

medical service for Hampstead was successfully inaugurated by the adoption of rules and the enrolment of members.

The service is the outcome of an endeavour to co-ordinate upon a sound footing the contract medical work in the district, and to provide medical attendance and medicine for persons unable to pay the ordinary medical charges in the usual manner. The aim has been to organize a scheme which would be acceptable to the profession generally, with as little interference as possible with existing institutions, and to make it easy for clubs and provident dispensaries to affiliate themselves to the public medical service.

As this is a comprehensive scheme to put into medical hands the conduct and control of a variety of medical charity hitherto controlled by non-medical bodies, its progress will no doubt be watched with interest by medical men in all Divisions of the metropolis.

The work of organization has been very arduous, and the difficulties, as was to be expected, have been great, but not insurmountable by united effort. This preliminary statement will be followed by a more detailed account of the scheme, which might usefully and profitably be imitated by other metropolitan Divisions of the British Medical Association.—I am, etc.,

W. B. PARSONS,

Honorary Secretary, Hampstead Division, British
Medical Association.
London, N.W., Nov. 24th.

STRESS AND SHOCK AS CAUSES OF INSANITY.

SIR,—I was greatly interested in reading a statement made in the last issue of the BRITISH MEDICAL JOURNAL: "At one time 'moral causes,' including shock or fright, took first place in the returns made to the Board of Lunacy among the etiological factors; to-day many medical superintendents return hardly any cases under the head of 'mental stress.' . . ."

Only those who are actively engaged in asylum work know the difficulties with which one has to contend in obtaining satisfactory histories in cases of insanity. In pauper asylums a large percentage of patients are transferred directly from workhouses, where they are often friendless and unknown, and, beyond a few bald statements regarding age and occupation given by the relieving officer, one has no definite data on which to base a conclusion as to the causation of these patients' mental diseases. Again, one is often surprised, when interviewing a near relative of a patient, at the ignorance displayed concerning such patient's parents or relations. Though evidence of insanity may not be wilfully withheld, there is always an inherent reluctance in admitting it. In attempting to obtain a history of syphilis—as in many cases one naturally cannot rely on the statements of an insane patient—a relative will frequently deny any knowledge of such infection. To cite a case in point: Some time ago I interviewed the widow of a general paralytic, at whose autopsy I found well-marked syphilitic lesions. She had been compelled to give up her work as a schoolmistress, owing to loss of voice. Examination showed that she was suffering from syphilitic laryngitis, yet she could give me no idea when infection had taken place, and had attributed her hoarseness to a bad cold. All medical men know the type of patient who, when questioned as to previous illness, will wax eloquent, and give an exhaustive epitome of his past ailments and their attendant symptoms; but, when attempting to extract useful information regarding the causation of an attack of mental disease, one often meets with the greatest difficulties, and I am certain that if more accurate histories could be obtained it would be found that shock and mental stress play a much larger part in the causation of insanity than is usually suspected.

I have recently had under my observation two cases that can certainly be classified under these two headings. A platelayer, employed on the railway, was struck by an express train and hurled up the embankment. He was found lying unconscious, with a compound fracture of the forearm, and conveyed to the infirmary. Whilst in that institution he became miserable and depressed, was subsequently certified and sent to the asylum, where he made a rapid and complete recovery. The other case was that of a young electrical engineer employed

at a colliery. Having finished work, he was about to start home, when, in the absence of his "chief," he was summoned to attend an electrical coal-cutter that had broken down. He worked for twenty-four hours continuously before the job was completed, and, having no one in authority to appeal to in his difficulties, he was kept at high mental pressure all this time. He eventually returned home after working nearly thirty-six hours without rest, and, though physically fatigued and mentally worn out, he could not sleep. In the course of a few days he developed auditory hallucinations, which necessitated his removal to the asylum, where he recovered satisfactorily in a few weeks.

In both these cases, though the most careful inquiry was made into the personal and family histories, there was nothing other than shock and mental stress to account for their mental breakdown.

If any one cares to study the painful details and histories of many cases of suicide that figure so largely in the daily press, one cannot get away from the fact that mental stress is a most important etiological factor in the causation of insanity, and must be acknowledged by all students of mental disease.—I am, etc.,

GUY R. EAST, M.B., D.P.H.,

Morpeth, Nov. 22nd.

County Asylum.

THE INTESTINAL FUNCTION.

SIR,—As a general practitioner, I find the BRITISH MEDICAL JOURNAL very interesting, though it "takes one all his time" to keep up to it. I suppose there is no occupation of which it is more true that the worker must be a "perpetual student"; indeed, one of my acquaintances said to me, "We have to go to school again every week"! To me, at least, this is true: almost every number of the JOURNAL brings fresh light or, at any rate, helpful and suggestive observations upon one or more subjects of special interest to one's self; often upon the very case in hand one is most needing such help for.

For instance, in a recent number (July 10th) we have the original observations of Dr. Stacey Wilson on the colon. These are of special interest, for they undertake to describe, for the first time that I have seen, the *feel* to the clinical examining hand of the normal and abnormal caecum and sigmoid flexure. In interpreting these observations, Dr. S. Wilson invokes an entirely new theory of muscle action—namely, that at least the unstriped muscular fibres of the bowel both *push* and *pull*, that they can lengthen as well as shorten! If this becomes a substantiated fact it will have far-reaching effects, and its recognition should greatly advance our efficiency as practitioners.

A question I should like to ask is: Does not the large intestine in mankind consist of two portions—diverse in function, in anatomical and physiological relations, and in disease? I have proposed the names Colon and Omegon, the former comprising the ascending, transverse, and descending portions; the latter the so-called sigmoid flexure and the rectum. It would be very helpful if clinicians would bear this in mind, and observe and record any distinctions that can be demonstrated between, for instance, the caecum and the sigmoid in the light of this new theory of perverted muscular action. When I was a student in the London Hospital "perityphlitis" was in vogue; twenty years ago appendicitis got its innings, and latterly we have been learning much about the sigmoid—its angulations, stricture, diverticula, prolapse, and "peridiverticulitis." Meanwhile the physiologists have been defining the functions of the alimentary tract and its various divisions, and unravelling its complicate and hitherto undreamt-of movements, by experiments on animals, and by the *x* rays. But do we even yet realize as we might the ideal, normal rôle of the so-called "large intestine"? I think if we had a clearer idea of the *normal* we could better observe and differentiate the *abnormal*, and I therefore wish to refer to my description of the human alimentary canal as five retort-like portions, in series: (1) The mouth and gullet (*laimon*); function, deglutition. (2) The stomach—*fundus plus antrum (gastron)*; function, "digestion," primary, of the meal—the gastric "mill." (3) "Small intestine" (*enteron*); function, the main digestion, absorption, etc.—the most vital part. (4) Part of the so-called