. We shall first study isolated symptoms, then the forms produced by the grouping of these symptoms, and finally the association of these forms themselves with other diseased conditions.

(1.) *Signs.*—Among the aggregate of symptoms of every kind observed in the neurasthenical, there are some which are distinguished not only by their constancy, but also by their character, so as to deserve (in analogy to the equivalent symptoms of hysteria) the name of *stigmata*, using this word in the well-known sense given to it by M. Charcot in his teaching. We shall explain these *stigmata* first of all, for they constitute under these conditions diagnostic points, and afterwards we shall deal with the variable symptoms.

(a.) *Neurasthenic Stigmata.*—These may be arranged thus: headache, rachialgia, intellectual depression, enfeeblement of the bodily powers, and gastric troubles.

M. Lafosse, in the above mentioned work, has met with headache in 44 out of 45 cases. Thus we have to do with a symptom of great frequency. The headache rarely consists, and this is a point of real importance, in true pain. It is rather a sensation of weight and constriction seated in the frontal and occipital regions and comparable to that produced by a heavy, tightly fitting, helmet (neurasthenic "helmet" of M. Charcot). Its habitual localisation is represented by a circular zone starting from the nucha and passing round the temples and forehead, the maximum of discomfort being felt in the nucha. Occasionally the headache only occupies the

occiput (occipital patch). It may, on the other hand, be localised between the eyebrows. Finally, it is sometimes unilateral.

The headache occurs most usually in the day. It rarely disturbs the sleep. It disappears during the night, when insomnia is present. It appears at the waking hour, and persists. It is better for a short time after meals, but it soon returns during digestion with greater insensibility. The headache is increased by sensorial stimuli—by noise, strong odours, emotion, mental work. When not continuously present as it usually is, these causes habitually provoke it. At times it is accompanied by hyperæsthesia of the hairy scalp, but this hyperæsthesia is rarely to be compared in intensity with that met with in hysteria. M. Huchard has specially insisted upon this symptom. There often exists noises in the ears, heaviness of the eyelids, dimness of vision and even vertigo. Besides this feeling of weight, which is the most constant form, some patients complain at the same time of feelings of emptiness or tension in the head, and occasionally of a sensation as if a foreign body were there following the movements of the head. Rachialgia is less frequently met with than headache, but it may be associated with it. By the fixity of its characters, however, it deserves to be placed among the stigmata of neurasthenia. M. Charcot employs for this rachialgia a name equally striking as that of "helmet" for the neurasthenical headache. He habitually uses the term "sacral patch," and this points out well the usual site and limits of the pain. "The sacral patch is to some degree the counterpart of the occipital or cerebellar patch." (Charcot.)

The dorsal pain consists of a sensation of pressure or heat rarely amounting to true pain. Sometimes there is, however, sharp pain resembling that of neuralgia. We have habitually noticed that these painful phenomena are accompanied by some objective troubles of sensation, anæsthesia or hyperæsthesia of the skin. In the latter case the patient hardly tolerates the least touch, even the rubbing of the clothes. At other times deep pressure upon the spinous processes is painful. The site of predilection of the pain is

in the sacral region, but it may be localised in the cervical or lumbar region, or it may even occupy the coccyx. Rachialgia is found more frequently in woman than in man. As to its duration, it may be either temporary or permanent.

The chief troubles by which the mental depression of the neurasthenical manifests itself are diminished power of attention and weakening of the will. Intellectual work is generally trying, and application to any subject difficult. There is often a mental inertia, a kind of cerebral fatigue contrasting strangely with the conversational animation. Diminution of memory is habitual, consisting in a retrograde amnesia affecting proper names especially. The alteration in the power of attention makes reading difficult. The enfeeblement of the will is especially marked in cases of traumatic hystero-neurasthenia. The patients are unable to work intellectually or manually, and they experience a marked sadness and discouragement on that account. The character is changed, so that the patient is dull, dejected and sulky. Response to emotion is excessive. A mere trifle affects him. He shuns society, and seeks isolation and solitude. These mental troubles, taken as a whole, are constant, but they undergo great variations in intensity according to the individual cases.

The diminished strength of the patient must be mentioned as being among the most common signs of neurasthenia. Under these circumstances it does not only consist in a sensation of prostration and lassitude, but there is a real weakness which can be demonstrated by the dynamometer. Without there being a trace of paralysis present, and when the patient is able to execute without apparent difficulty the various movements asked of him, the dynamometer shows a difference of twenty to sixty degrees from the normal.

Sensations of fatigue, and depression in neurasthenia are felt particularly in the early morning, after emotion or moderate physical exercise. It may lead the patient to pass the greater part of his time in lying down. Gastric disturbance is rarely absent from the symptoms of neurasthenia. M. Bouveret recognises two kinds or rather degrees of it, according as to whether it is accompanied or not by objective

signs of the enteroptosis of M. Glénard. In the first case the appetite is generally diminished, the tongue a little coated, and the ingestion of food is quickly followed by distension of the stomach, leading the patient to loosen the clothes.

The distension extends from the epigastrium to the rest of the abdomen, and is accompanied by sensations of malaise and fulness. Abundant eructations supervene, and at the same time flushes of heat mount to the face. This trouble lasts for two or three hours or even longer. Constipation is habitual, and accompanied occasionally by phenomena of auto-intoxication, or more frequently by colitis with glairy stools. From this it necessarily follows that the patient presents an earthy tint in his complexion, and such wasting as may suggest cancer of the stomach or rectum. We have ourselves had the opportunity of seeing both one and the other mistake made by distinguished practitioners. By methodical examination one finds in the severe forms of this gastric disturbance, a flaccidity of the abdominal walls, and the various signs of enteroptosis to be referred to later.

(b.) *Variable Symptoms*.—Neurasthenia is remarkable for the great number of its manifestations (non morbus sed morborum cohors) for the multiplicity of suffering, cramps, visceral pains, nameless discomforts, so as to constitute a condition described by a physician well-known for his neurotic disposition, as "the punishment of the nerves" (supplicium neuricum). With these patients the state of suffering is a general one. All their organs may be affected one after the other, and yet none of them undergo any coarse change. It results from this that there is often no possibility of localising the mischief, either on the part of the patient or even the physician, and that one may say of neurasthenia what Mead said of hypochondriasis, "non unam sedem habet sed morbus totius corporis est." These words admirably depict the difficulties almost always encountered in the examination of these patients; and which we meet in endeavouring to give an account of the symptoms. We shall describe these under each organ, at the same time pointing out their clinical importance.

Cerebral symptoms. We have already mentioned some disorders which by their frequency merit the name of "stigmata." Disturbed sleep is also one of the most common. Rarely is sleep more prolonged than it should be, for one cannot look upon the somnolence which often torments the neurasthenical after food, as true sleep. Most commonly we observe obstinate insomnia, which at times resists remedies most effectual in other cases. Vertigo is a frequent symptom of neurasthenia. It comes on in paroxysms during fasting, and diminishes after food, or again it may be almost continuous giving rise to slight staggering.

It is not exceptional for the neurasthenical to present certain psychical phenomena which are known under the name of "incidental symptoms of degeneracy," agoraphobia, claustrophobia, pathophobia, &c. We have seen that M. Régis would have it that these perverted emotions are veritable symptoms of neurasthenia, and that he went so far as to group them together under the name of psychical neurasthenia; but we think the conception is not justified, and in our view these fixed ideas only belong to neurasthenia in the sense of complications. They do not result directly from the illness, but they appear in its course, complicating the clinical picture in the same way as they are observed in the tabetic or hysterical. In all these cases they are engendered from the common source of hereditary neuropathy of which they are characteristic.

Yet we cannot say the same of the hypochondriacal ideas which are almost constant among these patients. The neurasthenical, says M. Pitres,¹ is a restless reasoner or writer, and at bottom a noso-maniac. He is occupied with the symptoms he experiences beyond all reason. He believes himself affected by some organic and incurable disease. He feels his pulse, palpates himself, examines and studies himself. He delights to talk about his illness, and to recount his sufferings. Some very significant peculiarities must be added. These patients have mostly consulted, and read all the books on medicine they have been able to find. On the other hand they have

¹ Pitres, loc. cit.

the custom of writing down their sensations in long memoranda which they hasten to read, and to explain to the physicians whom they successively consult. This last detail is characteristic in that it almost suffices to establish the diagnosis.

Objective troubles of sensation are according to our opinion not so rare as some authors make out. For these hardly anything but subjective symptoms exist. We have proved in nearly all these cases a more or less regular and localised alteration in cutaneous sensation at the site of the pain, consisting in a loss or an increase, whenever we have looked for it. Not infrequently all the integument may be the seat of a true hyperæsthesia. *Subjective* troubles of sensation are innumerable, and assume very different forms both in their character and situation. Painful crackling in the vertebral column, neuralgic, or more or less lightning pains, numbness, and sensations of heat and cold.

The organs of special sense are frequently affected. As regards sight they may consist in heaviness of the eyelids, weakness of accommodation making reading impossible. In hearing there may be hyperacousia, buzzing and whistling in the ears. Taste and smell may present remarkably increased susceptibilities. Thus certain odours may produce at times attacks of headache and vertigo.

Besides the general *motor* weakness, there remains to mention the frequency of cramps and muscular tremors in the lower extremities at the time of going to sleep, and finally the phenomenon known under the name of giving way of the legs.

Circulatory disturbances are illustrated by the neurasthenic angina pectoris described by Landouzy.¹ M. Huchard² has differentiated it from true angina pectoris, basing the distinction on the absence of effort as an occasional cause, on the return, sometimes periodically, of the attack, and its longer duration on the more marked agitation of the patient and the lesser intensity of the agonising sensations. There may also be observed in the neurasthenic attacks of palpi-

¹ Landouzy, *Progrès Medical*, September, 1883.

² Huchard, *Maladies du cœur et des Vaisseaux*, Paris, 1889.

tation and of frequency of the pulse, which latter is at the same time unstable according to M. Huchard's expression.

Vasomotor troubles are, so to speak, constant. Among most patients, the meningeal *tache* is readily obtained, but, moreover, vascular spasm leads to coldness and pallor of the extremities. Owing to its intensity the sensations of cold referred to above may be attributed to it.

The respiratory system is less often involved. Attacks of dyspnœa are rarely observed, simulating asthma. A peculiar character in the voice, by which it becomes feeble, confused, and drawling, should be mentioned (Beard).

The generative organs also present functional disorders, consisting in seminal losses and impotence. The bladder is most often unaffected, but a true oxaluria has been described and an excess of urates and uric acid in the urine. This latter, if at all constant, would acquire a great diagnostic importance.

The various secretions are at times more or less affected, watering of the eyes, salivation, profuse sweating of the extremities, and on the other hand dryness of the skin and mucous membranes have been described. When treating of the stigmata, we pointed out the principal signs observed in the digestive symptoms. We shall not return to them here, for we purpose completing what has already been said about them in the following paragraphs on the varieties of the disease.

(2) *Varieties*.—Many forms of neurasthenia have been described owing to the fact that the clinical appearances are so varied. This diversity results not only from the grouping of the symptoms just described, but owing to the preponderance of some of them.

Passing by the inexhaustible nomenclature of Arndt, we may mention that M. Bouveret describes as types a feminine, a traumatic, and a general neurasthenia; and that he distinguishes, moreover, a cerebral form or cerebrasthenia, a spinal form or myelasthenia and an acute form. On the other hand Pitres recognises the following kinds:—(1) Cerebral; (2) spinal or rachialgic; (3) neuralgic; (4) cardialgic; (5) gastro-intestinal; and (6) that connected with the generative

organs. We shall propose a new division, and which although less complex, will embody a certain set of facts, hitherto, it appears to us, insufficiently differentiated, viz., local neurasthenia. It may suffice, we think, to divide neurasthenia into two forms according as to whether an excessive prevalence of one set of symptoms is absent or present. In this latter case we admit that such symptoms constitute a variety in relation to the localisation apparently revealed by it.

The following scheme explains this division :—

Neurasthenia.	{ Without an excessive predominance of any one set of symptoms.		General N.	
	{ With such a predominance arising more particularly	{ from the central nervous system.	{ Cerebral.	{ Cerebral N.
			{ Spinal.	{ Spinal N.
		{ from the peripheral nervous system.	{ Sympathetic.	{ Sympathetic N.
				{ Local N.

(1) *General Neurasthenia*.—Under this category we shall place those cases in which the grouping of symptoms produces a uniform picture, but in such fashion that not one of them predominates over the others. These cases are in reality most common and widely distributed. We shall embody them into a concrete example, as a means of comparison. The subject is mostly a patient about 30 years of age suffering from the effects of moral distress or excessive work. He is wasted, pallid, and finds it difficult to get through his business. He feels weak and fatigued. He has almost continuous headache, and he indicates the nucha as the situation of it. Moreover, he experiences a crackling there. He fears lest it should be the beginning of some brain disease, the more so as sleep has often quite forsaken him. His appetite is diminished, his digestion slow, and he has a feeling of distension after food so that he has to loosen his dress. He has eructations and flushes of heat in the face. When asked, there is no particular organ in his body that he can refer his trouble to. He complains of pain at the heart and palpitation. Breathing requires an effort, the intestine is sluggish, and genital power diminished, &c. Yet objective examination reveals nothing more than a diminution of muscular power as made out by the dynamometer. Sensation is hardly affected, but

pressure on the lumbar spines is painful. There is nothing abnormal found in the special senses. The tendon reflexes are present. The pulse may be irregular and increased in frequency, but auscultation does not discover any sign of organic disease. Examination of the lungs is negative. As to the digestive organs, there may be a slight dilatation of the stomach, which, however, cannot be made responsible for the symptoms presented by the patient.

(2) *Cerebral Neurasthenia*.—In this, as in the following variety, the symptoms seem to arise more exclusively from the nervous system. The cerebral affection may assume a hemiplegic form (hemi-neurasthenia) as has been pointed out by Beard and confirmed by Prof. Charcot. In these cases the headache and weakening of the motor power is on the same side of the body. The various paræsthesiæ, sensations of tingling, cramps, &c., are equally unilateral. At times great difficulty of diagnosis results from these symptoms. Cerebral neurasthenia (cerebrasthenia) occurs mostly among the intellectual. It corresponds to overpressure in the ordinary sense of the word. It is more rarely attended by disturbance of nutrition in the shape of the wasting pallor and referred to above. The gastric symptoms are reduced to a minimum, and are absent in many cases. It is the mental fatigue which predominates, a sensation of emptiness in the head and an inaptitude for all intellectual work. Conversation itself soon becomes burdensome; hypochondriacal tendencies are almost always present. The character is modified, the patient is sad and preoccupied; he avoids society; he is extremely emotional and irritable. Moreover, headache, with its usual characters and situation, is constant. At times it reaches a degree of intensity so as to be able to make one fear a cerebral tumour. Insomnia is frequent, and sleep is disturbed by painful dreams. Finally vertigo completes the picture of the symptoms. At times this form of neurasthenia lasts long, and is rebellious to the varied methods of treatment.

(3) *Spinal Neurasthenia*.—This variety has been called myelasthenia. It corresponds to spinal irritation. It often follows upon venereal excess. It differs a little in man and

woman, although in both there is rachialgic pain and troubles in the reproductive system. In man one finds pain in the back, weakness in the lower extremities often accompanied by giving way of the legs. In addition, there is more or less complete impotence accompanied by spermatorrhœa. In the female the pain in the back radiates more frequently, and extends to the abdomen in the form of peri-uterine or ovarian pain. Pruritus vulvæ may exist. It is to this form that the type of disease wrongly known as neurasthenic pseudo-tabes ought to be referred. Pains more or less simulating lightning pains. Sometimes visceral crises, and a gait rather like that of vertigo than ataxia¹ are observed in these cases.

(4) *Sympathetic Neurasthenia*.—It will easily be understood that we should describe here cases in which there predominate troubles in one or other of the great systems, (1) cardiac, (2) gastric (cardialgic gastro-intestinal neurasthenia of Pitres), and (3) respiratory (visceral neurasthenia of Huchard), as they partly draw their nerve supply from the sympathetic. We would include here a very interesting variety to which Professor Charcot has called attention, and where disturbances of nutrition prevail (trophic neurasthenia—might one say?).

Cardiac neurasthenia is typified in the neurasthenic angina pectoris of M. Huchard. This angina is benign, and has peculiar symptoms. The pain is less severe, its radiations less regular, and perhaps absent or appearing on both sides. The attack is often nocturnal, frequently repeated, and very often accompanied by palpitation and varied sensations. These cardinalgic crises have a "blustering" behaviour, alternate with other symptoms, and have at times a frequency and periodicity, quite distinct from true angina.

It is to the cases in which symptoms connected with the digestive system prevail, that the "enteroptoses" of M. Glénard are to be referred. The principal symptoms, both functional and physical, related by this author are the following:—

1. Asthenic symptoms, debility, and habitual lassitude, weakness of the stomach, and of the kidneys.

¹ See upon the subject of neurasthenic pseudo-tabes, Author's Review, *Gazette des hôpitaux*, 1890, p. 321.

2. Mesogastric symptoms (sensations of uneasiness, weight, emptiness, craving, sinking, dragging, and many other analogous morbid subjective feelings).

3. Gastric symptoms (flatulency, choking sensations, distension, oppression, wind, eructations, gaping, pain, acidity, cramp, burning, vomiting).

Both the asthenic and mesogastric symptoms present a close relation with the four following characters with which they are always associated.

1. Waking at 2 a.m., and after this *malaise*, and more or less sleeplessness.

2. Exacerbation or appearance of the *malaise* at rising in the morning, and at three o'clock in the afternoon.

3. Constant relation, marked or not, of discomfort according to character of the food (its aggravation by fats, starch, acids, vegetables, uncooked food, wine and milk.)

4. Irregularity and insufficiency of stools (constipation, diarrhoea, alternation of the conditions).

As to physical signs, methodical examination of the abdomen (mesogastrium), yield four important signs.

1. Flaccidity of abdomen (diminution of tension, "ventre en besace, gourde, bissac, bateau"); abdominal hypotaxis.

2. Prolapsus, falling down of the intestinal mass, viz., enteroptosis, and as possible accessory signs, floating kidney (*nephroptosis*), moveable liver (*hepatoptosis*), moveable spleen (*splenoptosis*).

3. Narrowing of the colon ("boudin cæcal rénitent et sensible, cordon sigmoïdal, corde colique transverse," and as a consequence epigastic pulsations)—enterostenosis.

4. Gastric splashing, through prolapse and flaccidity of the stomach—gastroptosis and gastric atony.

In the paragraph concerning its pathogeny, we shall have to enquire whether the greater part of the cases of neurasthenia may be attributed to enteroptosis as M. Glénard pretends, or if, on the contrary, as we think, it only constitutes a single variety of the neurosis. It must be added that Glatz has proved, by examination, that the secretion of the gastric juice is arrested in a large number of the cases of gastric neurasthenia. In a case observed by us

(the diagnosis being confirmed by Professor Charcot, and proved by the subsequent behaviour of the case) an analysis of the contents of the stomach by M. Durand-Fardel shewed an absence of hydrochloric acid, lactic acid, and peptones.

The variety called by us *trophic* neurasthenia presents this peculiarity which is characteristic of the case, viz., a condition of falling off in the patient almost amounting to cachexia. In these instances there is a general and marked weakness, a real wasting (the body weight diminishes, more or less rapidly in a notable proportion of cases), and a pallid earthy tint of the integuments. If we add to these signs certain more or less localised and painful phenomena, it will be readily seen that it may easily be mistaken for the cancerous cachexia. But the following facts are noted:—more or less rapid variations in the body weight, the preservation of the appetite, habitual absence of vomiting, and finally, a prolonged duration with the alternations already referred to.

(5) *Local neurasthenia*.—This form, which we have not found described by authors, at any rate not as a distinct type, might be called partial or dissociated neurasthenia. It is characterised by a single set of symptoms, although the patient suffers from hereditary taint, and from the mental condition peculiar to the neurasthenical. One might, we believe, legitimately compare this form to mono-symptomatic hysteria, where there exists but one symptom, contracture, vomiting, &c., with no other, and say that neurasthenia in such cases assumes a mono-symptomatic form.

By reason of the extreme variety of the subjective symptoms complained of by the neurasthenical, and because each of these symptoms may present itself alone, the aspects of this mono-symptomatic form are very numerous. The most characteristic is the one which I have proposed to call *topoalgia* (τοπος αλγη). Here there is pain fixed and localised in a region which does not correspond anatomically or physiologically to any recognised locality.

To this new class may be attached many cases wrongly classed under hysteria and hypochondriasis, when not left

undetermined and relegated under the heading of "nervous symptoms." The symptoms are chiefly represented by pain. This appears in the form of patches—paræsthetic plaques—in very different parts, for instance, in the forehead, nucha, chest, præcordium, epigastrium, loins, buttocks, and upper and lower extremities. These painful areas are variable in extent and form, so that they do not lend themselves to description. Often the pain remains definitely localised in the particular region it has seized upon; at other times it may radiate from thence in different directions, and these radiations existing only at the time of the paroxysms, hardly ever attain the same degree of intensity as the fixed pain. The pain is continuous, disappearing only with sleep. It does not prevent sleep, but if the patient wakes up it returns in these wakeful intervals. It is not usually influenced by pressure exercised upon the body surface above it but it is liable to variations either spontaneous or brought about by stimuli, psychical or other. We have noted that it is generally not felt when the pain produced by faradisation is substituted.

The pain also presents paroxysmal crises returning with a certain periodicity and without cause, but at times called forth by physical *malaise*, intercurrent organic disease, or by emotion. It is to be remarked that the painful patch does not correspond in any sense with the distribution of a nerve, not any more than with the outlines of any organ. Moreover, objective examination carried out very attentively does not reveal anything abnormal. Yet in some cases a certain slight alteration in the cutaneous sensation corresponding more or less exactly to the area of the painful part, and consisting at times of hyperæsthesia or more frequently of hypæsthesia, may be observed. Moreover, there exists, and not very rarely, a vasomotor disturbance at the same spot consisting in an intense and rapid rubefaction of the skin under the influence of slight pressure.

It seems probable that a certain number of morbid conditions such as the glossodynia described by M. Verneuil, several forms of coccydynia, as also certain observations analogous to those reported by M. Galippe,¹ under the heading

¹ Galippe. *Archives de Neurologie*, 1890.

of "obsessions dentaires" may be included in this class, and considered as local neurastheniæ. We are also ready to classify as analogous forms of mono-symptomatic neurasthenia the instances of essential impotence, both psychical and spinal lately pointed out by us.¹ These local forms like their hysterical analogues are generally very obstinate.

(3) *Associations*.—Neurasthenia is associated in a variety of ways with a large number of other neuropathies, and particularly with hysteria, progressive locomotor ataxia, Graves' disease and general paralysis.

It may happen that one or other of these affections may develop in an already neurasthenical subject, or that neurasthenia shows itself at the same time as hysteria and exophthalmic goitre, or finally that it appears during the course of the myelopathy.

Among its most interesting relations are those with hysteria, especially with hysteria of traumatic origin. As already stated this question has been very fully elucidated in the later works of Professor Charcot. He has shown by the aid of clinical analysis that the supposed traumatic neurosis generally presents a variable mixture of neurasthenia and hysteria, which he has designated under the name of hysteroneurasthenia. It should be observed that previously to the full development of hysteroneurasthenia, a sort of premonitory stage, or incubation period so to speak, occurs. This is scarcely marked by anything, but slight neurasthenical symptoms. The hysteria appears then upon this neurasthenical basis, giving to this malady its well marked characters, but which, in spite of their combination may, nevertheless be referred each to its original neurosis.

The forms of neurasthenia which are most commonly combined with hysteria in these cases are the cerebral and spinal varieties—psychical phenomena, mental depression, sombre ideas, absence of will-power, excitability, insomnia, headache, enfeeblement of the sexual functions, seminal losses, and the sacral patch.

When neurasthenia is associated with tabes, it is unusual for the neurosis to precede the myelopathy. Generally it

¹ Blocq. *Mercredi Médical*, 29 Octobre, 1890.

establishes itself when the latter has been developed for some time. In these cases it usually acquires the character of obstinate tenacity, and shows itself under a cerebral form, viz., in melancholic ideas, and hypochondriacal thoughts. Exophthalmic goitre is also often complicated with neurasthenia, but the co-existence of the two neuroses offers no noteworthy peculiarity.

When neurasthenia precedes general paralysis, which is not a rare occurrence, it may through its own psychical symptoms mask the onset of the meningo-encephalitis, and open the way to unfortunate errors in diagnosis. Therefore, it is important to be forewarned of the possibility of this succession of events.

Progress, Duration, Termination.—As regards the course of the disease, an acute form has been described (Bouchut, Bouveret), to which indeed M. Huchard believes the phenomena of "nervous fever" properly so-called, should be attributed. We think that the observations alluded to here need much reserve. If acute neurasthenia exist, it is certainly very rare.

In the very great majority of cases, neurasthenia, even when following upon accident, commences slowly, and follows a continuous course with alternations of periods of aggravation and amelioration. This latter fact gives to the disease a sort of circular course (Déjerine¹).

All cases are susceptible of improvement; most are completely curable, but others resist. Hereditary and obstinate neurasthenia may end in an incurable state of hypochondriasis. Moreover, the general debility of the neurasthenical makes them more vulnerable to external circumstances, which may prove fatal. It is necessary to know that neurasthenia, though apparently quite cured, may sometimes remain latent, only impressing its mark on whatever affection that may ultimately supervene.

Prognosis.—It will be seen from what has preceded that the prognosis as regards life is not serious, and that recovery is most often possible. However, neurasthenia is obstinate in resisting treatment, and prevents the

¹ DÉJERINE. *These d'agregation.*

patient from attending to his occupation ; and it may even last indefinitely, all of which considerations diminish in some degree the favourableness of the prognosis.

From this point of view, neurasthenia may be divided into two classes, the primitive and the hereditary. In the case of the acquired neurasthenia, recovery is the rule. In the other case, where the neurasthenia is hereditary, and one might almost say allied to insanity, it is the most often incurable.

It should also be borne in mind that neurasthenia may lead to morphiomania and suicide, and that it constitutes a neuropathic taint capable of bringing about the development of various maladies in the descendants.

Diagnosis.—If it were necessary to deal here with all the diseases which have been, with more or less reason, mistaken for neurasthenia, we should have to review the greater part of both internal and external disease. We shall limit ourselves to mentioning those morbid processes which are more particularly apt to be mistaken for it. In the nervous affections of this kind, general paralysis and tumours of the brain must be referred to among cerebral diseases ; locomotor ataxia among the spinal diseases, and hysteria and hypochondriasis among the neuroses. The mental depression, weakened memory, and melancholic tendencies, may suggest on-coming general paralysis. One is, up to a certain point, assured about this by the absence of any affection of the pupil, of difficulty in speech and of tremor ; but it is often necessary to keep the patient under observation for some time, for the subsequent development of the case to settle the diagnosis.

Vertigo and headache might easily give the idea of a cerebral neoplasm, but the absence of eye changes, and the special characters of the headache in the two cases, will not permit of doubt for any length of time. If the neurasthenic patient be also syphilitic, the difficulty of diagnosis is greater, although the neurasthenic manifestations, both cerebral and gastro-intestinal, permit of avoiding error.

The proposed name of neurasthenic pseudo-tabes shows that a certain set of clinical manifestations have suggested the idea of tabes. The pains have not, however, the

intensity, nor yet the fulgivating character of those met with in locomotor ataxia. The knee jerks are not abolished, nor are ocular troubles to be made out, nor do the visceral phenomena resemble, in any degree, the visceral crises of that affection.

Hysteria, even when associated with neurasthenia, may be distinguished by the convulsive seizures, the presence of stigmata, sensitivo-sensorial hemianæsthesia or segmental anæsthesia, hystero-genetic zones, diminution of the field of vision, and anæsthesia of the palate.

The hypochondriasis of insanity is differentiated by the fixity and intensity of the morbid ideas and the complete inability to displace them by any kind of reasoning.

M. Huchard has asked whether neurasthenia should be diagnosed in that form of rheumatism which is known as vague or neurotic rheumatism. The diagnosis, he continues, consists rather in comparison, for we are convinced that the two maladies are nearly always confounded, and that they form one and the same morbid condition. The gastric troubles of neurasthenia may cause the neurosis to be mistaken for organic disease of the stomach, gastritis or cancer. The error is so much the more to be feared, inasmuch as examination often shows, as has been already pointed out, a diminution or even absence of the gastric juice, as in the true gastropathies. The diagnosis is then based upon the absence of vomiting in neurasthenia, upon the duration of the disease, upon the fluctuation between improvement and aggravation, and finally upon the absence of a tumour or glandular affection. We shall not return to the signs which permit of the diagnosis being made between true angina pectoris and the neurasthenic form of the disease, for they have already been pointed out.

Nature and pathogeny.—Neurasthenia has not in reality any pathological anatomy proper to it, for it cannot be granted that it depends on any such anatomical substratum as the lesion in the digestive tract advocated by M. Glénard. These lesions, even supposing them capable of producing the symptoms of neurasthenia, a possibility we are about to examine, would, at any rate, only act indirectly

by changes in the general condition, and consequently in the nervous system in particular, brought about by them.

Thus failing a firm basis of necroscopical proof for building up a pathogeny, we shall only indicate, and that with reserve, the hypothesis justified by the clinical aspects of this affection.

In the first place we think with Professor Charcot¹ that neurasthenia is a morbid state, the nosographical position of which cannot be disputed, since it is seen to preserve its individuality through the very varying conditions under which it arises. It seems to us equally true that the statement of M. Huchard, that in the majority of cases neurasthenia is an arthritic neurosis, cannot be applied to it. Finally, we believe that in spite of the variety of its appearances (which latter alone have served as a guide in the clinical classification proposed here), neurasthenia is a neurosis essentially localised in the brain. Its characteristic is the enfeeblement of energy in the various cerebral functions.

The subjects affected with neurasthenia are generally proof against suggestion, especially if they be compared with the hysterical, in whom the aptitude for suggestion is one of the fundamental characteristics of the mental state. Hysterical patients have a perversion of the will, the neurasthenical a "catalepsy" of the will, following the expression of M. Huchard. Whence this difference, capable, in our opinion, of explaining the psychology of neurasthenia? And this is a matter of capital importance in the question of the pathogeny of the disease.

In the hysterical individual, it is as a result of a sort of limitation in the field of consciousness that the idea acquires an intensity which makes it dominant. It is in relation to this concentration of the conscient activity that the other brain-functions appear to be depressed when they are only inactive. The neurasthenical, on the other hand, is unable to generate a strong idea in consequence of the real depression of all the parts of his intellect. If he perceives, and more particularly if he preserves for long, certain

¹ Charcot. *Policlinique*, 1888-1889, 12^e leçon, p. 260.

sensitive images, which are more or less intense and which take possession of him, it is the result of the abnormal activity of ordinarily automatic and silent mechanisms presiding over the organic functions.

This enfeeblement, localised chiefly in the intellectual centres, determines the cerebral form of neurasthenia. The diminution of the regulating power exercised normally by the brain over the other parts of the nervous system, the spinal cord, and sympathetic, explains the existence of the spinal and sympathetic form of the disease. The visceral functions especially, usually performed unconsciously, enter into the sphere of the patient's consciousness, giving rise to a whole series of abnormal sensations.

As to the local forms of neurasthenia, and particularly topoalgia we think that they represent the clinical manifestations of a persistent and fixed sensory image, analogous in the domain of sensation to what the fixed idea is in that of the intellect. The mechanism of this manifestation differs from that of the auto-suggestions of pain belonging to hysteria, and of the emotional prepossessions of the hypochondriacal.

What is the relationship between this neurosis and enteroptosis, according to this mode of looking at the nature of neurasthenia?

The fact of the co-existence of visceral prolapse with the nervous phenomena and the disappearance of the signs of neurasthenia in consequence of the treatment of splanchnoptosis appear to be strongly in favour of the subordination of the one to the other. Enteroptosis would act according to M. Glénard, in bringing about a lessening of the lumen, or atresia, of the bowel, and in consequence gastric atony.

Without denying the relations of enteroptosis and neurasthenia, it does not seem admissible that the meso-gastric troubles should be considered as specific ætiological elements of the neurosis. In the first place it is very frequent to see neurasthenic patients in whom there are none of the objective signs of M. Glénard, and in whom even gastric symptoms are very little complained of. Moreover, certain

forms of neurasthenia are developed more or less rapidly as a consequence of mental overstrain, of emotions, of traumatism, all of them causes which do not usually produce mechanical intestinal disorders. Hereditary influence, finally, is often undoubted from the point of view of pathogeny, and moreover, a favourable termination without treatment directed to the intestinal tract is not uncommon.

It is rather through the general disorders of nutrition from gastric atony (and which are the least doubted consequences of enteroptosis) that this ailment plays its ætiological rôle in the production of neurasthenia—a rôle reduced thus to that of an exciting agent.

The neurasthenic state is the first step of the neuropathic ladder, and "a soil eminently favourable to the development of nervous disease in future generations" (Bouveret). This idea, which has been especially developed by Mœbius,¹ has afterwards been taken up, and adopted by M. Déjerine.²

Treatment.—Before explaining the rules of treatment suitable to the varied forms of neurasthenia, it is necessary to formulate certain considerations of a general kind.

Not only does this malady offer considerable resistance to medicinal treatment, but what is more, these patients exhibit idiosyncracies to drugs. In some cases therapeutical agents do not produce their usual effects; and in other cases they bring about exceptional results. "In a word, one often has to deal," as M. Huchard says, "with a veritable therapeutic ataxia, since in neurasthenia, that which should react, viz., the organism, either does not react or reacts abnormally to chemical and medicinal substances." If then it is necessary to guard oneself against the abuse of drugs, it is not less necessary, in order to secure the success of the treatment, to inspire confidence in the patient, and to exercise over him considerable authority.

For this purpose, it is undoubtedly proper to ask oneself how far hypnotism and suggestion are indicated.

¹ Mœbius. *Ueber Nervöse Familien*. Allg. Zeitschr. f. Psych., Berlin, 1884.

² *L'hérédité dans les maladies du système nerveux*. Thesis 1886, pp. 170, et 226.

There is no better test example, in our opinion, than that of neurasthenia, to show the limits of hypnosis from a therapeutical point of view. In fact, would it not appear, *a priori*, that in this psychical and dynamical affection, hypnotic suggestion should work wonders? In reality there is nothing to be expected from it. Very few neurasthenic patients are hypnotisable, according to the statement of even Professor Bernheim.¹ The mental state of the neurasthenic patient such as we have described, appears to account for this fact of observation. It ought to be stated, however, that M. Bernheim has reported some examples of cure of affections which he terms "neurasthenic;" but in the majority of these cases it appears as if neurasthenia properly so-called were out of the question.

We think that hypnotic suggestion cannot figure among the usual therapeutic methods of the treatment of neurasthenia, and that it can scarcely be of service unless in exceptional cases. In the ordinary and benign form of neurasthenia, hydrotherapeutic treatment associated with the use of the actual cautery and of bromide of potassium is generally sufficient.

In the severe forms the Weir Mitchell method may be had recourse to with success. It consists as is well-known, in isolation, absolute repose, massage, faradisation, and over-feeding. In the cases in which the presence of enteropneurosis is proved, one may rightly make use of the method employed successfully by M. Glénard. Succinctly stated, it consists of (1) the use of the pelvic belt, day and night; (2) regulation of the bowels—a daily laxative; (3) feeding—including four meals. A bread-soup, or *café au lait*, in the morning. A meal of meat consisting of roast beef or mutton; and a boiled egg with bread at 11 a.m.; a repast at 4 p.m. with bread, jam and tea. At 6.30 p.m., a meal like that at 11 a.m. Beer or alkaline water is taken as drink; (4) alkalinisation—sodium bi-carbonate or Vichy water; (5) hydrotherapy of the form of cold douching, or 20-30 seconds.

In the local mono-symptomatic forms we have used

¹ BERNHEIM. *Hypnotism, Suggestion, Psychotherapie*, Paris, 1891.

with success, faradisation localised to the seat of the painful phenomena by means of the electric brush.

We may add the exhibition of the fluid extract of kola, suggested by M. Huchard, and the employment of static electricity, often prescribed by M. Charcot, in order to complete the list of the therapeutical measures most commonly used, either isolated or combined, with benefit to the patient.