neoplasm, but sometimes occurs in cases of tuberculosis. The predominant cell in a pleural effusion due to new growth is the endothelial cell. Growth cells are practically never found though lymphocytes or degenerated endothelial cells may be mistaken for them.

(8) In lymphadenoma there are usually palpable discrete glands to be felt in the neck, axilla or groin, and the spleen is often enlarged. A mediastinal mass shown by X-ray may, however, be the only sign. The possibility of intrathoracic goitre should be remembered.

(9) In hydatid disease the right base is usually the site of the cyst. On X-ray examination there is a translucent area between the shadows of the cyst and that of the diaphragm. There is eosinophilia. The complement-fixation test is often negative in an unruptured cyst.

(10) A gumma is very rare, but I have seen a case in which there was one producing pleural effusion. Stridor may be due to syphilitic disease.

(11) In a case running an unusual course the possibility of actinomycosis should be borne in mind.

(12) A good general condition and absence of toxæmia should be taken as evidence in favour of neoplasm rather than of tuberculosis.

TREATMENT.

If the tumour is malignant the only possible chance of saving the patient is its removal by surgical operation. This chance is very slight but as the alternative is certain death it should be taken unless the tumour is obviously inoperable. In doubtful cases an exploratory operation should always be performed.

The apparent size of the tumour as seen by X-ray or determined by clinical examination is often due partly to collapsed lung, so that a case should not be considered inoperable merely because the tumour appears to be large. In one case a large

mass was seen but at the operation the tumour was found to be about the size of a walnut growing in and obstructing the bronchus. It was easily removed and the patient made a good recovery. It appeared much larger on X-ray examination owing to the associated collapsed lung. A tumour which is thought to be malignant and inoperable is sometimes found to be non-malignant and operable.

In no branch of surgery have there been greater strides in recent years than in intrathoracic operations, and in skilled hands exploratory thoracotomy is but little more dangerous than laparotomy. Dermoid and hydatid cysts can usually be removed quite successfully and even in the case of carcinoma of lung lobectomy may be possible.

For inoperable carcinoma of bronchus radium should be used. At present this offers but little hope, but it is still in the experimental stage and in the near future may prove as valuable as it is in carcinoma of the tongue or lip. X-ray treatment often gives good immediate results in lymphadenoma or sarcoma, but recurrence is the rule. Apart from these measures treatment consists in relieving the symptoms.

CRIME AND INSANITY. LECTURE V.

GIVEN AT THE MAUDSLEY HOSPITAL, MAY 28, 1929.

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(Continued from p. 67.)

THE principles involved in the determination of responsibility for criminal acts or omissions resulting from drunkenness and delirium tremens were outlined in a previous lecture. It is necessary now to refer briefly to pathological drunkenness, alcoholic automatism, and mania à potu before considering

the association of crime with the more chronic forms of alcoholic insanity.

Pathological drunkenness has been defined as "drunkenness that exhibits unusual features, which leads the individual to perform strange acts, or acts of violence, or which produces serious physical symptoms." Another observer states "that pathological inebriation occasionally resembles the physiological variety, the only difference consisting in the small quantity of alcohol which has induced the condition."

Now it is obvious that criminal conduct will be favoured by the impaired reasoning, and the inability to appreciate consequences, the emotional disturbance, excitement or depression, the loss of inhibition, and dissociation from realities which result from alcoholic intoxication. Clinical experience also demonstrates the fact that acts committed during drunkenness may be partially or completely forgotten, the result depending upon the amount and strength of the alcohol taken, the rapidity with which it is drunk, and the susceptibility of the drinker. And it appears more direct to tell the jury that persons with a tendency to mental instability are liable to be disproportionately affected by alcohol, than to use a technical term like pathological drunkenness which may confuse the jury by its ambiguity, and become in consequence the subject of reproachful criticism by the judge.

Alcoholic automatism is frequently associated with serious crime, with murder, attempts at suicide and other crimes of violence. In this condition more or less complicated and connected acts may be committed of which there may be no recollection when the effects of the alcohol have passed off. The higher mental functions are interfered with while the lower brain centres and the spinal cord are relatively little affected. The events leading up to the crime may be connected with the normal conscious life of the subject, or dissociated therefrom, as in epileptic automatism. A labourer, aged 33, married, and living fairly

happily with his wife and two children, was in regular work and free from anxiety. He had no quarrels and no debts of any consequence. He had no insane relations and had never been considered mentally abnormal himself. He indulged in a bout of drinking lasting three days, going to bed drunk each night. He came home at midnight, and making a rope with his leather belt and a piece of cloth, attached them to the cistern pipe in the closet and hanged himself by this means. He retained no recollection whatever of the attempt or of the actions or motive which led up to it.

When satisfied that a crime is automatic, it becomes necessary to differentiate between alcoholic and epileptic automatism, as the latter absolves an accused person from criminal responsibility. In some alcoholic cases there is a slight recollection of the events which take place, but apart from this the differential diagnosis may be difficult, for epileptiform convulsions may occur as a result of alcoholic toxæmia. And although the withdrawal of alcohol may result in the subsidence of the motor demonstrations in individuals who are not epileptogenic, it is to be remembered that essential epileptics frequently have fewer convulsive attacks when under observation removed from the stresses and strains of the outer world.

The short and sudden attacks of intense excitement which sometimes occur as the result of alcoholic intoxication may be associated with crime. If the attack passes off quickly there may be difficulty in distinguishing mania à potu from the violent outbursts which are common when aggressive and impulsive persons drink to excess. The diagnosis then may rest perforce upon hearsay evidence and inference. In these cases the defence may attempt to show that the accused was unable to form an intent to commit the crime. If accepted the charge may be reduced to one of less degree, and the effect may be regarded as more advantageous to the prisoner, inasmuch as it will involve a definite sentence of imprison-

ment, and not the indeterminate detention consequent upon a verdict of guilty but insane. When the attack of excitement is more prolonged there is usually no difficulty in associating the crime with legal insanity.

The chronic forms of alcoholic insanity most frequently associated with crime are chronic hallucinatory insanity, alcoholic pseudo-paranoia, alcoholic pseudo-paresis and alcoholic dementia. Jelliffe and White have directed attention to the fact that delirium tremens may precede alcoholic hallucinosis. And in pre-war days, when delirium tremens was common in prison practice, it was frequently observed that the delirium did not run an acute course, and that hallucinations persisted after the excitement had passed off. The impression formed at that time was that this was most likely to occur in those cases in which the delirium was gradual in its onset.

Alcoholic hallucinatory insanity is not infrequently associated with crimes of violence. The hallucinations may be as terrifying as those of delirium tremens; the patient may attempt suicide to avoid a worse imaginary fate, or he may act in obedience to imaginary commands to kill himself or others. A man believed that he conversed with a person in hell, and that he was in wireless communication with a youth and two prostitutes, one of the latter concentrating her name and face on him by television. He believed the woman tried to make him mad, and spoke to him through God. He said he had signs from God directing him to kill them. One sign showed itself as white waves with a red wave on either side, out of which came three daggers. Another sign was a revolver, two daggers and a cross. These were together and signified that he was to kill the youth and the women. He was fortunately arrested on a charge of drunkenness before carrying out his intentions.

Sufferers from this form of insanity are liable to give themselves up for imaginary murders. In the following case a man gave

himself up for a crime he had committed as the result of hallucinations. He was a middle-aged widower, who had attempted to commit incest on several occasions with his daughter aged 13. He heard imaginary voices calling after him in the street accusing him of the crime; the same thing occurred in cinemas and beneath his window at night. He gave himself up to the police in consequence, and when his daughter was questioned it was found that the man's self-accusations were true. The hallucinations persisted for some months. No delusions were detected at any time.

When delusions form the main feature of the case, as in alcoholic pseudo-paranoia, they usually centre round morbid suspicion, sex jealousy, and delusions of marital infidelity. They may be accompanied by hallucinations, and may be expressed at first only during intoxication. But as the case progresses and they become more fixed and dominating, and self-control diminishes, they are hinted at and then openly declaimed apart from intoxicated interludes. In men the result may be murder and suicide, or attempted murder and suicide, and in some cases damage to property; in women, child murder, attempted suicide, and occasionally unwarranted accusations of marriage. A woman described in detail her marriage with a man; it was obviously delusional. She broke a window of the house of another respectable man whom she claimed as another husband, but who had no knowledge of her. She accused him of misconducting himself with other women in her presence, and alleged he was poisoning her.

It is most important to interview the alleged unfaithful married partner of an accused alcoholic in order to satisfy oneself of the delusional nature of the allegations, and to ascertain their evolution. In general, before the victims are attacked they are aware of the delusions and attribute them to a disordered mind. Repeated threats may precede a homicidal attack, but the addict's control may be suddenly lost.

The delusions may be persecutory, the patient believing he is followed about and accused of homosexual or other crimes, and he may attempt suicide to free himself from them or commit crime to gain the sanctuary of prison, as in the case of a man who committed wilful damage for this purpose.

In criminal work the chief interest of alcoholic pseudo-paresis lies in its differentiation from general paresis. Grandiose delusions, tremors, ataxy, speech defects and pupillary abnormalities suggesting general paralysis of the insane may result from alcoholism. The Argyll-Robertson syndrome, presumptive evidence of cerebro-spinal syphilis, has been associated with alcohol and the light reflex returned upon its withdrawal. The diagnosis may be complicated from the fact that alcoholic subjects tend to become infected with syphilis, and the period of observation before trial may be insufficient to determine whether the symptoms improve upon the withdrawal of the drug. But it is to be observed that in either case irresponsibility will depend upon the presence of legal insanity and not upon the particular poison causing it, be this alcohol or syphilis.

An intemperate man was charged with stealing a cycle. He was exalted and had grandiose delusions. He believed he found one hundred million pounds in the street in a man's hat. He said he was going to keep ten pounds for himself and give the rest to his family. His wife reported he had been kissing shop girls at their work, and a short time before arrest had walked into a post office and demanded fifty thousand Treasury notes. His pupils reacted to accommodation but only sluggishly to light, the knee-jerks were exaggerated, but syphilis could be excluded.

In alcoholic dementia hallucinations and delusions may be present, but in most of the cases associated with petty offences they are absent or transient. The accused may only show a slight degree of moral turpitude, failure of memory and inattention,

lack of capacity for sustained effort, loss of interest in the present, unconcern for the future and mild confusion, but these may suffice to render him unemployable and cause trivial crime. A man, aged 54, was charged with stealing a quart of milk. He was at one time a scientific instrument maker, and was later engaged on land surveying. He had grandiose ideas; he believed he had blown up a million men in one explosion during the Great War, and was himself responsible for stopping the German advance. He also believed that his wife followed him about thinking he possessed a large sum of money, but he was, in fact, living on unemployment pay. His speech was slurred, the facial expression vacant, and the pupil reflexes reacted sluggishly to light. But the knee-jerks were normal and the Wassermann reaction was negative. There were no tremors and no paresis. He was confused, disorientated, and his mental reaction was slow. He was facile, apathetic and stupid; his memory, attention, perception, judgment and reasoning were impaired. He was unable to appreciate his position or the possible consequences of his acts.

Two further points of interest remain. Since alcohol removes the higher control of cerebral function, its effect upon an insane person may be to remove the control which has enabled him, when sober, to hide his delusions from his fellows. A man was sentenced to a term of imprisonment for wilful damage to a certain shop window. On release he promptly smashed the same window and came under my observation for the first time. His conduct whilst awaiting trial was normal. I strongly suspected insanity from the circumstances of the case but was unable to obtain any evidence of it. He was convicted of the offence and served another sentence, during which his conduct was normal. On release he took some alcohol and again smashed the same window. When I interviewed him on this occasion he became confidential, being still

under the influence of alcohol, and the examination disclosed the delusions which were responsible for the three offences. It was then possible to deal with him as an insane person.

The remaining point to which I would direct attention is that alcoholic insanity is often recurrent. Some prisoners give a history of several attacks, and during their periods of convalescence in mental hospitals have opportunities of observing the symptoms of insanity in their fellow-patients. The alcoholic will not scruple to malingering such symptoms in his attempt to avoid the consequences of a future crime. But it must be remembered also that a history of repeated attacks of insanity may indicate an undue susceptibility to alcohol, and feigned insanity must not be diagnosed except upon unmistakable evidence.

There is a tendency to exaggerate the importance of epilepsy as a cause of crime. Only 0.5 per cent. of the prison population are epileptic, and the crime in many of these is not attributable to the disease. Moreover, the proportion of epileptic patients in Broadmoor Criminal Lunatic Asylum does not exceed that in the ordinary mental hospital population.

Epileptic automatism is frequently set up as a defence in cases of serious crime, and it is important to consider in such cases not only the family and personal history of the accused, but also all the known events connected with the crime. There may be considerable difficulty at arriving at the truth, more particularly in cunning and mendacious epileptics who have committed crime, for it must be remembered that the epileptic as such is not immune from punishment. Moreover, it may be very difficult to investigate a case of alleged epilepsy, and to avoid putting questions to a cunning and alert criminal without suggesting the answers. After a family history has been inquired into the next and fundamental step is to establish the fact that the prisoner is really an epileptic. This being determined the events preceding,

accompanying, and subsequent to the crime must be closely analysed, to ascertain whether there is any motive and whether the acts are dissociated from the ordinary conscious life of the accused.

Certain points connected with epileptic automatism assist the diagnosis. The dream state is more conspicuous and prolonged after minor epileptic attacks, and may occur instead of a fit—the so-called epileptic equivalent. Mercier considered that automatic action never followed fits that were extremely severe. He also stated that when automatic action occurred after any one fit it followed other fits in the same person. But an epileptic of many years' standing only knew of one automatic act, although he suffered previously and subsequently from rather frequent major attacks. He reached home one evening and found his wife and the maid were out. He took off his coat to light the sitting-room fire and remembered being about to put some coal in the grate. He remembered nothing more until he found himself in the street nearly a mile from home in his shirt sleeves and with the coal scoop in his hand. He had crossed busy suburban roads in a state of oblivion.

Automatic action may be of the same type in the same patient. Dr. Aldren Turner describes the case of an epileptic who automatically took out his watch after he had had a fit. A prisoner thrice indecently exposed himself during periods of automatism, and some patients can be observed to attempt to undo their clothing after a fit. In other cases the automatic acts may vary. Dr. Aldren Turner records the case of an epileptic who sometimes turned out the contents of his pockets, and on other occasions was observed to pile the crockery on the dinner table, and at other times became aggressive after a fit. In a case with which I was concerned an affectionate husband cut his wife's throat as she lay in bed. Seen a few hours later he described how he remembered nothing after leaving the lavatory until he found himself standing over his dead wife.

He was greatly distressed and said that he returned to the bedroom three times before he could convince himself that what he saw was true. He gave himself up to the police, and no motive for the crime was discovered. But his relations described how he had on one occasion thrown a handful of gold and silver money on the fire and refused to allow them to rescue it. On another occasion he was nursing a favourite dog and suddenly threw it through a window. He had also been aggressive and violent when dissociated. These dream states were spontaneous, unprovoked, unconnected with preceding events, and were followed by complete amnesia. He was found to be insane at his trial.

Post-epileptic action is usually of the nature of an habitual act or the caricature of such an act. Witness the case of the woman who was cutting bread and butter for her children's tea when she had a fit, and in the subsequent automatism cut the arm of one of her children so that it died. In another case a highly respectable man, devoted to his family, after a period of mental stress suddenly attacked his wife and two daughters with a coal hammer. His wife died from the injuries she received. The accused stated that he was following his usual custom and was about to make his wife a cup of early morning tea. Whilst the kettle was boiling he commenced to break up some coal with a hammer and remembered hearing the kettle boil, then he said blood came from the coal and he found his daughter standing by the front door with blood on her face saying he had struck her. He at once went to the police station and told them to come to his house. There was no motive for the crime and no reason to doubt his statement that he had no recollection of what he had done. He was found guilty but insane at his trial.

The automatic actions of the epileptic may be transient or prolonged, simple or complex. The cross-examination of the medical witness generally centres round the question whether or no any recollection of an auto-

matic act persists when the subject regains his normal mental state. Savage, Mercier, Maudsley, Hack Tuke, Jelliffe, Gordon Holmes, and other authorities consider that the epileptic preserves no memory of his actions on his release to his normal level. This conclusion is of the utmost importance in certain cases. Frequently a prisoner makes a voluntary statement to the police which shows that he has some memory of his criminal actions. If there is a partial amnesia the explanation of the facts is often found in a history of alcoholism, Jacksonian attacks or hysteria. W. A. White observes: The amnesia of epilepsy is absolute, but in hysterical amnesia there are islands of memory varying on going over the same ground on different days. The field of memory fluctuates. And I would add the same phenomenon is frequently present in cases of feigned insanity. Indeed the majority of alleged amnesias associated with crime are feigned.

Epileptic automatism absolves an accused person from responsibility for a crime if it is accepted by the jury, for it is a temporary disease of the mind which prevents the individual from knowing the nature and quality of his act and that it is wrong. The condition is so frequently alleged without justification that a recapitulation of its characteristic features may be excused. In genuine cases the accused person is known to be an epileptic, that is, to have suffered previously from major or minor attacks or epileptic equivalents; the crime is motiveless; the automatic actions may be unconnected or appear to be continuous with those immediately preceding them; they may be connected and show purpose during the automatic period, but are dissociated and purposeless in relation to the normal conscious life of the individual; they may be caricatures of actions habitually performed by him; they may repeat themselves in successive automatisms and there is no recollection afterwards of what took place during the automatic state.

Bearing these facts in mind the following cases are given at some length for purposes of comparison. In the first the symptoms were feigned, in the second genuine: A young man was charged with attempted murder. He courted a widow who did not respond to his advances and he became jealous of her, and sent letters to her threatening her life and falsely alleging that immorality had taken place between them; he also made veiled threats at suicide. He was forbidden the house on account of his conduct. On a certain afternoon the widow and her daughter arrived home, and the accused tip-toed into the room in which they were. They inquired how he got in and he replied by the front door; he was told this was untrue as the door was locked and he was ordered out. He refused to go, and after further words attacked the widow with a sharp instrument causing her serious wounds; he also injured the daughter's hands when she came to protect her mother. The women screamed and got away from him, and as they left the room the accused made a motion across his throat with something shining in his hand. A police officer arrived and closed with him. He then said, "Where am I? Oh my head!" He was examined by the police surgeon, who found nothing abnormal about him and no evidence of any injury. A table knife and blood-stained razor belonging to his own home were found in the room. The accused gave me a history of attacks of giddiness, in which he said everything became dark, that he then fell down and became unconscious for from two to ten minutes, or longer. He at first said that he did not become drowsy after an attack, but later amended this after a somewhat leading question, and stated that "he might feel sleepified after an attack." He alleged that the attacks occurred every week and sometimes twice a day, and that he got drunk about twice a week. A near relation was interviewed and said the accused was not intemperate, had never had any attacks of falling or unconsciousness, but had a vile

temper and had attempted suicide when out of employment. The accused denied any recollection whatever of the attack on the two women. He alleged he had no recollection of taking the table knife and razor from his home, but remembered being in a public house a little later and drinking and playing a game there with some men. He then alleged a period of which he retained no memory during which the crime took place, his memory not returning until he was in the hands of the police. According to his own statement, therefore, the early events connected with the crime—taking the knife and razor from home—were forgotten, the next remembered—drinking and playing in the public house—later events forgotten, and still later recollected. Compromising actions were forgotten and excusing ones remembered. Whilst awaiting trial he alleged attacks of unconsciousness but there was nothing to support this, although he was under the constant observation of trained nurses. He alleged he had not passed urine for three days, but his bladder was empty. He was regarded as a calculating and clumsy malingerer, and was found guilty at his trial and punished.

Very different is the history of a genuine case: A manual labourer, aged 45, single, of good character and temperate habits, was charged with being on enclosed premises. Ten years before, he received a blow on the head which rendered him unconscious for about four hours and caused his detention in hospital for five weeks. The situation of the injury was marked by a scar. He complained that he had never been right since, and suffered from diplopia, giddiness, headaches and fainting fits in which he lost consciousness, and had been told he fell down and struggled. He had bitten his tongue in these attacks; he never urinated in them, but sometimes went to sleep afterwards. He lost no work on account of his attacks as his mates could tell when they were coming on. They told him "he stood and studied," and they stopped him working

then and looked after him until the attack was over. A female relation who lived with him confirmed these details; she said the fits lasted about three minutes, and the accused had related to her periods when he lost consciousness outdoors. He had been treated at two hospitals for fits and had been out of work a year at the time of the offence. He stated that on three or four occasions recently when out of doors he had found himself in some strange locality, and had not known how he had reached there, but he had had no convulsive attack for three months at the time of the offence. He went through the open door of a house and picked up a baby placed in a perambulator inside the entrance and walked upstairs with it in his arms. The mother, hearing the infant cry, came down and met the accused and tried to get the baby from him, but unsuccessfully. She became alarmed and ran out for a policeman. Returning with the officer they met the accused coming out of the house without the baby, who was quite unharmed. She said that he then seemed quite a different man. The account the accused gave was as follows: he remembered listening to an outdoor meeting on unemployment in the same street as that in which the house was situated, then came a complete blank until he found himself standing between two policemen outside the house of the prosecutrix. On examination the prisoner's facial expression was vacant, the pupils reacted to light, the knee-jerks were normal and the plantar reflexes flexor. Tremors of the tongue were present. His mental reaction was slow. He was apathetic and unconcerned at his position and showed a lack of interest in current affairs.

One day when under observation he walked to the door of the prison hospital ward saying, "I'm coming, I'm coming," and appeared to an experienced nurse to be quite unconscious of his surroundings. He was got to bed at once, and was seen almost immediately by a medical colleague. He was then conscious but had no memory of

what had just occurred, and the plantar reflex gave an extensor response for a short time. The following points favoured the diagnosis of epileptic automatism. He was a recognized epileptic who had previous automatic periods, and an undoubted automatism when under observation; he showed also some permanent mental deterioration as the result of epilepsy. The crime was motiveless and was unconnected with the events immediately preceding it; his actions were dissociated and purposeless in relation to his normal conscious life; they were perhaps a caricature of actions associated with a nephew, aged 2, of whom he was said to be very fond; and his statement that he had no recollection of his conduct was consistent with the known facts of the case.

Mental depression, the result of epilepsy, may lead to attempts at suicide, and dementia secondary to this disorder is not infrequently associated with minor crimes. Epileptic excitement (furor) may result in crimes of violence, and the actions then committed may be remembered by the accused. A recognized epileptic had a fit in the street and cut his face; the ambulance was sent for, and when he was asked to go to the hospital in it he became extremely violent and abusive, striking and kicking those who had endeavoured to befriend him. He remembered what he did. He appeared to have had previous attacks of a similar nature, as the neighbours were reported to be afraid of him.

It is sometimes suggested to the medical witness that the violence of an epileptic is due to the well-known fact that he may be unduly aggravated by opposition during a seizure. This may happen in cases of epileptic excitement, as seen in the above case, but is not always so. The circumstances of many automatic crimes have precluded any previous provocation.

The manic-depressive psychoses may result in criminal conduct even when the accused is only slightly affected by the disorder. There is, however, a very marked

difference in the type of crime committed by the excited or depressed patient. In mania the most common crime in a series of 52 cases was that of theft, 10 cases; next in order of frequency were crimes associated with insulting words and behaviour, 8 cases; and there were 7 crimes of violence, 6 assaults and 1 murder. In 53 cases of melancholia there were 34 cases of violence, 17 attempts at suicide, 10 murder, 6 attempted murder, and 1 for causing grievous bodily harm. There were only 4 cases of theft, and 3 of insulting behaviour. The remaining cases in either group were unimportant in themselves, and the contrast in the two groups less marked.

The trivial nature of the crime so often associated with mania is probably due in part to the fact that the maniac directs the attention of others to himself, and to the necessity of protecting them from the consequences of his conduct. It seems also due in some measure to the fact that the slighter cases exercise some control over their conduct, and that when the excitement is more severe their actions lack the premeditation and co-ordination found in many cases of melancholia.

The mild cases of mania and melancholia may present serious difficulties in diagnosis. If slight cases of mania pass unrecognized there is less likelihood of serious crime resulting than when this happens in slight cases of melancholia, for comparatively mild degrees of depression sometimes cause murder and attempts at suicide. The nature of the offence in mania or melancholia often suggests mental disorder. A man with a history of two previous attacks of insanity was arrested for stealing pieces of carpet on which door-step cleaners knelt to do their work. He was restless, excited, exalted, talkative and boastful. He said that he provided Jack the Ripper with women for the purpose of mutilation. He was arrogant, devoid of decency and suffered from insomnia, and it was necessary to certify him as insane. In cases of melancholia the only

rational explanation of the murder of a loved one may be mental alienation.

There may be some difficulty, when an accused person first comes under observation before trial, in deciding whether the symptoms are due to mania or alcohol or a combination of both. A man was charged with being drunk and disorderly. He failed to gain admission into a Poor Law institution and went to a police station to complain. He became so obstructive there that it was necessary to arrest him. When he came under observation there was no evidence of exaltation, confusion, disorientation, delusions or hallucinations, but he was hostile, truculent, excited and talkative. I inclined to the view that he was suffering from hypomania but had insufficient evidence to certify him. A few months later he returned, again charged with being drunk and disorderly. His condition was now aggravated and grandiose delusions were also manifest. It was clear he was passing through an attack of mania and was dealt with accordingly.

(To be continued.)

EDITORIAL.

FINAL FELLOWSHIP CLASSES.

It is proposed to hold in the autumn a series of special classes in Clinical Surgery and Pathology. Although intended primarily for those who are entering for the Final Fellowship Examination of the Royal College of Surgeons in November, the classes will be open to all post-graduates.

These classes are not intended to take the place of the various Fellowship Courses held at certain hospitals, but are intended to afford intending candidates an additional opportunity of examining patients and being questioned on the diagnosis and treatment in a manner similar to that which obtains in the Fellowship Examination.