THE POST-GRADUATE MEDICAL JOURNAL

VOL. V.

JANUARY, 1930.

No. 52.

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CRIME AND INSANITY.

LECTURE IV.

GIVEN AT THE MAUDSLEY HOSPITAL, MAY 14, 1929.

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(Continued from p. 54.)

It will be unnecessary to consider crime in association with secondary dementia as the patients are usually under care prior to its onset. In other cases the history of a previous attack of insanity with subsequent mental deterioration renders the diagnosis clear.

Senile dementia, however, is a frequent cause of crime, and although its recognition is easy and we all have experience of the

condition, it may present difficulties to the medical witness.

The mental deterioration is essentially a quantitative reduction of the former mental capacity of the individual, which may be declared by a failure of memory, attention, capacity for work and receptivity for new ideas which is the common heritage of the long-lived. Each individual must be judged according to his own previous standard, for a man of superior intellect may show evidence of senile mental deterioration, which is obvious when compared with his former capabilities, but he may be superior still to a less intelligent person who shows no deterioration. This fact may arouse criticism in a criminal court, for the jury will more readily accept a contrast between an accused dement and a normal person than the difference between the present condition of a prisoner, which is a matter of fact and observation, and that which is alleged to

have been his previous mental capacity, which may be only a matter of hearsay and inference. It may be possible to show that a man who has been a success in life has so far deteriorated that he is unable to perform the work he did formerly, but with less skilled workers the very circumstances of the case may prevent so clear a demonstration.

It should be remembered that senility is a wide term, which denotes the involuntional period and not any particular decade, and that in some cases retrogression occurs prematurely. In some cases dementia develops late and progresses very gradually, in others the change occurs with considerable rapidity. A crime committed by an elderly man may not be attributed at first to this disorder, but may eventually appear to have been a prodromal symptom of involution. But an elderly man with a previous good character is not necessarily suffering from senile dementia if he is detected in a compromising situation, or is arrested for some sexual offence. He may have been addicted previously to similar conduct extending over a considerable period without drawing suspicion upon himself.

The crimes associated with senile dementia are on the whole of a minor character and suggestive of mental weakness: vagrancy, begging and wandering, drunkenness, insulting behaviour and refractory conduct in the workhouse. More serious offences such as fraud, false pretences, theft, assaults, carnal knowledge and indecencies of various kinds are met with from time to time, and occasionally charges of serious wounding or murder. I found in a series of cases under my observation that 15 per cent. were charged with sexual offences. The most important factor contributing to this result appears to be the loss of higher control which may demonstrate clearly for the first time the psychotic change. Moreover in some cases sexual power may persist into advanced age, and in others sexual desire may be strong although it has outlived physical com-

petence. The latter cases demonstrate the importance of considering both the psychological as well as the physical accompaniments of any sexual crime. But sexual power if persistent, or sexual desire if strong, may easily lead to crime if failure of inhibitory power is also present and circumstances are favourable for its commission.

The sexual offences are of the usual kind: carnal knowledge, indecent assaults, indecent exposure and homosexual offences. But they are not infrequently carried out in a somewhat open manner. The victims are generally children or young girls who are likely to be easier prey than their elders. And it is interesting to note that some men tend to forsake the bolder and more aggressive acts of exhibitionism and indecent assault as age advances, and may stimulate their sexual phantasies by less direct means such as obscene letter writing or sending indecent drawings through the post.

It may be a matter of considerable difficulty to connect a sexual offence with this psychosis. If however there is evidence to indicate that the sexual activities of the accused are recrudescant there are usually grounds to attribute the same to a pathological cause, and there is reason to believe that an enlarged prostate itself is an infrequent causal factor of sexual crime.

The transient phases of mild mental excitement which the dement occasionally exhibits may lead to a charge of drunkenness, particularly if a small amount of alcohol has been imbibed also. The periods of depression, whether transient or prolonged, not infrequently lead to attempts at suicide. The depressed dement may experience short attacks of excitement as in the case of an old man, aged 70, who was under observation charged with attempted suicide. He was depressed, and one night developed a short attack of acute excitement in which he was confused and thought the prison hospital was on fire. The next morning he had no memory of the event, and if he had committed a criminal offence during this period

would have had probably a genuine amnesia concerning his actions.

The confusion which is a distinct feature in some cases of senile dementia may result in amnesia. And if some interval elapses between the commission of a crime and the arrest and trial of the guilty dement, the loss of memory for recent events which is so common a symptom of the disorder may result in his more or less complete ignorance of his actions at the time. This loss of memory sometimes leads to the accused being unable to appreciate the reason for his detention; convinced of his own innocence he demands release from custody, which failing he becomes irritable, suspicious, obstinate, hostile, and sometimes threatening and violent.

The senile dement not infrequently explains his offence by fatuous reasoning which deceives no one but himself. An old man with a public school education was charged with begging. He was demented and mildly excited. He said he could supply his wants with singing, painting or begging and was a better singer than a well-known vocalist. He believed he was a very good dancer and was about to give dancing lessons on the music hall stage. He informed me that as he was a special constable he had a good mind to arrest the officer on night duty in the prison hospital ward for sending him back to bed from the lavatory where had gone because he had a cold! When the charge was referred to he said he could not understand it, as he was singing in the street for pleasure and not for money. He quite expected me to accept his explanation.

The senile dement, like other simple-minded folk, becomes the dupe at times of the more astute criminal. One man whom different employers had lately found unemployable was said by his wife to be childish, wet and dirty in his habits, and to have lost all sexual power. He had a clean record as regards crime until he met a younger man who induced him to carry

cardboard boxes containing stolen articles through the streets. The prisoner lacked the initiative to commit any offence himself and was only capable of carrying out simple instructions.

The waning physical and mental powers of the involution period are often associated with depressive ideas as well as a depressed emotional tone. Unaware of his growing limitations, the senile dement who thereby becomes unemployable may come to believe that there is a conspiracy to keep him out of work, and his suspicions are transferred from one person to another with facility. An old man who was charged with assaulting the police was deluded and hallucinated, childish and depressed. He wept as he unfolded his troubles to me, and related how he often went hungry and cold. But when I inquired if he had any money to maintain himself if he was discharged at court, he at once became suspicious and replied that what happened to him had nothing to do with me. And when I attempted to assure him that I did not want his money, if he had any, he retorted that "money was always useful."

Crimes of violence due to senile dementia may result from premeditation, impulse, depression or delusions. W. C. Sullivan directed attention to the fact that the dementia is usually too marked to allow of the development of any more or less coherent delusional system, and that in consequence the delusions are less intrinsically absurd than in alcoholic cases. And the medical witness may have difficulty in satisfying the jury that allegations of a wife's infidelity are delusions and not facts, particularly if she is young and attractive. There is obviously less difficulty if the wife is about the same age as her husband, but in every case it is important for the medical witness to interview the wife, and if possible one or more relations from both sides of the family.

Circumstances may leave the alienist himself in doubt as to whether the allegations are delusions or not. A woman, aged

72, murdered her husband, inflicting several wounds on his head and hands with a knife; one hand was almost severed from the wrist. The couple had been married some forty years and were childless; the husband was some years junior to his wife. She alleged that he misconducted himself with a woman and that the liaison had been going on for four years. The accused was admittedly intemperate, the deceased may have been so. Shortly after the murder, which the woman admitted committing, she said that she thought she saw her husband kiss the woman once but was not sure about it. Later she added to her story, she said her husband neglected her, spent money on the woman and admitted adultery with her. She made allegations that the woman kept a brothel, which was probably quite untrue. But it was impossible to decide whether the allegations against her husband were delusions, facts, or wicked inventions. She described how she attacked him as he climbed through a window, how she had locked the doors of the house when he went out that evening, and how she waited for his return. She said that she must have struck him too hard, and that she had had a lot of provocation and that the murder was not premeditated, but the result of passion. She was markedly senile, her memory for recent events was bad, she was confused and mistook the identity of people she knew quite well and was seeing daily. She had periods of depression and two brief attacks of excitement whilst awaiting trial. The jury refused to accept the evidence I gave of insanity, it was impossible to say that she did not know what she was doing, or that what she did was wrong. The events connected with the crime refuted the legal definition of insanity. She was found guilty and sentenced to death. This was not executed, and she died a few years later.

Most of the crimes associated with senile dementia occur in the early stages of the disorder, and the symptoms then may be

insufficient for certification under the Lunacy Acts, or for acceptance in a criminal court. Failing this, the defence may call medical evidence in mitigation of punishment, and in the absence of hallucinations or delusions, depression or exaltation, or overt act indicating disorder, the medical witness must base his opinion upon the lack of those mental capacities which the subject was known to have possessed formerly.

Systematized delusional insanity is a frequent causal factor in crime. The diagnosis may demand much time, and information from disinterested persons may be necessary to clear up certain points. The witness pieces his evidence together in such cases with a firm conviction that he has a clear case of insanity to put before the jury. But although there may be no difficulty in presenting evidence of mental disorder sufficient for the certification of the accused as insane, there may be none to support the opinion that the prisoner is insane according to the criminal law. Indeed it may appear conclusive from the evidence that the prisoner knew what he was doing and that what he did was wrong, that is, was punishable by law. He may, however, be convinced that he had the moral right to do the act. It is in this class of case particularly that medical men feel most disposed to criticize the legal definition of insanity. I need not repeat my remarks in a previous lecture on the matter, it will be sufficient to remember that no alternative definition of insanity has been offered which meets with general approval. And further, that the law provides means by which such cases can be certified as insane after conviction and then according to the usually accepted standards in civil cases.

In a series of sixty-six cases of paranoid crime 42 per cent. were conspicuously aggressive in character, twelve were crimes of violence to the person, ten violence to property, and in six cases violence was threatened. Fifteen per cent. were crimes

of acquisition : theft, false pretences, office breaking and the like. The remaining offences were of a more trivial character, vagrancy, using insulting words and behaviour, libel, sending obscene matter through the post, neglect of family and drunkenness. No prisoner was charged with a sex offence, a matter of some interest inasmuch as the delusions are often sexual in character.

The persecuted paranoiac may postpone violence for many years in spite of the provocation resulting from his delusions. But these may become so dominating that his control at last succumbs. This is most likely to be the case when the subject has tried lawful means of protecting himself from his persecutors, and finds no assistance from his appeals to the police or other persons in authority. He may then come to believe that he is justified in protecting himself at all costs, although he may appreciate that his acts are punishable according to the law. Such was the following: A temperate man was found one morning shaking an iron gate in the street, and when asked by a uniformed police officer what he was doing replied by stabbing him in the chest. He was under the impression that he was about to be arrested as his imaginary enemies had discovered that he was going to make some money and would then be in a position to overthrow them. He believed that the Government and the police had plotted against him for many years, and prevented him from obtaining employment, and that when he went into a lodging-house or coffee-house and was refused accommodation or refreshment it was the result of their orders. He informed me that to test the animosity of the police he once begged in the streets for a month, but he was not arrested because the authorities were too artful to fall into his trap. He went on the Continent to avoid his persecutors, but he believed a fellow traveller was a spy, and that he was followed by his enemies. He wrote from abroad to Scotland yard hoping

to get to the bottom of the plot against him, and when he failed to obtain any satisfaction he applied to the Burgomaster, and later to the English Consul. He returned to England and consulted many solicitors, but they refused to act for him and he believed they were overawed by his enemies. He believed that he was followed by "hirelings of the Government," and that his genitals were operated upon during three consecutive nights in a lodging house. He was at first willing to detail his troubles to the medical staff, but we were soon included among his persecutors. He refused a defence of insanity at his trial and was sentenced to a term of imprisonment during which he was certified as insane. He knew what he was doing, and that what he did was wrong and punishable by law, but he believed he had the moral right to protect himself from such persistent persecution.

The crimes associated with this disorder may be impulsive or premeditated. The more unsystematized the delusions the greater on the whole is the tendency for criminal acts to be impulsive in character. The more systematized the delusions the less the liability to impulsive action, the more deliberate the crime, and the more closely is it associated with the delusional system. The medical examiner may have great difficulty in showing that the subject's premises are faulty, for he may be consistent in the systematization of his delusions and have a logical reason for his attitude ; and as he has rationalized and adjusted his beliefs to his own satisfaction he may be difficult to criticize unless their foundations can be clearly shown to be untrue.

In some cases the accused are extremely difficult to examine as they consider the medical man is in league with their enemies before he has been able to conduct his first examination. Perhaps in few cases is the art of the physician more called upon to enable a correct diagnosis to be made on facts observed by himself. In one case a homicide refused for a long time to discuss

his delusions, for he said he wished to get rid of his persecutors once and for all, that if he discussed his troubles with me he would be sent to Broadmoor for the rest of his life, whither his enemies would follow and annoy him, and that he preferred the peace the gallows offered him.

The delusional patient may be not only reticent and suspicious but also cunning. A man charged with libel knew I was examining him for the purpose of giving evidence at his trial. He regarded me as an enemy who wished to get him placed in an asylum for some ulterior purpose. He asked me what evidence I was going to give at the trial, for he said if I was going to say he was insane he would arrange to make statements which would support my evidence. His real purpose was to be forewarned, so that he could make preparations to rebut the evidence of insanity which he surmised I was about to give. And at his trial he disputed my evidence strenuously but ineffectually.

A quite contrary class of case is sometimes met when the subject has some insight into his condition and deliberately commits a crime so that he can be remanded for medical examination. A man who had been previously convicted broke into a Poor Law institution and took therefrom some bedding and a clock. He placed them on a window sill and stood by waiting to be arrested. His wife was aware that he was suffering from delusions and he had been troubled by "a voice" for some time. When his wife told him "the voice" was imaginary he wished to be medically examined to ascertain whether she was correct or not.

The perturbation which these patients may experience is well illustrated by the case of a medical man who left a northern city and came to London armed with a portion of an electric battery with which he intended to break a window so that he might be imprisoned, and thereby escape from his persecutors. He believed they pursued him from town to town and

knocked on his bedroom door, or on the walls, in any hotel he lodged at. He believed that his neighbours endeavoured to drive him away by throwing things at his front door and windows. He was amazed that he had been able to carry on the fight against them for so many years. He was remanded for an inquiry to be made into his mental condition, and was for a time contented and undisturbed in the prison hospital, but inevitably in a few days innocent occurrences in the ward were believed to have some sinister reference to himself, and the persecution recommenced.

Medical men usually have much hesitation in certifying many of these cases, and probably advisedly, in view of their litigious character. This is extremely unfortunate, as they are potential homicides. The friends are often misled themselves with regard to the seriousness of the delusions, they appear so much a part of the subject's personality that their true significance is often overlooked.

I have already directed attention to the difficulty of dealing with patients whose allegations of marital infidelity may be delusional. Perhaps the majority of these cases seen in the criminal courts are alcoholic in nature, but there can be little doubt that paranoidal and other states of mental disorder may result in crimes associated with delusions of this type in which alcohol plays no part. And I find it difficult to accept the view of those observers who consider delusional jealousy is always alcoholic in origin. If the paranoiac develops the disease along the lines of his personal peculiarities, and the judgment of the jealous, suspicious, quarrelsome or litigious subject is thereby rendered faulty, their temperamental anomalies tend to become exaggerated. It would appear that delusions of marital infidelity may arise in this way.

In discussing senile dementia it was inferred that when delusions are systematized they may be obviously illogical. The point is illustrated by the following case: A man

was charged with using threats to his wife, and was remanded for medical observation.¹ He was a man in regular employment, temperate in habits and with an exemplary character. He married a widow with a small family and she had borne him three children. Shortly after marriage he thought she had misconducted herself with his friend. This arose because he saw his wife, who was sitting on the chair nursing the baby, lean towards the sofa on which the friend sat. The prisoner was watching from an opposite room and saw nothing wrong take place, but the movement appeared to him full of meaning. On another occasion he thought they were misconducting themselves, but he took no action to interrupt them, and when his friend left he shook hands with him amicably. He then went with his wife all over the house to make sure the friend had not returned. He accused her of misconduct with two men living in the house on the first day that she got up after a confinement. He threatened her, and the men said they had all better go down to the police-station and settle the matter. Before going the prisoner took a poker and some poison from his pocket saying he had intended to poison his wife and the children whose paternity he had come to doubt. He believed that one of the men had seduced his wife because he alleged the man's wife had made overtures to himself. He could give no reason at all for suspecting the other man. He attacked a woman living in the house for no apparent reason as she prepared some food for his wife. He believed that he was spied upon by people who wished to be aware of his whereabouts so that they could have illicit intercourse with his wife during his absence. He went to an evening party and danced with a knife and fork in his hand, and because the company became alarmed he considered they had guilty consciences. He had threatened

to kill his wife with a razor because of her infidelity. She was interviewed, and also a woman living in the house, and it became clear that his allegations were entirely imaginary.

A good deal of information can be obtained regarding the mental condition of the delusional patient by a perusal of the letters he writes. He may be suspicious and reticent in personal conversation, but when he settles down to write his feelings may command his pen so that he expresses the imaginary grievances he otherwise will not hold. His suspicions may include his legal advisers. One man said he was going to defend himself at his trial because "he could trust no one but himself, and counsel might be in the conspiracy against him. Even the jury may be suspected. A paranoiac charged with murder declared that the jury knew all about his case before the trial, and how he had been persecuted, and considered they had already made up their minds against him. Some such belief might cause an accused paranoiac to refuse to plead, his judgment may be subordinate to his delusions. He may be so suspicious that he refuses to question witnesses, fearing that he may give them some opportunity to injure him further. He may see some hidden meaning in the replies of different witnesses which detracts his attention from the main purpose of his defence. His capacity to plead may be a matter for consideration in these circumstances. But if fit to plead he may take a keen interest in the evidence and closely question the various witnesses.

I have already given an example of impulsive violence in the case of the prisoner who stabbed the policeman. Let me now describe a case of premeditated violence. A man believed that he was "a human wireless," and that he was followed about by people who controlled his actions against his own wishes, preventing him from doing what was right and making him do what was wrong. He believed also that broad arrows were chalked on the pavement to show the

¹ This case and others referred to in these lectures appear in my book "Forensic Psychiatry," J. and A. Churchill, 1927.

he was a jail-bird, and that he had been victimized for years. He believed that a man lodging in the same house as himself was one of his persecutors, and he kept awake one night until he thought this man had gone to sleep. He then cautiously crept up to his bedroom and stabbed him, and later went and gave himself up at the nearest police station, saying, "I want to give myself up. I think I have done a fellow in. I went to do him in. I stabbed him in the neck as far as I know."

It will be apparent from this statement that the accused knew the physical character of the act he had committed; viz., its nature and quality. And it was clear from his action in going and reporting what he had done to the police, and from his statements after arrest, that he knew that what he had done was wrong.

The prisoner who assumes insanity usually feigns insane delusions. He obtrudes them for the medical man's benefit, whereas the truly insane more often endeavour to hide their beliefs from others. Assumed delusions are usually unconnected with the crime, they may change from day to day in a manner that should raise suspicion, and they may be limited to one or two assertions which are repeated only in the presence of interested persons. They are generally persecutory, less frequently grandiose, and seldom self-depreciatory. The malingerer fails to systematize his delusions or to reproduce the history of such, extending over many years, with the peculiar regard for trivial incidents, and the accuracy of memory for minute details, unimportant conversations and chance expressions which are so manifest in paranoiacs.

The litigious paranoiac is on the whole probably seen more often in the civil than in the criminal court. He is sometimes sent to prison for contempt of court, for he firmly believes in the merits of his own case and is extremely obstinate. He may be recognized by his friends and relations to have been eccentric for years, but his im-

prisonment often offers the first opportunity for a medical examination. There is perhaps less difficulty in uncovering the delusions in this class of case as the patient is generally anxious to ventilate his grievances and enlist sympathizers. But it may still be difficult to disclose the defects of his premises without assistance from his acquaintances.

General paralysis of the insane is a factor in criminal conduct in both early and later stages of the disease. Moral changes of character are frequently noted among the prodromal symptoms, but I am disinclined to accept the view that crime occurs earlier in this form of mental disease than in many others. It frequently happens that a case comes under observation in which a crime has been committed and mental disease is suspected, but evidence is lacking to support this opinion; and if opportunity arises and the case is kept under observation, mental disorder, other than general paralysis of the insane, is declared later on. There is, however, I think, little doubt that the conduct of the general paretic becomes affected so early in the course of the disease that apart from any criminal tendency his friends and associates appreciate quite soon that he is abnormal. In other disorders they may be unable to give any information indicative of insanity, when to the practised eye it is evident that the patient has been affected for some considerable period. But they are often of material assistance in early cases of general paralysis, having observed conduct which was opposed to the subject's former mode of life.

The student of general medicine is apt to associate this disease with grandiose delusions, but there seems to be general agreement that the classical symptoms of the disease have changed in this respect. The bombastic statements of an accused person are liable to mislead the medical witness at any time unless carefully checked; otherwise he may be unable to withstand cross-examination in the witness box. A man was remanded for an inquiry to be made into

his mental condition. He was of humble origin and alleged he was a world champion; this was untrue, and it seemed probable that it was only another of the grandiose delusions from which he was suffering. But inquiry showed that he had been the English champion in a particular form of sport some years before. He also had exalted ideas about the capabilities of his wife, but here again information was obtained that she had been employed as cook in the highest families, and was probably unusually proficient in her sphere of life. Certain of his statements were of this nature, and were mere exaggerations of actual events, but they were intermingled with other statements which were undoubtedly delusions. It was desirable to differentiate the one from the other, otherwise opposing counsel might have caused the jury to doubt the medical evidence in general, if it was proved to be incorrect in certain particulars.

The general paralytic, unlike many insane persons, shares with feeble-minded aments the inability to appreciate that others about him are insane. The cases awaiting trial usually say they are very well, however ill they may be, and are unable to appreciate their physical and mental infirmities. They usually have no insight into their condition, and this may be a useful point in diagnosis.

Cases occur when crime is committed in general paralysis and the symptoms and physical signs remain obscure for some time. The Wassermann reaction and other laboratory tests may then assist the diagnosis. It is important to remember that the symptoms may become more apparent as the date of trial approaches, and thus suggest malingering. This is particularly likely to mislead if the charge is a serious one, and if the physical signs are inconclusive, and the delusions are of the grandiose type, which are easily assumed. This class of case must be kept in mind, it is important to guard against errors, and they are of special interest in view of the fact that certain authorities find their syphilized patients

have passed through a period of stress before symptoms became evident, and that this appeared to decide the course which the infection took. It seems probable that the anxiety associated with a serious trial may accentuate the symptoms when the disease is declared. But an exacerbation of symptoms, physical or mental, may occur as the result of epileptiform or apoplectiform seizures, or the less obvious crises which may escape observation. In cases which progress rapidly, and there is a considerable interval between the commission of a crime and the date of trial, an accused person may so deteriorate that he is unfit to plead when he comes before the court, although there was nothing in the circumstances of the offence to suggest the criminal was suffering from mental disorder.

The remissions which are observed in some cases may also tend to mislead the medical witness, for they may be rapid, more or less complete, and prolonged. And if a crime is committed which appears to be the act of a mentally disordered person, and the general paralytic who is responsible for it remains at liberty for some time, he may be found, when eventually arrested, to present almost negligible symptoms of the disease.

A man aged 48 was arrested for indecently exposing himself in a London Underground Station. He alleged that the liftman hearing that he wanted to urinate advised him to do so in the lift, although it was full of passengers, but that he waited until he reached the booking hall. On admission into prison he exposed himself to some twenty prisoners, making an obscene remark at the same time. His history showed that he had syphilis seventeen years before, and that he had been a capable and energetic business man. He had been recognized as mentally affected for five months, and his relatives had reported his conduct to the police, but the latter were unable to take any action. A short time before, he arrived in Paris without a ticket or passport, and was

arrested for bilking a cabman, and was returned to England. On arrival he engaged a motor car and took a chance female acquaintance many miles in it to a fashionable hotel where they had supper. He was arrested for being without means to pay for the supper or the car. He bought numerous articles of clothing, saying he had thousands of pounds; he did not pay for them, and discarded them as soon as he got possession of them. On reaching home he drew three hundred pounds out of the bank, which he spent or gave away in three days. He was stated to be have been gentlemanly in his manner before his illness, but was now regardless of conventions or consequences. His private doctor had believed him to be suffering from general paralysis of the insane. I found Argyll-Robertson pupils, the central portions of the optic discs were very pallid, the vessels appeared normal and cupping was absent. There appeared to be slight anæsthesia of the lower extremities, the knee-jerks were brisk, the planter reflexes flexor and there was no Rombergism. The joint sensations were normal and sphincter control was retained. He described typical horizontal lightning pains. There were no tremors, the speech was normal and the blood gave a positive Wassermann reaction. He omitted words in his letters, stole food from other patients in the ward, was exalted, restless and offensive in his habits, and a nuisance to other patients. Evidence was given at court that he was insane, and he was sent to a mental hospital. Twenty months later he was still alive, and although the physical signs were marked he had been free, or practically free, from mental symptoms on more than one occasion. But it was considered that he would undoubtedly die sooner or later from tabetic general paralysis.

In a series of thirty-three general paralytics charged with various crimes half were charged with acts of acquisition, next in frequency came sexual offences and then crimes of violence. Wilful damage to

property, arson, window-smashing and vagrancy were infrequent. Two cases were charged with drunkenness, and it is well to remember that the general paralytic may be intemperate.

The crimes may result from premeditation even in well-advanced cases. They may be impulsive, they may result from delusions or express excessive emotional reactions. They generally show loss of control, lack of judgment, entire disregard for social values and conventions, neglect of moral obligations, indifference to consequences, and inadequate motives or foolish methods. In one case a general paralytic murdered a woman for a few shillings and left behind him, near the dead body, personal articles which were traced to him with ease. In another case the accused openly stole cutlery in a coffee shop before several witnesses. In a third case the accused struck a civilian in the street for no apparent reason. He told me he did so because he was out of temper with society. Often the patient is at an entire loss to explain his conduct. A man aged 38 smashed a plate glass window and waited to be arrested. He said something came over him to make him do it, but admitted that it was a funny thing for him to do, he had never done anything like it before, and would go round to the owner and apologize.

Sexual desire may be excessive in the preliminary stages of the disease, and sexual power may return temporarily after a period of impotence, although it is generally recognized that both are lost early in the disease. The licentious conversation and attraction for doubtful female acquaintances suggest a potency which may not exist, and in spite of the patient's claims to great physical and sexual power and many lovers, the sexual offences are as a rule of a minor character.

The diagnosis of general paralysis of the insane in a criminal court should not rest upon symptoms only but the physical signs must be evaluated also. The mental symptoms as well as the physical signs may suggest alcoholic insanity. A general sense

of well-being and grandiose delusions may be associated with either psychoses and both are not infrequently associated with crime. In both there may be facial and lingual tremors, the pupils in either disease may be unequal and sluggish. Argyll-Robertson pupils and primary optic atrophy favour general paralysis, and although presumptive evidence of cerebrospinal syphilis, have been associated, although rarely, with other conditions such as alcohol. Jelliffe and White quote a case reported by Nonne¹ in which it was demonstrated to be due to alcohol; syphilis was excluded by four negative reactions, optic neuritis by careful ophthalmological examination, and the light reflex returned upon the withdrawal of alcohol. The facial expression may be lost in either condition, and the slurred speech of the paralytic is not always easy to differentiate from the thick hesitating speech of the alcoholic. Epileptiform attacks may occur in either, the tendon-jerks may be exaggerated, unaffected or lost in both. In general paralysis the plantar reflexes become extensor, sooner or later, unless they disappear altogether, as in the tabetic form of the disease. An extensor plantar reflex may be the only physical sign present, and when coupled with mental symptoms may assure an early diagnosis. Hallucinations are more common in alcoholic cases. Fear or apprehensiveness suggests alcoholism. Either may improve markedly, following upon institutional treatment. The differential diagnosis can be determined by examination of the cerebrospinal fluid, but it is immaterial as far as criminal responsibility is concerned. For if the symptoms cause a person to be so affected that he does not know what he is doing or that what he does is wrong, he is thereby irresponsible, whether the cause be alcohol or syphilis.

THE TECHNIQUE OF TREATMENT OF VARICOSE VEINS, OF HÆMORRHOIDS, AND OF BLOOD TRANSFUSION

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VARICOSE veins and hæmorrhoids are pathological conditions constantly occurring in practice, and until recent years have given considerable anxiety as to the correct line of treatment to be adopted or advised. Such treatment was generally palliative or operative, but the institution of the treatment by injection has given a remedy which is to a great extent curative without the disadvantage of operative procedures.

VARICOSE VEINS.

The treatment of varicose veins consists of injecting some sclerosing substance into the lumen of the veins with the object of producing a thrombosis. Many such substances have been used, but in this country the quinine and urethane solution and sodium salicylate solutions are the most favoured. I use the latter, as I am of opinion that, although the sodium salicylate solution produces a definite cramp at the time of injection the subsequent discomfort is much less than with quinine. 20 per cent., 30 per cent. and 40 per cent. solutions of sodium salicylate are employed. The solution is prepared by dissolving the sodium salicylate in distilled water, filtering and boiling for three to five minutes to sterilize it. Too prolonged boiling produces discoloration due to oxidation, but it seems to me to make very little difference. Variation in the strength of the solution is due to the fact that in some cases 20 per cent. will not produce the desired effect and then resort must be to the more concentrated ones, 40 per cent. invariably producing thrombosis. Injections are given

¹ *Neurol. Centralbl.*, 1915, Nos. 7-8.