

CLINICAL CASE.

RECOVERY FROM MELANCHOLIA FOLLOWING PLEURISY.*

BY J. M. MOSHER, M. D.,

First Assistant Physician, St. Lawrence State Hospital, Ogdensburg, N. Y.

Except the few instances which defy explanation and are recorded as the curiosities of psychiatric literature, recoveries from insanity due to intercurrent physical disease, fall naturally into two groups. In one group are the patients in whom restoration of mental health follows shock, presenting in this reaction an analogy with the physical disturbances in the sane due to strong emotion. Dr. Labruyère's case of recovery from melancholia of several years' duration, after a severe bodily injury, is an illustration. His patient was extensively wounded by machinery about the head, face, and arm, the bones of the cranium were fractured and the brain partially exposed. Mental improvement was coincident with the process of cicatrization.†

Not less remarkable is the case reported by Dr. Allison, in which recovery twice followed separate fractures of both thighs, the first after a course of turbulent insanity of eleven years' duration.‡

The second group comprises recoveries attributed to altered conditions of the blood, or to the presence in the blood of toxic constituents. Analogous conditions in health are the artificial mental states produced by drugs, as the sudden insensibility of prussic acid, the languor of opium, the busy restlessness of belladonna, mania of alcohol or *erethism* of Indian hemp. The so-called metastatic insanities belong here, as well as the insanities cured by acute infectious and febrile diseases. The case of profound melancholia reported by Jacobi, in which improvement was simultaneous with abatement of tertian fever, typifies this group.§

*Read (by title) before the Association of Medical Superintendents of American Institutions for the Insane at Washington, May, 1891.

†Quoted in the *Journal of Psychological Medicine*, Vol. II., page 169.

‡*American Journal of Insanity*, Vol. XLIII., page 104.

§Quoted by Griesinger: *Mental Pathology*, Amer. Ed., p. 165.

Variola, pneumonia, diphtheria, scarlatina, dysentery, typhoid and typhus have likewise exerted favorable influence upon insanity, and as a stimulant of mental energy, even in far advanced dementia, there has been noted no such effective agent as erysipelas.

¹ Influenced by a case in his own practice in which recovery from acute mania occurred during the course of an attack of pleurisy, Dr. Willerding reviews the records of the favorable influence of pyrexial conditions upon mental disease, and refers to the fact that in some institutions for the insane an epidemic is hailed with satisfaction, and in others, inoculation has been actually practiced.*

F. E. F., a railroad conductor, was admitted to the Willard State Hospital, October 11, 1889, suffering with acute melancholia. His mother had been subject to puerperal melancholia; with this exception the family record was without blemish.

The history of patient's disease dated from the beginning of overwork in 1882, seven years before admission. At that time he purchased a new home, and devoted what should have been leisure to its improvement. To compensate the additional demand upon his strength he resorted to stimulants, and soon felt the disastrous effect in failing appetite, loss of sleep and severe headaches.

He persisted in excessive labor until the third summer following, when an attack of vertigo, occurring one night after he had retired, accentuated the earlier symptoms of failing health, and brought the first realization of their significance. A short vacation was without benefit, and symptoms of mental disturbance soon appeared. The patient became irritable, morose and seclusive. He continued his railway service, but appreciated an increasing weakness, which rendered difficult the performance of routine duties. During the spring before admission, he began to lose interest in his surroundings and in his customary forms of recreation. Of somewhat poetic temperament he had had a keen sense of the beauties of landscape. To this he now became indifferent; outlines gradually became indistinct, and there was finally an actual blurring of vision, with confusion of objects and distances. There then came a sense of oppression originating in the hallucination that space was "closing in"

*Allgemeine Zeitschrift für Psychiatrie, 46. 5.

upon him; he felt that he "had no room." Periods of depression, rapidly increasing in frequency and intensity, developed, and growing dislike of the company of others became a condition of apprehension and suspicion. In August, two months before admission, patient began to dread insanity. He became rapidly worse, and yielded to the sense of enveloping gloom, and to the idea that he was hopelessly lost. Soon afterward he passed into a condition of stupor, in the beginning of which he made two frantic, ill-devised attempts at suicide, and the next day was admitted to the hospital.

On admission patient was confused, and after answering several questions about himself with some intelligence, lapsed into a silent, stupid condition, evidently unable to direct his thoughts to what was taking place. He removed his shoes in the office, saying that he had only one pair of woolen stockings, and that his feet were cold. He also said that he had not slept well, and once or twice put his hand to his head as if in pain. His physical condition was fair; weight 148 lbs., (seventy-five pounds less than in health;) pulse, weak; circulation, sluggish; extremities, cold.

During the following week the patient sat with head bowed, avoided others, and ate sparingly, though it was not necessary to resort to the tube. This state of stupor was interrupted by occasional short attacks of mild frenzy, during which in anguish he started from his seat, clutched at his clothing, complained that from an overpowering dread he could obtain no rest, and pleaded that he and everybody else be relieved of suffering. The stupor was then replaced by a delusional state, in which the prevailing idea was the loss of soul and the inability of the sufferer to atone for his wickedness. He wished to endure punishment for others in order that they might be happy. In November the headaches increased, and he was often prostrated by the severe pain. He spent the month of December at home and returned January 6th. He now relinquished his delusions and lapsed into simple melancholia. His depression was extreme, and was complicated by ill-omened choreiform movements of the limbs and head, which he tried in vain to control. Every method of diversion and every resource of hygienic and therapeutic treatment were employed without avail; patient became worse from day to day, and his case was finally considered

hopeless. There was progressive diminution of strength and flesh.

Early in the following April he complained of pain in left side, shortness of breath and excessive weakness. On the 20th of April physical examination was made with negative result. On the 26th of April he was obliged to remain in bed and was oppressed by dyspnœa and intercostal pain. He had a chill in the morning and in the afternoon his temperature arose to 103°. Physical examination revealed the presence of a fluid effusion in the left pleural cavity, and the diagnosis was confirmed by the hypodermic needle. Palliative measures carried the patient through the night, but the next morning he was seen to be in critical condition from the agony of the pleuritic pain and orthopnœa. The operation of thoracentesis was successfully performed, and fifty-six fluid ounces of serum withdrawn. The relief was only partial, as the inflammatory process with its lancinating pain continued. Patient pleaded for relief from the pain and from the oppressive constriction of his chest; he prayed for a "long breath." Three days later the operation was repeated and two pints of serum evacuated. Chloranodyne was prescribed at bedtime; following its administration patient secured a few hours of uninterrupted sleep and the next morning awoke refreshed "for the first time in seven years." The next night his sleep improved, there was a sudden relief from pain, and he awoke the following morning hopeful of recovery and smiling.

Mental improvement dated from this time, and after two weeks patient felt that his mind was "perfectly clear." He improved slowly in physical health, was discharged recovered from insanity, October 1, 1890, and has spent the following winter in a dry warm climate for relief of his lung. There has since been gradual improvement in strength and flesh, and no indication of return of mental alienation.

In the case above recorded the pyrexial state was prominent and may have influenced the operations of the brain. The intrinsic value of the clinical history, however, rests with the predominating element of shock, and the accompanying process of reasoning, during which there was transition from apparently hopeless melancholia to mental health. Severe pain and dyspnœa united in the production of thoracic anguish, suddenly and without warning awakened the sense of impending death, and directed

the whole energy of the system to the cry for relief—"a long breath." Unlike the simple mental reaction of change of purpose in the wavering suicide who jumps into the water and swims ashore, there was a conflict between mind and body and body conquered.

Into the ill-defined region between consciousness and reflex activity, which marks the ending of body and the beginning of mind, light is thrown by the phenomena of the above case. There was strong assertion of the vital principle of self-preservation, which, hitherto dormant in the perverted consciousness of the patient, was excited by the powerful reflex stimulus of physical suffering. Forceful and renewed expression of the sympathy between body and mind inaugurated the normal train of thought, and the patient passed on to recovery.

Thus the record reveals not only the nature of the shock which produced a change in the intellect, but what the action of the shock was, and why that action was followed by sanity.