Abstract 51 Table 1

Patient Number	Gender	Age	Medications on Admission	Current Medications
1	M	65	Thiamine; Perindopril; Olanzapine; Ensure; Lorazepam; Ipratropium spray; Sodium Valproate; Trazadone	Perindopril; Bisoprolol; Lactulose; Ipratropium bromide; Sinemet; Macrogol; Sodium Valproate; Folic Acid; Mirtazepine; Ferrous fumarate
2	M	58	Pyridoxine; Sertraline; Lorazepam; Lactulose; Movicol; Paracetamol; Cetrine; Zopiclone; Trazadone; Cyclizine	Fortisip; Sertraline; Artelac drops; Olanzapine
3	M	68	Haloperidol; Lorazepam; Fresubin; Cyclizine; Symbicort Turbohaler; Lansoprazole; Spiriva.	Sodium Valproate; Seretide; Tiotropium; Sertraline; Olanzapine; Pregabalin; Zopiclone; Fresubin; Calcichew D3.
4	F	51	Zopiclone; Trazadone; Lansoprazole; Lorazepam; Haloperidol.	Tiotropium; Vit D3; Sertraline; Sodium Valproate; Mirtazepine; Topiramate; Aripiprazole; Atorvastatin; Haloperidol; Citalopram.
5	M	75	Quetiapine; Zolpidem; Lipitor; Glucophage; Aspirin; Ramipril; Tamsulosin; Valproate; Diamcron	Atorvastatin; Aspirin; Quetiapine; Sertraline; Bupropion; Procol Nutricreme; Sodium Valproate
6	M	58	Multitamin; Forticreme; Cubitan; Calogen; Olanzapine; Calcichew; Omeprazole; Alendronic Acid	Citalopram; Sodium valproate; Omeprazole; Prolia; Timolol/latanoprost drops; Calcichew D3; Olanzapine; Iron.
7	F	59	Mebeverine; Clonazepam; Olanzapine; Haloperidol; Atrovastatin; Diazepam; Tegretol; Thiamine; Clonazepam; Lipitor.	Multivitamin; Vitamin C; Clonazepam; Atorvastatin; Carbamazepine; Sertraline; Olanzapine; Neurontin; Calcichew D3; Alendronic Acid; Haloperidol.
8	M	84	Quetiapine; Donepezil; Levetiracetam; Frumil; Aspirin; Flurazepam;	Levetiracetam; Ketoconazole; Artelac drops; Vit D Macrogol; Tamsulocin/Duasteride; Sertraline.
9	M	55	Thiamine; Haloperidol; Trazadone; Fexofenadine; Omeprazole:	Folic Acid; Sertraline; Clonazepam; Mirtazepine; Pregabalin; Bupropion; Sinemet; Aripiprazole.
10	F	73	Thiamine; Zopiclone; Sodium Valproate; Clonazepam; Risperidone; Procyclidine; Mirtazepine.	Aspirin; Calcichew D3 Sertraline; Sodium Valproate; Furosemide;
11	F	84	Venlafaxine; Spironolactone- aldactone; Aspirin EC; Pantoprazole; Furosemide; Bisoprolol; Temazepam; Aldactone	Lansoprazole; Nutricreme; Olanzapine; Citalopram.
12	F	61	Quetiapine; Lorazepam; Sodium Valproate; Procyclidine; Carbamazepine; Mirtazepine; Risperidone; Phenergan; Thiamine; Citalopram.	Mirtazepine; Quetiapine; Sodium Valproate; Lorazepam.
13	M	58	Glicazide; Doxazosin; Aspirin; Amlodipine; Aripiprazole; Simvastatin; Omeprazole; Metformin; Nebivolol; Lisinopril; Olanzapine.	Amlodipine; Nebivolol; Simvastatin; Aspirin; Sodium Valproate; Aripiprazole; Lansoprazole; Doxazosin; Sertraline; Lisinopril/Hydrochlorothiazide

52 THE ARC DE SIÈCLE- AN EXAMINATION OF ATTITUDES TO HYSTERIA IN TWENTIETH-CENTURY MEDICINE, THROUGH THE EYES OF NORMAN DOTT AND HIS PUPILS

¹Max Fend*, ²Louise Williams, ¹Alan J Carson, ¹Jon Stone. ¹Centre for Clinical Brain Sciences, Chancellors Building, University of Edinburgh, UK; ²Lothian Health Services Archive, Centre for Research Collections, Edinburgh University Library, The University of Edinburgh, George Square, Edinburgh, UK, EH8 9LJ

10.1136/jnnp-2019-BNPA.52

Objectives Hysteria was once a topic of research for leading neurologists; however this interest faded over the course of the twentieth century. Little has been written about the presentation and management of functional disorders in the post Charcot period, and some have gone so far as to suggest that the patients ‘disappeared’. This project aims to shed light on how Edinburgh neurologists interacted with and managed this cohort during the period from 1930–1970.

Methods The Lothian Health Services Archive holds 28 000 case files written by Norman Dott CBE, the first chair of Neurosurgery in Scotland, and the department he built around him, with cases spanning the years between 1930–1970. Cases

pertaining to hysteria or hypochondriasis were analysed, recording demographics, symptoms, diagnostic and management processes, and evidence for any attitude or opinion exhibited by the physicians. Retired neurologists from Edinburgh and elsewhere also provided oral histories on how they interacted with this group.

Results 209 cases were analysed, of which 178 were relevant, and 100 of which included a diagnosis of hysteria. Of these 100, it is of note that 42 were referred to psychiatry. The majority of the remaining patients were given advice or reassurance (48).

Conclusions Hysteria in Dott’s department was both a diagnosis based on positive findings of inconsistency, and a personality trait. Although there is evidence of a negative sentiment towards functional patients, there is equal evidence of sympathetic responses, and it is likely that neurologists of the mid twentieth century were often less cautious and more candid in their remarks. Whilst the management of hysteria was not seen as a neurologist’s job, patients were regularly referred to psychiatry, signifying an acceptance of the legitimacy of the condition.