frequency and the gravity of the attacks. In combination with atropine and bromides still better results are obtained.

Of the borates, potassium boro-tartrate is the most efficacious, and its use is not attended by any unpleasant after-effects.

In his final summary the author reverts to the value of bromides, and states that administration of bromides together with a partial salt-free diet remains the most effective treatment of epilepsy.

W. Johnson.

[190] Phenobarbital (luminal) treatment of insane epileptics.—IRA A. DARLING. Arch. of Neurol. and Psychiat., 1923, ix, 478.

The author records the treatment with phenobarbital of a series of insane, hospitalized, male epileptics, and the conclusions given below are based on observations made on the following groups of patients: (1) 15 idiopathic epileptics treated for 8 months; (2) 13 idiopathic epileptics treated for 21 months; (3) 12 idiopathic epileptics treated for 8 to 13 months; (4) 6 traumatic epileptics treated for 13 months; (5) 6 senile epileptics treated for 8 to 13 months; (6) 2 syphilitic epileptics treated for 14 months.

His conclusions are summarised as follows:

1. Phenobarbital has a cumulative effect that appears to be successfully combated by a break of two days in each week during its administration.

2. A sudden break in its administration is sometimes followed by a series of seizures. There is much less danger of such trouble if bromide is given as soon as the other is withdrawn.

3. One and a half grains (0.09 gram), given five days in each week, appears to be a safe dosage. If larger amounts are given, very careful observation is necessary to detect possible toxic symptoms early and to prevent the more serious disorders.

4. The use of this drug may be followed by: rash, simulating measles or scarlet fever; symptoms like those of alcoholic intoxication; severe cholera-like diarrhoea; mental hebetude; delirious states; and other like troubles.

5. Favourable results were obtained from the administration of phenobarbital in cases diagnosed as idiopathic and traumatic epilepsy. The results in cases diagnosed as senile and syphilitic epilepsy were doubtful.

6. The drug is not to be considered as a 'cure' or specific for epilepsy.

7. Phenobarbital and bromide may be combined and better results thus obtained in selected cases.

8. Each case should be considered as an individual problem and phenobarbital, bromide, or a combination of the two used according to the results.

E. B. G. R.

Psychopathology.

PSYCHOSES.


Dr. BENON combats the generally accepted ideas of Kraepelin on periodic
depressed states. True melancholia is a distinct clinical entity. Recurrent depressed states he terms ‘periodic asthenia.’

The following clinical facts serve to distinguish the different mental states:

The true melancholic is usually forty to fifty years of age. The onset is gradual and accompanied by a sense of sorrow, and often regret. Agitation and anxiety may follow. Ideas of self-accusation, of ruin, of fear for the future predominate.

Periodic asthenia begins suddenly at any age, its onset being measured in hours or days. Deep depression and retardation are the chief characteristics of the mental state.

The true melancholic gradually develops a secondary general asthenial. This exhausted condition is present during the whole of the periodic asthenia. Accusatory and self-depreciatory delusions are more marked in the true melancholies. These cases often recover, and recover slowly, and rarely relapse. The periodic asthenias make brusque recoveries and relapse frequently. One recovers by lysis and the other by crisis. An unusual type of true melancholia is described in which there were four relapses.

The author gives it as his opinion that confusion and hallucinations are quite common in true melancholia, but rare in the periodic asthenia cases.

G. W. B. JAMES.


The author considers that Kraepelin’s conception and clinical descriptions of manic-depressive states should remain open to examination and discussion. He quotes a lengthy clinical description of a case in which a man of forty-one with a bad family history had an attack of acute depression, with delusions of sin and unworthiness, and finally hallucinations, though they were not marked. The condition became relieved after some months and ‘asthenic’ (e.g., exhaustion) signs became very marked. These exhaustion signs were slowly replaced by evidences of excitement and psychomotor restlessness, and finally a condition of mania was reached. This condition disappeared, and the patient was discharged recovered.

Benon concludes from this example that the excited phase had nothing to do with the melancholic condition which commenced the illness, but followed the secondary asthenic condition resulting from the depressed phase. Briefly, his thesis is that what Kraepelin and most English writers describe as the ‘stadium debilitatis,’ or exhaustion condition following the melancholia in the case described, must actually be considered the cause, and true opposite of, the mania which supervened. The ‘mixed states’ of Kraepelin, Benon considers a conception for which there is no foundation in clinical observation.

G. W. B. JAMES.
[193] Constitutional psychoses ending in permanent recovery.—Rosanoff and Bergmann. Arch. of Neurol. and Psychiat., 1924, xi, 70.

The general assumption seems to be that the outlook in the constitutional psychoses is either for recurrence, chronicity or deterioration. Permanent recovery does, however, occur, probably more often than has been generally supposed. The authors were successful in securing data concerning the after-histories of eight cases, and their inquiry showed that their former patients had attained late middle life, and had been free from psychoses for periods of from thirty-one to forty years.

R. M. S.


Cases are reported in which a definite change in personality appeared at puberty, the actual psychosis developing later. Most of the cases also gave a history of rapid growth or other disturbance of metabolism at puberty. The relation of puberty to psychopathic behaviour is discussed. In certain cases of dementia praecox it is difficult to determine whether seclusive behaviour appearing at puberty is a part of the personality or a part of the psychosis.

C. S. R.


1. Data on 581 children, the offspring of 145 matings of non-psychotic parents, were collected from the Medical Out-Patient Department of the Peter Bent Brigham Hospital, Boston.

2. The parents were comparable to the parents in the dementia praecox study (see this Journal, 1928, iv, 76) in economic levels, nativity, and number of children per mating.

3. There were available data on 500 living children. Of these, 145 deviate from the normal either mentally, physically, or socially. The deviations are: 1 dementia praecox, 1 pre-praecon, 10 feeble-minded (one with convulsions), 12 backward, 12 nervous, 8 cases of conduct disorders, 101 physically diseased. One hundred children were under and forty-five over sixteen.

4. The death rate of the non-psychotic offspring is lower than that of the dementia praecox issue, and considerably lower than that of the epileptics.

5. The conduct disorders, though of the same types in the two groups, are eight out of 500 for the non-psychotic offspring, thirty-six out of 381 for the offspring of dementia praecox parents. The number of backward and nervous is the same among the non-psychotics as among the dementia praecox cases, though the percentage is less in the former group. The greater number of physically diseased among the children of the non-psychotics is hard to explain.

6. One undoubted case of dementia praecox was found. One other was of praecox type, though the patient partly earns her living.

H. M. R.

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