

THE
Journal
OF
Nervous and Mental Disease
Original Articles

HAVE THE FORMS OF GENERAL PARESIS ALTERED?*

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There has been considerable speculation in recent years regarding the variations of the forms of paresis. Many neurologists and alienists believe that the disease has undergone great modifications in types and in their proportionate frequency. Thus Paton, for example, believes that until recently the expansive form included the majority of the cases, but that now only one-tenth to one-fifth are of the expansive type; while the depressed type forms the majority of all cases, and the increase of the demented type is apparent only. Unfortunately Paton's generalization is based upon comparatively few cases.

Paresis with excitant and exalted delusions is considered by Brower and Bannister, on the other hand, as still the typical form of paresis, a statement to which most clinicians readily subscribe. The megalomaniac type is held by Diefendorf (who also quotes Kraepelin to the same effect) as becoming much less prominent, until now it is encountered in the disease in less than one-fourth of the cases. The dementing form is also held by Kraepelin to be the prevailing type, forming two-fifths of all cases; while the depressed form exists in more than one-fourth

*Read at the thirty-third annual meeting of the American Neurological Association, May 7, 8 and 9, 1907.

of the cases of paresis. One gains not a little insight to our subject in Kraepelin's statement that the neurologist sees more dementing forms of paresis than the alienist on account of the absence of the grave mental symptoms which necessitate asylum care.

As a representative of the English view one notes with interest that Clouston holds that one-third of paresis belongs to the dementing form and that all the older physicians in asylums believe the type is increasing at the expense of the grandiose type. However, it is interesting to note that not a few English writers fail to diagnosticate paresis in the absence of euphoria during some stage of the disease, a view largely dependent upon Mickle's teaching two decades ago.

Italian, French and Russian alienists make no extended comment upon the modern views of variations of type in paresis. Indeed, it may be said that not many writers of to-day in any country even, make anything like a genuine attempt to differentiate types or forms of paresis, hence our task of a wide geographical interpretation must be somewhat imperfect. Our own experience in hospital, dispensary and private practice led us at first to believe an affirmative answer should be returned to the query title of this paper.

On account of the varying opinions respecting the types of paresis and their proportional frequency, we have endeavored to dispel the present confusion of the subject and bring the whole subject up for general discussion here by making a careful analysis of 3,000 cases of paresis covering the period of the last three decades. The material under immediate study was drawn from the asylums of the New York Metropolitan district at Ward's Island and Central Islip Hospitals. Only male cases were considered in the study.

We have found it practicable to subdivide paresis in but three forms: grandiose, depressed and simple dementing. The grandiose form embraces all cases in which euphoria and expansive delusions obtained, whether attended by motor restlessness or not. The depressed includes all cases that have exhibited depression and excessive emotional element, depressive delusions or hypochondria throughout the major part of the disease. The simple dementing form includes those cases that show primary progressive deterioration without further mental symptoms the existence of

which would permit their being placed in either of the other two types.

Our analysis naturally possesses the advantage of covering the entire course of the disease, as all the cases were under asylum care and the histories were very complete, and the diagnosis was confirmed by death in the majority of cases. One appreciates the advantage of viewing the whole course of the disease in classifying types of paresis, inasmuch as the grandiose complex is not infrequently established late in the course of the disease. It often suffers a preliminary cloaking of hypochondriacal depression. Again, etiological factors other than syphilis, such as alcohol, very often tinge the prodromes of the disease, giving rise to persecutory ideas, ideas of marital infidelity, etc.

The gradual increase of the simple dementing form during the last few years shows that some cases of cerebral lues are finding their way into this class. Many simple dementing paretics of earlier years were, moreover, lost in the former classification of terminal dementia. Not a few cases in old records show that acute melancholia terminating in dementia should have been classed as the depressive type of paresis. All these facts explain the natural numerical advance of this form of paresis.

The same explanation can not, however, be urged of the acute maniacal phases of insanity, as the agitated types of paresis, for which they might be mistaken, usually present the wildest extravagance of euphoria.

In considering our analysis by year periods one finds no distinctive feature in the curve-charts. Although there is considerable variability from year to year in the thirty-year period we have analyzed, there is no constant law deducible. If one groups the data in *five-year* periods, however, there appears to be a fairly constant ratio between the total admission, the total parietic class and the total grandiose type; in other words, the ratio is constant between the cardinal features of the disease study. This fact alone teaches us that the grandiose element in paresis is the true disease complex. The principle may be considered so firmly established that no immediate change in it may be looked for in the future. (Time may be saved if the charts are allowed in the main to speak for themselves.)

We found the euphoric syndrome in recent years less extrava-

gant, less grotesquely exalted. Patients in the last decade spoke of possessing, or hoping to possess, a few thousand dollars, instead of having billions of trillions as formerly. The frequent persecutory ideas of the grandiose state have a curious exalted trend and are strangely mixed with true euphoric concepts, even in the same sentence.

A percentage analysis of the grandiose type by five-year periods shows that there was a steady increase from 1877 to 1896, from which date there has been a gradual decrease to date. Fully 70 per cent. of paretics are of the grandiose type to-day. Even in mild euphoria the manner of grandiose reasoning in paresis is as characteristic as that encountered in the persecution of paranoia.

On the whole one may say that the depressed type of paresis has steadily decreased in frequency since the first five-year period (1877-81), at which time it was 15 per cent. of the total parietic class. It reached its minimum frequency in 1892-96, when it was about 10 per cent. It has increased slightly in the last ten years. During the last five years it has stood at about 12 per cent. of the total parietic data.

It is interesting to note in passing that while Bayle in 1822 first recognized paresis as a morbid entity characterized by ambitious delusions which he believed to be pathognomonic, it remained for Baillarger of Paris, nearly forty years after, to show that the depressive syndrome might exist in certain forms of paresis. The French school exemplifying the old adage, still persists to-day in making no provision for these cases in parietic classifications. There is often a strangely enlarged view even in the depressive phase of paresis. Patients believe they have murdered all the people in the world, have killed all the numerous members and relatives of their family, etc.

The greatest period of frequency for the simple deteriorating class of paresis was in the first five-year period of our analysis (36 per cent.), since which time there was a steady decrease until during the last ten years it has remained constant at about 17 per cent. As the type runs a rapid course, without remissions, and almost invariably ends in convulsions, the majority of the cases remain outside of asylums until late in the disease. Indeed, the greater part of the disease course is an extra-asylum state. This fact accounts somewhat for the opinion among neu-

rologists that the simple dementing form is gaining in frequency at the expense of the grandiose type. Difficulties in diagnosis here, as elsewhere in paresis, are largely removed if one depends more on the somatic signs than on any mental criteria.

In conclusion it may be said but three types are needed for analysis of paresis, and variations between types of late years are less great than formerly held.

The true explanation of the occurrence of a considerable number of depressed and simple dementing types of paresis rests upon a more exact analysis of cases and a recruiting of these two classes from the melancholias and dementias of former years. The real but slight variations in types are due to a better system of treatment and earlier diagnosis. Moreover, the specific treatment of syphilis, in paresis, has largely been discarded for more rational principles of hydrotherapy, dietetics and hygienic surroundings, both in and outside of asylums. The more prompt detection of the disease has made paresis a younger disease; more cases occur between 20 and 30 than formerly and fewer occur over the age of 50. In whatever light paresis is viewed we can hope for but little variation in the disease, inasmuch as the fixed and definite causes of paresis are syphilis, alcohol, sexual excesses and mental stress. We believe the relative percentage of the various types should be more generally expressed in textbooks, in order that readier comparisons and deductions may be made.

The whole subject under study here is far from being merely academic. The different types of paresis have a widely dissimilar prognosis. The determination of the true syndrome of the disease and its atypical forms is, therefore, a very practical and timely issue.

Finally, from our study of 3,000 cases we deduce that paresis is essentially a disease in which the grandiose type predominates in about 70 per cent. of all cases, the dementing form occurs next in frequency of 20 per cent., while the depressive form is found in but about 10 per cent.