with tincture of iodine, and a wheal of novocain is raised 1 in. posterior to the anus in the middle-line, by means of the fine needle. The syringe is filled and the 2 in. needle firmly attached; the left fore-finger, lubricated with vaseline, is passed into the rectum and the long needle is inserted at the site of the wheal and gradually thrust in deeply in the middle-line posteriorly; the novocain solution is injected as the needle advances, the entire 10 c.c. being injected here. The syringe is then refilled, and 10 c.c. are injected in turn into the sphincter, first on the left and then on the right side. The left fore-finger keeps the sphincter on stretch, and the needle is passed in deeply until its point reaches approximately to the level of the anterior anal margin. Generally the sphincter can be felt to relax immediately the solution is injected. If much tissue is to be excised from the anal margin, a few additional drops of novocain may be injected anteriorly or at any particular point that seems indicated. If a fissure is to be incised backwards, a further subcutaneous injection of novocain should be made posteriorly. If the operation is being performed in the lithotomy position, the patient can be turned on to his back and put up into position immediately.

I have used this method now for more than a year as a routine for all haemorrhoid operations, and also for the other conditions as indicated above. The advantages are as follows:

1. Ease and safety.
2. Rapidity of anaesthesia.
3. Complete relaxation of the sphincter.
4. Absence of subsequent vomiting and of liability to pulmonary complications.

Post-operative pain has been particularly investigated, and I am convinced that pain is less than after a general anaesthetic. The patients are able to return quietly to bed, have their tea or smoke a cigarette, and have in general expressed a decided preference for this technique. Most cases receive a single injection of ½ gr. of morphia about midnight on the day of operation, and many patients have not needed anything but a small dose of aspirin. The absence of external oedema after operation has been very noticeable, and is probably due to the fact that these patients have no vomiting or straining after operation.

CRIME AND INSANITY.
Lecture V.
Given at the Maudsley Hospital, May 28, 1929.

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(Continued from p. 158.)

Patients suffering from manic-depressive insanity are liable to recurrent attacks, and may have an extensive experience of mental hospitals. In an earlier part of this lecture I pointed out that patients who had frequently suffered from attacks of alcoholic insanity were liable to feign insanity when accused of criminal conduct as a result of their experience gained in mental hospitals. The same moral deterioration does not seem to occur with manic-depressive patients, and they do not usually assume insanity in order to escape the consequences of a crime. They do, however, sometimes tell untruths in an endeavour to cover their offence. A manic patient was charged with assaulting a police officer. He alleged the officer was drunk and struck him a violent blow with a truncheon. His statement was proved to be untrue. Five weeks later he stole a van and two horses and made an obviously false excuse. He had by then become more excited, his relations were afraid of him and it was necessary to certify him.

A man who was depressed and deluded came under observation thirteen days after he had attempted to murder his wife and himself. His memory was good, but
although he said he remembered going to bed on the night of the crime and cutting his own throat, he denied any recollection of attacking his wife. When I told him that he could not expect me to believe him he smiled and replied that if he said he admitted remembering the attack he would convict himself. It was clear that he remembered doing so, and assumed a pathological condition as an excuse for the crime, unaware that he was legally insane. He was, in fact, an example of an insane prisoner malingering insane symptoms. This is an uncommon circumstance, but must be constantly borne in mind and may present great difficulties in diagnosis.

Considering that erotic sensuality may be exaggerated in mania, it is worth while observing that I found only three cases of sexual crime in the series of fifty-two cases of mania, and all the offences were trivial in character. Moreover, exaggerated sexual desires accompanied by sexual delusions do not always result in sexual offences in these patients.

Cases of melancholia may present serious difficulties in diagnosis if the attack is slight, or if the crime has been committed some time before the accused comes under observation, perhaps more particularly if he has injured himself severely at the time. Slight cases of melancholia may arouse no suspicion among their associates that there is anything abnormal in their condition, and it is a striking feature of criminal work to observe how rapidly a melancholic patient may recover after he has cut his throat or otherwise caused bodily harm to himself. The degree of depression itself may be no certain measure of the intensity of the disorder; two factors must be assessed—the degree of the depression and its causes. In this the medical witness may have a difficult task, firstly in ascertaining the precise emotional state of the accused and its attendant circumstances, and, secondly, in deciding whether the emotional reaction is so excessive as to be abnormal.

He may have difficulty in convincing the court that the case is one of melancholia and not melancholy, and must be prepared to point out the difference between a mental disorder and an emotional phase.

In melancholia homicidal and suicidal impulses frequently co-exist, and the majority of homicidal attacks are upon the patient’s own relations for whom he has a genuine affection. It is probably correct to regard the typical melancholic homicide as altruistic in character, but cases occur where jealousy and suspicion are less worthy motives. A young man with a bad family history had suffered from three previous attacks of mental depression, and was considered to be suicidal in at least one of them. He later married, but again became depressed, delusional and suicidal. He decided to commit suicide, but determined to save his wife the distress and disgrace which he anticipated she would consequently feel, and he arranged to kill her first. But to render her last moments on earth pleasurable he bought her a costly piece of jewellery, and as he presented it to her shot her. He then shot himself through the left breast. The girl died, but it was interesting to observe the rapid mental recovery made by the accused.

As an example of attempted murder from jealousy arising in the course of this disorder I may briefly refer to the case of a middle-aged man who married a widow with grown-up children. There was no doubt from the observations of friends and relations that they were a devoted couple, and both spoke highly of the other. The man became depressed, and sat at home brooding and weeping and unable to occupy himself at all. He suffered from insomnia, became delusional, hallucinated and suicidal. He cut his wife's throat as she lay in bed beside him, and then cut his own, believing quite erroneously that she had been unfaithful to him.

Partial or complete loss of memory for the events connected with a melancholic crime
are frequently alleged by accused persons, and this is sometimes true. It would seem that the loss of memory in these cases is sometimes produced by the repression of a memory too painful to be retained in consciousness.

The crime of the melancholic is often the result of deliberation and purpose, but is sometimes due to apparently motiveless violence. The accused may show little impairment of perception and disturbances of affection and conation may be difficult to demonstrate and associate with legal insanity. In certain cases the circumstances of the crime indicate a disordered mind so clearly that the jury have no difficulty in reaching a verdict of insanity. But the melancholic, even when delusions are present, may know the nature and quality of his act and that it is wrong in law. This was so in the case referred to in a previous lecture of a melancholic who attacked a lad in the street because he wanted to commit murder in order to be hanged.

The melancholic may be fit or unfit to plead. In cases of melancholic stupor there is no doubt that he is unfit to plead. In other cases it may be necessary to testify that the accused is unfit to plead on the ground that he is so detached and unconcerned at his own position, or so determined to suffer at the hands of the law, that he is thereby incapable of properly instructing counsel in his defence.

In mania as well as in melancholia the accused may know what he is doing and that what he is doing is wrong. The maniac may be unfit to plead, but the mild hypomanic may be fit to plead, and may on occasion conduct his defence with unwonted skill. The effect of the disease may be to cause a quick mental reaction and alertness of mind, a sense of well-being and self-reliance, which favours the accused when questioning witnesses or when giving evidence himself.

A final observation. The usual purpose of the examination of a mental patient is to ascertain the presence of mental disorder, its prognosis and treatment. But in criminal work mental disorder and insanity are not synonymous terms, and it becomes necessary to examine also all the known circumstances of a crime to ascertain whether the disordered person is legally insane.

**EDITORIAL.**

We wish to draw our readers' attention to the fact that the August issue of the Post-Graduate Medical Journal will be of augmented size and will, in fact, be a special post-graduate education number. In view of the combined Meeting of the British Medical Association and Canadian Medical Association at Winnipeg next month, we think our subscribers will be interested in reading the opinions of eminent authorities in regard to the facilities for post-graduate education available in Canada and in this country. Dr. Primrose has contributed an article which will appeal to the Canadian reader as it details the facilities offered in that country. Contributors from this side of the Atlantic include Mr. Donald Armour (a graduate of the University of Toronto), Sir John Rose Bradford (President of the Royal College of Physicians), and Mr. Herbert Carson and Mr. Herbert Paterson. The latter are honorary officers of the Fellowship of Medicine and Post-Graduate Medical Association, and can therefore speak with authority of the post-graduate work obtainable in London, as this Association is at present the chief organization for dealing with post-graduate education.

In connection with the Winnipeg meeting we have received from Dr. Linsey Williams, Director of the New York Academy of Medicine, a cordial invitation to any members who are planning to pass through New York on their way to the meeting to make full use of the Academy. The following facilities are available: the Library, open from 9 a.m. to 5 p.m.; meetings—two stated