Thyrotoxicosis is a disease which affects persons of all ages from early infancy to advanced life.

Emotional shock and strain—biological, social-economic, or sexual-traumatic—in apparently normal or neuropathic individuals, may lead to the clinical development of exacerbation of atypical thyrotoxicosis.

Marked thyrotoxicosis may exist for many years without any thyroid enlargement or exophthalmos.

The constitutional symptoms of thyrotoxicosis resemble closely the manifestations of the neuroses and, in the absence of thyroid enlargement and exophthalmos, have been mistaken for pure neuroses.

Many cases of nervous indigestion have been proved to be thyrogenous in origin.

A depressive psychosis may develop in the course of thyrotoxicosis, not as a mere casual phenomenon, but definitely dependent upon toxic thyroid products. Such a psychosis has cleared up and failed to recur when the thyrotoxic condition was controlled.

In cases of neurosis or depressive psychosis associated with tachycardia, tremor, heat intolerance, excessive sweating, loss in weight, diarrhoea with or without abdominal cramps, with or without thyroid enlargement—the possibility of thyrotoxicosis should be thought of and careful studies made to establish or rule out its presence.

The most valuable single corroborative laboratory test when positive is the presence of an increased basal metabolic rate. However, in atypical or borderline cases of thyrotoxicosis the basal metabolic rate may be only slightly raised or normal.

In doubtful cases the iodin therapeutic-diagnostic test, with marked amelioration or aggravation of symptoms after iodin medication, may be helpful in determining the presence of thyrotoxicosis.

Similarly, the radium therapeutic-diagnostic test helps in atypical or borderline cases to differentiate between thyrotoxicosis and pure neurosis. Marked clinical improvement following radium application over the thyroid speaks in favour of an underlying thyrotoxicosis.

The radium therapeutic-diagnostic test properly carried out by an experienced radium therapist is a safe and dependable method, yielding the desired information without subjecting the patient to the dangers of operation and its frequent sequelæ, e.g. myxœdema.

R. G. G.

PSYCHOSES


From his observations on criminal statistics, the author notes that crime in schizophrenics is found most frequently at those times when crimes are most
frequent. Criminal schizophrenia occurs most frequently at that age at which most crimes are committed. Between the ages of 16 and 21 recognizable criminal schizophrenics are not so common as such: (a) some have probably not exhibited their underlying state of mind, and are in prison or Borstal; (b) some are in mental hospitals; (c) some have not yet become insane at all. The discharge-rate of schizophrenia compares favourably with that of the average mental hospital. The prolongation of the period of care and control renders the recoveries more likely to be permanent. Heredity does not adversely affect the discharge rate. Previous attacks of insanity impair the prospects of recovery. The earlier the care and control and the longer the period of treatment, the better are the prospects of recovery.

C. S. R.


From this study it appears that a typical schizophrenic reaction may put in its appearance long before the initiation of pubescence. Because the child is limited in his verbalizations and his thinking is in the direction of concreteness rather than abstraction what little delusional formation there is is simple and naive. The outstanding symptomatology is found in the field of behaviour and a consistent lack of emotional rapport. The drive for integration with the environment, so characteristic of normal children and so essential for their personality development, is outstandingly absent. The six cases reported and discussed here represent typical schizophrenia in children. Their actual ages on admission were 4, 6, 10, 11, 12 years respectively. The three patients who were over 10 on admission presented undoubted evidences of the existence of their schizophrenia long before that age. With the exception of one case, none showed any physical indication of puberty. None of the cases showed any marked improvement over the period of hospitalization, ranging from three to 18 months. The treatment was that of continuous effort to intrigue the child’s interest through a carefully organized daily routine, modified to fit the individual. It was not possible to do a great deal with a direct psychotherapeutic approach because of the lack of an essential emotional rapport. There is a superficial resemblance of schizophrenic children to certain unstable mental defectives. The schizophrenic child often appears mentally deficient because the libido is invested within the patient himself, thus interfering with the objectification of the intellectual processes. The writer thinks that a careful psychiatric study, from a psychodynamic approach, of the patients in institutions for mental defectives, might demonstrate that schizophrenia in children is not as rare as is now generally believed.

C. S. R.
Seven cases of bromide delirium and one case of bromide hallucinosis are presented. In addition to the commonly known symptoms of delirium, the patients in this group showed to a noteworthy extent two disturbances: (1) disturbances of sensation (referring not to hallucinations, but to subjective difficulty in recognizing colours, macropsia, micropsia, etc.); (2) disturbances of the association of ideas of the type commonly seen in schizophrenia. It is suggested that these two are amongst the 'ingredients' of disorientation. The delirious individual misidentifies objects and situations partly because he does not perceive well and partly because, owing to a faulty association of ideas, he discriminates improperly what he has perceived. In addition to simple bromide intoxication, delirium and hallucinosis are clinical types. There seems to be a possibility that bromide intoxication may also manifest itself as a paranoid state. No case has been reported in which a paranoid state supervened during bromide intoxication without a previous delirium. The distinction between paranoid and delirious disorientation is demonstrated. The possibility of post-intoxication psychosis is suggested by a case in which a woman previously non-psychotic developed a bromide delirium which, four weeks after the discontinuance of bromides, merged into a chronic delirium with marked psychomotor embarrassment. It seems possible that under certain conditions bromide intoxication may precipitate a chronic psychosis which remains long after the intoxication has subsided. The etiological factors of bromide psychoses are reviewed, and attention is drawn to several objections to the recently proposed hypothesis of the occurrence of 'withdrawal delirium.'

C. S. R.


The initial findings for all groups showed a definitely normal haemoglobin count in all but a few cases which were low. There was no significant or general change after the course of oxygen therapy. This was correlated with a normal or low oxygen content, very few high values being observed. Both readings were in general slightly increased, if there was any change at all, in involution melancholia, epilepsy and dementia praecox. The manics showed a slight decrease in both. No striking variations were observed in the erythrocyte counts, and in the majority of cases the leucocyte count was high before oxygen and treatment seemed to aggravate the condition. All groups had normal or low readings for polymorphonuclear counts, no high counts being noted except in dementia praecox. The lymphocytes were
normal throughout with a lack of low readings in the dementia and epileptic groups. All cases had normal basophils, endothelial cells, and eosinophil counts throughout the observation period, except for a small percentage of high values in the eosinophils of the dementia praecox group. Thrombocytes had some low readings in the dementia praecox and melancholy cases. There was nothing characteristic about the blood-pressure, but the pulse-rate decreased in all cases except for the manic group, in which some increase was observed. The basal metabolic rates were mostly normal. High values were found in the groups of epileptics and melancholias. The oxygen content was low in most cases. In all groups except the melancholias there was some improvement of this condition on treatment. Oxygen therapy produced no consistent results, except perhaps that the improvement of dementia praecox and manics was more pronounced than the increase in the other two groups. The improvement in the catatonic may be ascribed to the improved capillary circulation, evidenced by the decrease in the cyanosis of the extremities.

C. S. R.


After making a survey of the many different views held on the subject, the writer concludes that the affective reaction-patterns of the depressive type should be regarded as being an attempt on the part of the patient to manage his social and personal integration by means of a regulative mechanism which is not functioning economically. Recapitulation of the psychobiological development of the individual makes it abundantly clear that affect as a regulator exercises a progressively more delicate type of control as age advances. It would seem that in the formulation of broad depressive groups there appears a set of alternative, side-track types of behaviour, equivalent experiments to normal affect mechanism, but not capable of being brought to useful conclusions. During the clinical examination of depressives and their social setting, it becomes well established that we are dealing with circumstances where specific affective responses have been much more unhelpful than otherwise, usually demonstrably so over a long period of time—unlike the state of affairs in the better integrated, where emotional drives help to push the individual to some end-result of satisfaction. Basically the specific emotional 'rises' of the depressive types work in terms of inhibition, either predominatingly psychological or biological. The extent to which motivation comes in is less important, because behind the motivation is the psychobiological constitution of the individual. Experience with depressive cases sooner or later leads to an appreciation of, and respect for, the biological features of a condition where, as Benon says, the best psychotherapy is sympathetic discussion 'sans métaphysique.'

C. S. R.
Notes on psychogenic depression and melancholia.—Paul Schiñer.

Psychoanalytic Review, 1933, 20, 10.

Following the analysis of a case of prolonged psychogenic depression, the writer concludes that in such a condition the chief point of fixation is in the oedipus region and accessory fixation points in oral sadism. In melancholia there are the same points of fixation, but the fixation in the region of the oedipus complex is less important. Oral sadistic fixation is in the foreground.

Generally speaking, in every neurosis and psychosis we must consider not only one point of fixation but the whole development, and there will always be accessory points of fixation in this development. The various symptomatologies of the neurosis and psychosis depend upon the primary as well as the secondary points of fixation. We may ask the question why hysteria takes the form of a depression and why it has this particular symptomatology. The preliminary answer would be that in psychogenic depression we deal not only with the primary point of fixation in the region of the oedipus complex but also with secondary fixation points in the oral sadistic sphere. The similarity with melancholia is based on a partial identity of the points of fixation, but the relative value of these fixations to the whole development and to sexual structure is different.

C. S. R.


After citing the experience of other investigators, the writer briefly recounts his own work with 15 female patients, of whom all except one were schizophrenic, the other being an epileptic. Using different doses of bulbocapnine, and by different routes, he was unable to produce somnolence, flexor attitudes, psychomotor torpor, amimia, catalepsy, or even the accentuation of a previously existing state of the kind, by this method. His results were persistently negative, differing materially from those of some other observers. The conclusion is that seemingly much heavier doses will have to be used, and these are without question ‘very dangerous.’

A. B.


After a survey of the literature on the subject and a discussion on the relation of cholesterol to metabolism, the results of a study of 55 cases of schizophrenia with a range of blood cholesterol values of 55 to 300 mg. are given. Many of the factors which might alter the blood cholesterol other than that induced by the mental disorder itself were investigated. It was
found that there is a definite tendency to a lowered blood cholesterol in schizophrenia as a group. There are cases in which the cholesterol is normal or increased, but the majority of cases show values below the lower limit of normal or in the lower limits of the normal range.

C. S. R.


High blood-urea levels in psychotics are most commonly found in the confusional group. In 80 successive cases, only 18 gave blood-urea findings that were always within normal limits. Of the 17 cases with raised levels, six gave figures between 45 and 70 mgm. per cent., but none of these suffered from nephritis, although in each case the diet was arranged and graded to reduce the level to normal and to keep it so. The remaining 11 cases suffered from chronic nephritis. Five of these had a blood-urea between 100 and 200 mgm. per cent., and six between 60 and 100 mgm. per cent., while confirmatory signs were found in all.

In 15 successive cases of mania 11 had normal blood-ureas. The remaining four had raised levels above 60 mgm. per cent., and three others, without evidence of chronic nephritis, were all complicated by a degree of confusion which improved rapidly on a strict milk and water diet. Blood-urea estimations in three cases of acute delirious mania suggested that the results were useful guides in prognosis. Originally the figures were high and remained so in the fatal cases, but fell to normal in one that recovered. High blood-urea levels were rare in 40 cases of melancholia. In five it was 40 mgm. per cent., and only one case had a persistently high reading. In nine cases of schizophrenia the blood-urea varied between 34 and 18 mgm. per cent. Two further cases gave abnormal results. In 11 cases of non-systematized delusional insanity the reading varied between 21 and 48 mgm. per cent. In nine senile cases the results varied between 25 and 50 mgm. per cent. The blood-urea was rarely below 40 in those with high blood-pressure, even if albumen was regularly absent from the urine. Normal readings were obtained in several cases of postencephalitic psychosis and in mental defectives.

C. S. R.

PSYCHOPATHOLOGY


The variations in the appearances of the gland are extraordinarily wide. No constant findings could be established to connect mental deficiency with histological abnormality of the thyroid. It was not possible to find any