

About the eleventh month, she fell in a well-marked epileptic fit, in which she was much convulsed. One week afterwards, she began to show a difficulty in articulation; she stammered, but protruded the tongue well. This difficulty gradually increased. She was quite conscious of the change, and complained of it. She complained also about this period of occasional headache, and a sensation in her arm which she called a jumping of the bone.

After this, she became gradually excited, and disposed to be violent. Her movements were stiff and slow. The excited conduct extended from the eleventh to the fourteenth month from her admission. Her general health was not greatly impaired; she took her meals, and retained her usual amount of flesh. She had no return of fit. On May 10th (fourteenth month after admission), she was, after a day of great excitement, taken with vomiting. The bowels were also confined. She would not take medicine, but was relieved by an enema. A few days afterwards (May 14th), she became libidinous in her actions.

May 15th. She continued very excited; threw herself about in a wild manner and somewhat indecently. The skin was moist, and emitted an extremely offensive odour.

May 17th. She had a restless night, and had a very violent fit this morning. At my visit about 2 P.M., she had a second fit, from which she did not rally. She died in the convulsion; the face being flushed, and the limbs contracted.

[To be continued.]

DIPSOMANIA.

By F. D. FLETCHER, Esq., Liverpool.

[Read before the Medical Society of Liverpool.]

AMONG the many evils produced by drunkenness which come under our notice in the practice of our profession, not the least is the origination of that morbid state of mind and body to which the title of Dipsomania has been assigned.

I propose now to make some observations as to this condition; in reference to its characteristic features; the manner in which it is occasioned; the course which it runs; and the treatment by which we may attempt its cure.

The special symptoms which characterise this form of mania are, I think, as distinct as those which mark the individuality of any other form of monomania. The maniacal tendency to drink is as evident in the dipsomaniac as is the maniacal tendency to kill, to burn, or to steal, in the homicidal monomaniac, the pyromaniac, or the kleptomaniac. I may be asked, perhaps, what we are to understand by this general term of maniacal tendency, and I reply that I hold that tendency to be maniacal in its character which has acquired such power over an individual as to completely subjugate his will—so that in obedience to its impulses he will act in direct opposition to the dictates of his judgment, his instincts, his interests and his own desires. I do not consider a man maniacal whose conscience and judgment are simply silenced for a time by the voice of his passions, and who for a time surrenders himself voluntarily to their misguidance; but I do consider that man to be maniacal who, with his conscience and judgment alive and active, has a will so powerless that he is at the mercy of every influence brought to bear upon him.

I do not profess to be able to draw a line which shall exactly mark the boundary between that condition in which a man does evil of set purpose and that in which he does evil in spite of himself; but I think that facts bear me out when I assert that there is such a psychological condition as that which Coleridge described, from his own experience, as

“paralysis of the will,” and in asserting further that the place and influence of the paralysed will are usurped by other powers that act upon the mind and soul. It has often seemed to me that between our physical and psychical natures there is this analogy; that, as the physical part of us when its power is at a low ebb becomes susceptible of morbid influences which, at other times, and when its vigour is in full force, pass over it and produce no effect, so when the psychical part of us (which I take to be synonymous with the moral part of us) sinks low in depravity, it also becomes the helpless subject of forces of evil which are powerless against a nature which breathes a purer moral atmosphere and lives in a higher moral condition. Now to apply these general principles to the particular class of cases before us, I think that those who have many drunkards brought under their notice, and who inquire into their natural history, will see that they are divisible into two great general orders—those who drink because they like to do so, and those who drink because they cannot help it. I use the term drink generally, but I should of course group habitual opium eaters along with dipsomaniacs.

Inquiring into the causes of drunkenness, I find that by far the larger number of those who come under my notice at the workhouse ascribe the commencement of their debauches to drinking just because they are in a drinking company, or to drinking to drown care. A smaller number cannot say why they drink, and some acknowledge that having once begun they cannot stop.

It seems that there must be some constitutional difference of a physical nature and independent of the moral condition, which determines the desire for stimulants which we find in some people and the indifference to them that there is in others. Drunkenness does not always accompany moral degeneracy. We find some men who are neither moral in their habits nor scrupulous in their associations, who live in the society of those who drink, and who yet themselves do not drink. We find others whose moral character is good, whose associations are good, and in whom, nevertheless, there is a tendency to drink sometimes heroically vanquished, at others tyrannously asserting its power, over-mastering the most solemn resolutions and driving its victim into excesses to which he looks back with loathing and shame. Again, among drunkards themselves there is likewise discernible a fainter trace of the same diversity; there are among them the habitual deliberate drunkards, who can go to bed drunk every night and yet be up and fit for work every morning; and the impulsive, occasional drinkers, who, when once fairly launched on a debauch, can no more stop themselves than they can arrest the wind or tide.

How is this condition occasioned? At times we get clear proof of the hereditary transmission of this tendency from parent to child, coming out sometimes in the precocious appetite which some children manifest for stimulants, but more frequently evidenced by the later development of intemperate habits in successive generations of the same family. In some cases where drunken habits infest certain families, it may be difficult to say how much of the bad result is due to bad example and bad training; but we do find occasionally the drinking propensity developed where there has been no cause to blame the example offered to a child or the training to which he has been subjected. It is, however, but in a minority of cases that we can prove the hereditary transmission of this taint; far more frequently we can trace the course of the patient's drunkenness upwards to its source, and ascertain how the tendency has been acquired. We may find three distinct stages in the patient's history;

the first, in which his will had its full power and kept the passions in check; a second, in which the power of the will was impaired but not lost, and when he struggled with various alternations of success and failure against the temptations which beset him; and a third, in which the will had surrendered at discretion, all self-control had been lost, and in the full development of dipsomania he had become less amenable to reason and conscience, and more thoroughly a slave to mere appetite than a brute.

As a classical example of the inherited form of this disease I would instance the case of poor Hartley Coleridge, and of the acquired form that of the still more miserable Branwell Bronte, brother of the author of *Jane Eyre*.

Are we to consider all habitual drunkards as dipsomaniacs? I think not. A man who habitually drinks and who as a result only habitually gets drunk—whose senses return to him as often as the drink dies out of him, must be a very bad man, but may not be a mad man. Again and again I have noticed the fact that an overdose of alcohol which makes one man drunk will make another man mad. But it may be asked is not every drunken man mad—for a time in a condition of acute dipsomania? I think that the evidence points the other way. In simple drunkenness the old proverb comes true—"in vino veritas." The man's whole powers are in a state of unnatural activity, his passions are uproarious, their din drowns the voice of his conscience, and the real animal such as he is, when unrestrained by moral laws or conventional decencies, comes clearly into view. The same features which distinguished his character when sober are discernible when he is drunk, though it may be in an exaggerated and distorted form. But in another class of men there is something widely different from this. A few glasses of wine make the man truly "a man beside himself," make him a being as different from his former self as darkness from light—produce not drunkenness but mania. He does not go reeling through the streets, he does not go helplessly off to sleep. He is excited truly, but you have not the exaggeration of his own character but the development of another; "all that was intellectual has become devilish, all that was animal has become beastly." His mania may manifest itself in mere recklessness; in the manner he will stake hundreds or thousands on a game at "blind hookey," or the prodigality with which he will stand champagne all round for all chance comers. Just as frequently it shows itself in wanton destructiveness or blind ferocity. A man will go home from the public house and smash his windows or his furniture, or possibly his wife and children, if they happen to be the articles that come most readily to hand. There is further a difference noticeable in the secondary effects of prolonged excess, which results in some cases in delirium tremens, in others in fixed hallucinations without the sleeplessness tremor and depression of delirium tremens. Now though I cannot assert that the two classes of cases which I have described are divided by a sharply defined limit; still I think that evidence warrants the assertion that alcoholic intoxication eventuates, in some cases, in mere excitement, followed by corresponding depression, and that again by delirium; and in others it ends in the production of distinct mania.

It may not be out of place here to mention that analogous phenomena are sometimes met with among the effects produced in different persons by the fever poison, which occasions in most a confused delirium, but in some gives rise to acute mania; so that occasionally cases under my own notice have seemed to be those of simple mania till the appearance of the fever rash has revealed their true character. I believe, then, I may fairly assert that there are two distinct

sets of causes of drunkenness and two distinct kinds of results; that one set of men drink because they like it—they are drawn into drunkenness; another set drink to appease a craving which over-masters their will—these are driven to drunkenness; and that drinking results in some men in making them drunk only, in others in making them mad as well as drunk.

As illustrations I may quote two cases that have come under my own observation. A. B., a professional man, first seen under the secondary effects of drink, had no distinct delirium tremens, very slight delusions if any, was very violent and outrageous at times, but there seemed this method in his madness, that all his extravagancies and outrageous behaviour were just means to an end, simply employed to make those about him uncomfortable until they got him something to drink. I was informed that his father drank himself to death; that the patient had many years since manifested a strong tendency to drink, becoming at times uncontrollable; that his drinking bouts had become more and more frequent since the death of his wife. He had reduced himself to the most miserable condition, could neither eat nor sleep; he simply lay in bed and drank; sometimes to the extent of a quart of brandy in a night. As the result of this he had sunk into a condition like that of a patient in pyæmia or some other blood poison disease, with a cold skin, small thready pulse, almost constant vomiting, very slight delirium, but a constant cry for drink. Under the use of small, frequently repeated doses of morphia, the superintendance of a keeper, with the disuse of stimulants and the careful administration of food, he soon recovered. I then advised, as his only chance, complete abstinence from all stimulants. This advice he followed rigidly for some time; but now it became evident that he really did get thoroughly out of condition on the teetotal plan, that he lost flesh and became subject to the development of boils and carbuncles. I dared not advise him to resort again to any form of alcoholic drink, but earnestly counselled him to get away from town and to put himself under treatment at some hydropathic establishment, where he would be away from the temptation of drink, and where the change of air and scene would soon tide him over this period of depression. Unfortunately this advice was not followed. He began to take a little porter, thinking that he could keep to that and avoid spirits. The fallacy of this idea was only too soon made manifest, the old habit reasserted its supremacy, and even with more vehemence than before; all the old symptoms were reproduced, and brought with them a new one—epilepsy, a symptom which I have learned to dread more than any other, when it comes as the result of long-continued drunkenness. It was evident that no means were likely to be beneficial while any personal liberty remained to him, and he was therefore removed to an asylum, where he speedily recovered his health and strength, and whence, after about three months, he was discharged quite well. For a time he then went on steadily; but, as before, the old feeling of want of some support besides food, the old craving for drink, returned, and again he sank into a condition like that already described. He was again committed to an asylum, but this time the epileptic symptoms gained a fuller development than before, and proved rapidly fatal.

Another case recently under my care is worth notice, as an instance of the acquired tendency to drink. A lady, aged something more than fifty, a widow, first sent for me for what she termed a bilious attack. Under very simple treatment she soon recovered from her "bilious" symptoms. These, however, returned two or three times in a manner that somewhat puzzled me and made me suspect some unacknowledged cause. At last I was surprised

to find one of these attacks eventuating in distinct mania, the cause for which was betrayed by the discovery of a small battalion of empty gin bottles in her cupboard. I found that in her case no tendency to drink was perceptible, till some time after one of her confinements, when, being rather low and weak, she was ordered a certain quantity of stimulant as part of her regular diet. It unhappily occurred that her husband was a good deal out, and she therefore a good deal alone, and by degrees she unfortunately found how her solitude was rendered more tolerable, and her depression of spirits mitigated, by an extra glass or two. The habit thus acquired strengthened by degrees its hold upon her, till her reason for a time was completely unhinged, and she became for about six months an inmate of an asylum. Here she happily acquired the art of living without stimulants; for a long time never tasted a drop, and was, according to her own account, never better than during this period. In this respect especially this case differs from the former one; the patient made no excuses on the score of any alleged necessity that she felt for it, but said that a craving she could not explain, and that overpowered her strongest resolutions, drove her to drink. Happily for her, any large amount of spirit at once gives rise to considerable stomach disturbance, ending in violent vomiting and purging. In the last two attacks, both induced by brandy drinking, there have been no head symptoms, and only those referable to the stomach. She is now, I hope, keeping well, having most strenuously promised to be a strict teetotaler. How long this reformation is to last, however, I feel no certainty whatever.

One phenomenon in fully developed cases of dipsomania is the progressive deterioration of all the faculties, physical, intellectual, and moral. Conscience seems obliterated, and nothing is more marked than the loss of all truthfulness, and the acquisition of an actual talent for lying.

What can we do to prevent and to cure these miserable cases? Their prevention is only likely to be accomplished by the gradual spread of sounder ideas than appear to be generally current as to the use and abuse of stimulants. I do not think it likely that there will ever come a time when wine and strong drink shall be banished from our dietaries and immured in the pharmacopœia; but I do think it both likely and desirable that a time should come, and that speedily, when though we may profitably use these things as we use our food, yet we shall have outgrown those barbarisms and superstitions the remnants of which keep up a few of the old drinking customs which have been the curse of this and other northern nations. As to their cure two things have to be attempted—1, to relieve that physical depression which originates in some the craving for stimulants; and 2, to rouse the will to assert its rightful supremacy over the man. With regard to the first of these I need offer no advice to an audience such as this. With regard to the second, if in the early stage of the disease we can succeed in influencing the will, *via* the conscience, if we can make the patient determine that he will die rather than drink, we have a gleam of hope that we may check the tendency before it has acquired the mastery which a mania possesses when once inaugurated. But suppose we fail. Well, if the patient cannot restrain himself, we must perform that necessary function for him. Here we come to one of those practical difficulties which beset every thing that ought to be done—that of deciding when it is morally right and legally safe to deprive a man of his liberty, if he is mad upon one point only, and that drink.

As the law appears to be now generally understood, we must be able to allege some overt acts of the patient over and above the mere maniacal drunken-

ness in order that he should be committed to the safe custody of an asylum. We are thus cut off in many cases from the possibility of enforcing sobriety in the early stages of the malady, when some permanent good might be expected to result. Under present circumstances, also, the subjects of this mania are liable to be discharged from confinement very soon after they return to apparent sanity. This is in most cases at a period when their maniacal tendency is far from being eradicated, and is only repressed by the restraint which has been enforced. What can we do, then? If we are convinced that dipsomania is as real a morbid condition as melancholia, if we believe that, like other forms of mania, it is most likely to be cured by keeping the patient from scenes and circumstances which favour the growth of the ideas whose morbid development determines the specific form of his mania, we shall claim for the victims of dipsomania the same advantages which we accord to other mischievous monomaniacs. These others are not so unfortunate as to be left at large, nor is the fatal gift of liberty thrust into their possession as soon as the obtrusive symptoms of their maladies subside. No, they are as happily for themselves as for society, secured as soon as their monomania is distinctly developed, and they are retained in safe keeping till there has been time for morbid ideas to lose their hold, and for the mind to regain its vigour. We all know that in cases of homicidal monomania especially, imprisonment during her Majesty's pleasure, being interpreted into fact, very frequently signifies precautionary confinement for life. If it be possible for us to inaugurate a wise and successful plan of treatment for these cases, we shall rescue many a life from a miserable and disgraceful close, and save many a family from the penalty in which they would otherwise be plunged by the recklessness of a madly drunken parent.

I would suggest that means should be taken to ascertain what amount of dipsomania really exists, and whether it exists in such amount as would render justifiable the establishment of special legal regulations for the treatment of the victims of this mania; that the proof of an uncontrollable tendency to drink should be held by itself to legalise the confinement of the individual; that the necessity of restraint for some time after apparent recovery should be recognised by the Commissioners of Lunacy, and its enforcement authorised; that in cases of relapse this period of probation should be at least doubled every time that a patient is readmitted.

If it be objected that provisions such as these interfere with the liberty of the subject, I at once admit that they do; but, I ask, do they interfere more than humanity and common sense demand? If a man's liberty is incompatible with the well-being of society, or even incompatible with his own safety, we rightly take his liberty from him.

But there is yet one other way which has been tried, and I believe successfully in America and in Scotland.* Many a maniac is conscious of the impotence of his will to resist the impulses which sway his feeble mind and voluntarily surrenders liberty. Many dipsomaniacs may feel this too, and I believe that were reformatories for drunkards established in this country, many a one might be snatched from his doom.

Gentlemen, we all know that the cases to which I have referred are not few and far between—are not limited to any class of society. Which of us has not seen them blighting the families in which they occur, planting a sorrow more bitter than that of those who mourn for the dead in the hearts of those to

* I am informed that in the Isle of Skye and some other of the islands of Scotland, patients who are willing to place themselves under treatment may be kept from the temptation to obtain drink, without subjecting themselves to anything like the restraints of an asylum.

whom the victim is dear? Which of us has not seen men, or still worse women, possessed by this impulse, descending swiftly, and only too surely, that easy slope which leads from one level of degradation after another lower and lower to the dark waters of a hopeless death.

These cases come fairly within the range of our discussions. They demand, I think, our very serious consideration. Their prevention and their cure demand our most earnest efforts.

Transactions of Branches.

SOUTH-EASTERN BRANCH: WEST KENT DISTRICT MEETING.

TWO CASES OF MEDIAN LITHOTOMY: ONE RECOVERY: ONE DEATH.

By FREDERICK JAMES BROWN, M.D., Rochester.

[Read at Maidstone, Oct. 30, 1863.]

CASE I. Thomas F., aged nearly 2 years and 7 months, residing in Delce Lane, Rochester, was seen by me and sounded for stone on April 23rd, 1862. The child had been suffering for seventeen months from decided symptoms, which commenced suddenly one day after the return of the child from the fields in which it had been playing.

The sufferings were severe; so much so as to cause the child to tear its hair and to scream on the passage of the urine and of the feces. No blood was ever passed except when the sound was used by the surgeons that were consulted on his case.

I operated on the child at 3.30 P.M., on April 28th. Chloroform was administered with excellent effect by Mr. Fayle. I was further assisted by my brother John and by Dr. La Fargue. I used Millikin's No. 1 staff and Poland's forceps. I performed Allarton's operation. The large size of the stone made it necessary for me to introduce a probe-pointed bistoury and to incise the prostate on one side. I then introduced a larger pair of forceps and extracted the stone. The child soon recovered from the effects of the chloroform, and was removed to bed. The size of the calculus was one inch and a half in length, one inch and an eighth in breadth, and thirteen-sixteenths of an inch in depth. The weight was 270 grains. The surface was tuberculated in some portions, smooth in others, and the colour was yellowish and clay-coloured. The composition appeared to be a lithic acid nucleus coated by lithate of ammonia.

At the evening visit, the child was found sleeping, waking up at intervals and crying for a few moments. There was no vomiting and no hæmorrhage.

Next day, the child was visited at 7 A.M. It had slept through the night, but had been light-headed. The urine had passed freely through the wound.

Vomiting commenced early in the morning, and was increasing in urgency. The vomited matter consisted of mucus; cold water alone was retained. The abdomen was swollen. Calomel and fomentations were prescribed. The child changed for the worse at ten o'clock, and was found in a moribund state at 3.30. Death occurred at 4.40 P.M.

POST MORTEM EXAMINATION, twenty-six hours after death. The abdomen was distended by gas within the intestines. There was redness of the small intestines; and effusion of lymph on the most prominent portion of intestine near the umbilicus. The rectum was uninjured, and free from inflammation. The *cul-de-sac* between the rectum and bladder was free from injury and from inflammation. The

bladder was contracted and perfectly empty. No fragments of stone were found within its cavity. There was a violet tint on some of the folds; but the mucous membrane was firm and free from laceration. The walls of the bladder were hypertrophied; but they were healthy in structure. There was a bruised opening in the anterior part of the bladder, insufficient, in the dead state, to let the calculus pass through it. There was no extravasation of blood or of urine within the pelvis. The wound in the perinæum was in excellent condition.

The death-certificate was thus worded:—Calculus vesicæ, seventeen months; median lithotomy, twenty-four hours; peritonitis, twenty-four hours. *Post mortem* examination.

REMARKS. The remarks that I have to make on this case, relate to the duration of the complaint, the size of the stone, and the cause of death. The child suffered severely for the entire period of seventeen months, during which time the stone came to occupy the cavity of the bladder fully when this viscus was empty. The size of the stone was so great that it was impossible to remove it in an entire condition without injury to the fascia attached to the neck of the bladder, yet there was no extravasation of fluid. The cause of death—namely, peritonitis—and the early period of death have been noted as usual in the extraction of large calculi from children.

CASE II. William M., aged 3 years and 7 months, residing at Hoo, was brought into Rochester to be operated on for stone. I performed Allarton's operation on August 18th, 1862, at 5 P.M., assisted by Mr. Fayle, Mr. Hutchins, and my brother John. The symptoms had been present for eighteen weeks, and the sufferings had been severe. The child was in the habit of screaming twenty times in the night, or oftener, so as to disturb the neighbourhood. The rectum and bladder were very irritable. No blood was ever passed.

Chloroform was administered with good effect by Mr. Fayle. Millikin's staff No. 3 was used. When the finger was introduced into the bladder, the calculus was felt to be at the fundus. A short pair of forceps was used successfully after failure with a long pair. The calculus was extracted without force. The child was pale after the operation, and in a state of stupor, from the effects of the chloroform. Cold water was freely used. Silvester's method of artificial respiration was employed. The child soon recovered consciousness, and was removed to bed. The calculus measured fifteen-sixteenths of an inch in length, three-quarters of an inch in breadth, and half an inch in depth. It weighed sixty-three grains. Its composition appeared to be a lithic acid nucleus coated by phosphates.

The child was visited at 8.30 P.M. He had vomited at eight o'clock. He occasionally cried out from pain in the back and in the abdomen. Urine tinged by blood had passed through the wound. Tenesmus and dysuria were present. Flannels wrung out of hot water were applied to the perinæum.

August 19th. The child was found to have passed a good night, sleeping at intervals; but he cried out when urine escaped by the wound. There was no vomiting and no bleeding. The wound presented a healthy appearance, with its edges in close approximation. Milk and arrow-root diet were ordered.

Evening. The bowels had acted once, and the urine had passed freely through both the meatus and the wound. The child had been pulling at the penis to relieve the scalding pain caused by the passage of the urine through the meatus. There was some pain in the abdomen; but there was no swelling. Mercurial ointment was ordered to be applied to the abdomen.

August 20th. The child had passed a good night,