

place quite recently, so that they may be accounted for as due to the excess of personal worry to which I have of late been subjected." These worries were, as before, of a financial and domestic character. Into them I had not the time to enter closely, nor did I attempt to explore various other sources of mental disturbance elicited during my brief inquiry.

The consequence of my two interviews with the patient is that, instead of remaining a relatively useless member of society, he has now been occupied for several months in receiving a technical training at a large engineering works; and there can be little doubt that under appropriate conditions and with fuller treatment he will make a complete recovery.

#### Remarks.

The interesting features of this case are:—

1. The dependence of the narcoleptic attacks on the tendency to revival of certain memories repressed from consciousness. Probably the "conscious" type of fits depended on a weaker resistance against a less forceful intrusion of such memories, and the "blank" periods occurred during "sub-conscious" concentration on those memories.

2. The immediacy of the amnesia. Why, we may well ask, were the memories of the orang and cabin incidents immediately lost? The answer appears to be this: The sudden strong emotion which was aroused induced a change of personality, the patient passing into a so-called "somnambulistic state," on passing out of which all recollection of the events therein occurring was repressed.

3. The striking and immediate relief obtained by the restoration of the repressed memories to full consciousness.

4. The absence of emotion during the return of the lost memories, even the resumption of the arm attitude evoking no emotion. This and numerous other cases in my experience offer no support to the view that for a successful cure emotional "abreaction" is essential during the revival of dissociated memories. I believe this view to be based on the mistaken hypothesis that what is primarily repressed in "functional" amnesia is the *emotional* component of the experience. I wish to suggest that it is the *unpleasant*, not the emotional, component that is directly repressed (or inhibited), and that the resistance against revival expresses the inability to admit the unpleasant, not the inability to face the emotion. In every-day life we forget not the emotional component of experience, which may be pleasant or unpleasant, but the unpleasant component, which may be emotional or unemotional. By bringing the same explanation to bear on the present case and on similar "functional" cases, we link up a normal with a pathological process of forgetting. Because of its concomitant unpleasant tone, it is the cognitive experience which is *repressed*, while the emotional component is merely *dissociated*, is left free to wander into other fields of cognition, and may thus or by well-known ruses manage to re-enter consciousness.

5. The value of hypnosis in immediately eliciting memories which an expert physician had been unable to revive after several sittings with the patient fully awake. A dreamy state is, as every psycho-therapeutic practitioner knows, the most effective for the process of reassociation. There is, however, no fixed line between the state of reverie desirable in every mental exploration and that of hypnosis, into which, indeed, any

patient may quite spontaneously pass during such examination.

6. The value of exploration as compared with suggestion. Suggestion merely presents a motive for an action contrary to that which it sets out to cure. But it is a well-established fact of experimental psychology that one process does not destroy, but can at most merely inhibit, an antagonistic process, and that, other things being equal, the older tends to outlast the later acquired activity. Exploration, on the other hand, is a far more radical operation than suggestion, whether it be suggestion by trephining or hypnotic suggestion. Exploration is, in my opinion, the main, if not the only, ground for recourse to hypnosis. Suggestion, whether practised under hypnosis or in the waking life, is comparable rather to a stimulant or to a counter-irritant, whereas exploration attempts to probe the cause to its very origin, resting on the belief that repression and dissociation are at the root of the disorder and that reintegration alone can effect a true cure.

## Clinical Notes:

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### GALYL IN THE TREATMENT OF POST-MALARIAL ANÆMIA.

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Dr. A. G. Phear, in his interesting article published in THE LANCET of Jan. 24th "On the Treatment of Malaria in Macedonia," makes reference to the use of galy. The result of the use of galy in the following case closely corresponds with the beneficial action claimed by Dr. Phear on the post-malarial conditions:—cachexia, anæmia, and splenic enlargement.

A private in the Royal Serbian Army, aged 27, was admitted to the — General Hospital at Vertekop, under the care of one of us (R. F. L.), on Jan. 10th, 1918, suffering from marked anæmia, bronchitis, and pain in the chest of two months' duration. No reliable history could be obtained of any rigor or vomiting nor of his having received quinine treatment. On admission he was very anæmic, his complexion being of a pale lemon-yellow tint. Temp. 98° to 99° 6' F. There were signs of bronchitis in the lungs, and he was very breathless on the slightest exertion. The spleen was definitely enlarged, but there was no evidence of enlargement of the liver, and no œdema. He was given a tonic mixture of iron, arsenic, and strychnine three times daily, and an expectorant mixture from Jan. 10th to 29th. During this period his temperature fluctuated irregularly in the daily rises from 99° to 100°, 101° and 102°, more often between 100° and 101°.

A blood film examination made on Jan. 14th failed to show any malarial parasites. The condition of the red cells gave evidence of his marked anæmia by the presence of degenerated cell forms and megalocytes. In a second examination made on the 23rd the search for parasites was equally unsuccessful, nor were any particles of hæmoglobin pigment found. The following complete count was obtained:—

Reds ... ..	1,520,000	Hb ... ..	30 per cent.
Whites ... ..	3,600	Colour index ... ..	= 1.0

Differential count in percentages:—

Polymorphonuclears...	35	Small lymphocytes ...	54
Large lymphocytes ...	10	Eosinophils ... ..	1

In counting 100 leucocytes 4 nucleated red cells were seen (3 normoblasts and 1 megaloblast). There were also marked inequalities in size (anisocytosis) and chromatophilic changes of the red cells.

As the patient was evidently making no progress on the tonic mixture, quinine was administered in daily intramuscular doses of 15 gr. on Jan. 30th and 31st and Feb. 1st, and subsequently by the mouth in doses of 20 gr. each day from Feb. 2nd to the 7th. The temperature, which had remained at about 101.6°, showed no change till Feb. 2nd, when it fell to normal. On Feb. 9th, as the patient was still very anæmic, it was decided to administer galyi. Before doing so, however, a blood examination was made and yielded the following count:—

Reds ... ..	1,940,000	Hb ... ..	40 per cent.
Whites ... ..	6,000	Colour index ...	= 1.03

Differential count in percentages:—

Polymorphonuclears...	49	Transitionals...	1
Small lymphocytes ...	30	Eosinophils ...	2
Large lymphocytes ...	16	Myelocytes ...	2

In counting 100 leucocytes, 8 nucleated red cells were seen (7 normoblasts and 1 microblast). The red cells also showed poikilocytic and anisocytic forms and chromatophilic degeneration, but no parasites or pigment particles were seen.

Galyi (0.4 g.) was then given intravenously in 20 c.cm. of sterile solution of sodium bicarbonate. The temperature, which had been normal from Feb. 2nd to the 9th, rose during the course of the day to 100.2° but fell to normal on the 10th. The patient rapidly showed improvement, and on Feb. 16th a further blood examination gave evidence of the satisfactory response to treatment:—

Reds ... ..	3,250,000	Hb ... ..	65 per cent.
Whites ... ..	6,300	Colour index ...	= 1

Differential count in percentages:—

Polymorphonuclears...	41	Transitionals...	4.5
Small lymphocytes ...	40	Eosinophils ...	3
Large lymphocytes ...	11	Basophils ...	0.5

In counting 200 leucocytes, 1 normoblast only was seen. The red cells showed some variation in size and shape and chromatophilic changes, but no parasites or pigment particles could be found.

On Feb. 21st a second dose of 0.4 g. of galyi was administered intravenously as before.

The patient continued to show marked and rapid improvement in colour and general health. The temperature remained normal and the spleen could no longer be felt. On March 1st a blood count gave the following figures:—

Red ... ..	3,990,000	Hb ... ..	80 per cent.
Whites ... ..	7,500	Colour index ...	= 1.02

Differential count in percentages:—

Polymorphonuclears...	47	Eosinophils ...	7
Small lymphocytes ...	29	Basophils ...	3
Large lymphocytes ...	11	Myelocytes ...	2
Transitionals...	1		

No nucleated red cells were seen and there was much less evidence of irregularity in size and shape of the red cells.

Unfortunately this was the last blood examination made before the patient was finally discharged on April 4th, 1918, quite well, looking fat, robust, and of good colour: in fact, improved beyond all recognition.

The patient was subsequently readmitted to the hospital in the autumn, having been slightly wounded in the course of the final Serbian offensive in October, 1918. He then looked extremely well and had put on weight. There had been no recurrence of malaria and the spleen could not be felt.

In the failure to discover malarial parasites it would, perhaps, be rash to describe the anæmia in this case as a post-malarial condition; for such an assumption might well be regarded as unjustified and open to grave doubt despite the fact that quinine produced an alleviation of the febrile condition. With this reservation, however, we feel fully

entitled to attribute the man's cure to the use of galyi, whether his anæmia was a post-malarial condition or not.

# NOTES ON A CASE OF PANCREATIC INSUFFICIENCY.

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THIS case appears to be worth recording as it presents many interesting problems, both of physiology and pathology.

The patient, a man about 40 years of age, first came under treatment in 1888, when he suffered from renal colic and ultimately passed a calcium oxalate stone. He enjoyed fair health until 1905, when, after some attacks of gout, it was found that the urine contained sugar and a trace of albumin. The amount of sugar varied from 1 to 5 per cent, and finally in 1911 it and the albumin disappeared. During this period he again passed a stone of calcium oxalate. Early in 1911 he began to have diarrhoea with offensive stools. This continued for six months and he lost much weight. In August, 1911, when he was in a nursing home having a sebaceous cyst removed from the back, it was noticed that the stools contained oil. A skiagram of the pancreas was taken, and a calculus was clearly shown in the duct of the gland. A second and third skiagram confirmed this. A month later whilst at Eastbourne the patient was seized with an acute attack of pain in the lower part of the abdomen, with vomiting and diarrhoea. The vomiting and acute pain lasted for six hours, and he was confined to bed for several days. During the next few months the abdominal pain, diarrhoea, and fatty stools persisted, and it was decided to operate with a view to removing a pancreatic calculus.

However, the pain became less acute, and skiagrams taken in April and May, 1912, showed no trace of the calculus in the pancreatic duct. The operation was therefore abandoned, but as the patient's general health was declining, and as the stools were still frequent, large, fatty, and offensive, he went into Dr. Combe's Clinique at Lausanne. Here he derived considerable benefit, partly from the use of hydrochloric acid and pepsin after meals and partly by adopting a more farinaceous diet. By the end of the year he was passing only two motions a day, and these were free from visible oil. There was no sugar or albumin in the urine. Occasionally during his stay he suffered from attacks of acute abdominal pain.

During 1913 there were some attacks of fever of several days' duration. There was no explanation of these attacks, but they were marked by an increase in the number of stools and by the passage of large quantities of oil. Patient revisited Lausanne during 1913 and 1914, and was more especially benefited by this last visit. His weight had dropped from 15 st. 2 lb. to 12 st. 5 lb.

From this period until the time of his death five years later the patient was greatly troubled by diarrhoea, four or five motions a day, of which the odour was extremely offensive; they were clay-coloured, loose, frothy, and at times looked like pure linseed oil. They were very difficult to retain and gave rise to pain and soreness at the anus. The analysis of the faeces always showed an excessive amount of connective tissue and striated muscle, enormous quantities of fat, and increased amounts of fatty acids and soaps. He was able to get about freely, and for the next five years his weight remained unaltered.

In 1916 it was first noticed that the blood pressure was excessive (310 mm. Pachon), and no measures taken succeeded in reducing it below 250 mm. The amount of albumin in the urine increased slightly, and on one occasion there was a trace of sugar in the urine. In 1918 he passed three renal calculi (calcium oxalate). Dropsy appeared in April, 1919, and four months later, in his seventieth year, he died from cardiac failure with very extensive oedema.