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Original Communications.

MELANCHOLIA.*

BY HAZEL PADGETT, M. D., OF NASHVILLE, TENN.

All types of melancholia considered, the disease is possibly the most frequent of all forms of insanity, and is that form of mental disease or condition manifested by more or less depression with slowness of intellection, retained consciousness, and the development of secondary delusive ideas of a self-accusatory type, with now and then a great agitation and a pronounced tendency to suicide and sometimes homicide. While pure melancholia is an affection of advanced life I can not agree with Kraeplin in classing it solely as a senile affection. It does occur in youth and early

*Read at regular meeting of the Nashville Academy of Medicine, Tuesday, Sept. 29, 1908.

adult life, and these patients recovering leave no trace of the disease behind. It is not necessary to have an inherited tendency, though an unstable nervous system, harassed by the many ups and downs in this our hurly-burly life we are living, certainly is a predisposing cause. Sudden emotions, such as shock, grief, chagrin, long-continued depressing conditions, especially in persons of poor nutrition, overwork, and under the influence of various toxins, are well recognized causes and agents. I remember a recent case in a young healthy woman, precipitated by a grippal infection. The changes in the brain coincident with old age, seem specially to favor the development of the disease, and this is one reason why some consider it a degenerative insanity. It is claimed by some that it is more common among women than men, but this is not my personal experience, and one would naturally think it more common among civilized and cultivated people, and with the increase in responsibilities and anxieties of life. Some consider profound home sickness a type of melancholia.

It is interesting to note that melancholia is not strictly confined to man, but some of the lower animals have been known to have attacks. The disease is interesting in that it has no known morbid change. No gross or histologic change that is characteristic, though in senile cases and other cases also we do find arteriosclerosis sometime. The best explanation we have is that it is a nutritional disturbance of the cerebral cell, the nerve cell being acted upon by the many possible influences, as anæmia, congestion and toxins resulting in abnormal metabolism. The exact mechanism of the possible change is not known, but in prolonged cases of chronic melancholia we do meet with changes seen in terminal insanities of other kinds, changes like pial and arachnoid thickenings and opacities, vascular degeneration, and brain atrophy.

Under ordinary conditions melancholia is of slow onset, but cases have been known to develop suddenly. There is a multiplicity of prodromal symptoms and conditions, such as a history of great nervous strain and mental anxiety in responsibilities and failing health, with or without poor appetite and digestion. An almost constant state of insomnia before and after the melancholic state is established and insomnia is one of the most distressing states of

the disease, and when the patient sleeps 'tis often not refreshing, but short and disturbed. The patient is constantly worried and distressed about his business and home affairs. At this stage there are attacks of intense depression, and the patient often realizes the unreasonableness of his fears and worries, but it is impossible for him to get out of the atmosphere of his morbid feelings. A very common manifestation of these spells is a feeling of guilt or wrong-doing, and this phase later on becomes very prominent and distressing, especially to those who have to listen to the oft-repeated statements of moral guilt, unworthiness and sin. These spells of depression grow closer and closer together and more profound till the disease is thoroughly established. The intellect through much of the prodromal time, seems often clear, and the person may seek treatment for his condition, and if it is a second attack, fully realizes what is coming, but cannot prevent it. At this stage physical symptoms and conditions exist. Constipation is a most constant condition, often to a marked degree, and going with this is an ever-present occipital or suboccipital headache. The appetite fails with or without gastric irritability, and the patient will not eat, or does so with great reluctance, and has to be made to eat either by insistence or force. Early evidence of physical weakness and prostration are marked, and is easily tired upon the least exertion.

The general symptoms of the prodrome may not be recognized till the patient commits suicide or homicide. The tendency to suicide is an ever-present danger, and it does not always happen when the patient is at his worst, but often when he seems to be improving, and not considered dangerous to himself.

After the incipient stage of melancholia has passed and the disease becomes fixed the symptoms change. The condition now is one of a fixed, intense depression with a decided delusive tendency. In this stage of intense, fixed depression I have seen patients smile and appreciate the comic and then immediately lapse into that awful darkness again. His judgment now has given away. His whole mind is concentrated on his mental distress. When the patient first began he had that vague feeling of having done something wrong that now blossoms into a firm belief that haunts him day and night, as some unpardonable sin and un-

worthiness. Every thing is wrong with him. He is being punished for his sins, and that punishment will continue eternally. Now is one of the most dangerous times, in that he has thoughts of suicide. Often there is a certain amount of motor agitation, the patient walking the floor, wringing the hands, with the feelings of utmost despair; and just recently one of my patients become so violently agitated that he grew dangerous and had to be tied for a short time. Hallucinations do or rather can occur, but not until the pronounced or advanced stages, and are not characteristic of the disease.

There is a variety of melancholia in which the patient is so completely overcome by the depression and painful mental condition that he loses all physical activity and expression. This is called melancholia with stupor. There is no special change in the skin, except that it is quite often dry and very muddy or sallow. The circulation is generally poor and the temperature may be sub-normal.

I have spoken of the ever-present danger of suicide, and this does not always come when the patient is at his worst, but often when he seems to be better; and this is likely to put the physician off his guard. There is no form of the disease that is free from this danger. I have also spoken of homicide, which may show up quite unexpectedly. The course of melancholia is slow and of long duration, but we do have cases that are very mild and run a short course. One cannot hope for much improvement in less than three-months, and then the patient often has oscillations and remissions before convalescence sets in and then the patient improves both mentally and physically, just a little at a time in one little thing and another. He begins to show a little more interest in things generally; asks a few more questions and pays more attention to what is going on around him. Sleeps better, appetite improves, delusions gradually disappear until the individual becomes normal again; but when melancholia does not get well there are several possible terminations. Death may come by suicide. The wear and tear of the system in agitated melancholia may directly overcome the patient's vitality, and the general defective nutrition, plus probably the action of toxins, and the patient may

pass into the chronic form of the disease. The family and friends are always anxious about the result.

Melancholia is one of the specially curable forms of insanity, and if every form of the disease is considered, is the most curable. It is generally estimated of those cases that find the way to the asylums that 50 per cent. recover. Kraeplin, as I have stated, who recognizes it only as a degenerative affection, reckons his recoveries at about 32 per cent. The prognosis is better under 50 years of age than over that age.

The diagnosis of melancholia usually does not offer much difficulty, but there are several states or conditions that can be confused with it, such as the depressed state of general paresis, senile dementia and the depressed state of manic depressive insanity. Melancholia may last for an indefinite period and then get well rather unexpectedly.

The treatment is of vital importance, and the earlier the condition is recognized, the better. The treatment varies with the stages, the character of the attack, and the patient's financial condition. In the mild form the patient often does well with home treatment, but I personally always advocate getting these patients away from home, in order to give them new things to look at, new things to hear, and away from the wear and tear of a hum-drum life. Travel is, as a rule, beneficial when the patient can afford it, physically and financially.

I may mention that some cases of melancholia are so mild that they can care for themselves, but when the disease becomes well established, outside aid is essential. An excellent plan is a stay in a sanitarium, but I never like to send a primary and a supposed curable case to an insane asylum. The important primary things to do are to feed the patient well, overcome constipation, and give all the sleep you can. During the day, it is always well for a short period anyway, for the patient to rest in bed, and if the patient is very weak constant rest in bed is necessary and best. If the patients refuse food, and you cannot, by firm insistence, make them eat, resort to the tube and forced feeding is necessary, and this is a good time to incorporate medicine with the food.

Melancholiacs bear opium well as a rule, and I never hesitate to give opium as morphine or codeine, and it is interesting to

note that it does not always constipate, but often the bowels become more regular under its use.

I have personally found hyoscine, combined with plain morphia, given hypodermically, of the greatest service in the insomnia. Sulphonal, trional and veronal often give good results. Whatever drugs are used should be under the direct control of the physician. When the patient gets better tonics of various kinds can be given. Uncured cases of long duration, and incurable ones, usually indicate an institutional life.

THE DEEP COMPLICATIONS OF GONORRHOEA.*

BY J. W. HANDLY, M.D., OF NASHVILLE, TENN.

There is probably no disease in the category of medicine that has for so many years tested the patience and skill of the surgeon and physician and has been fraught with so many lasting complications as gonorrhœa. To treat a case in its early stages before deeper involvements have manifested themselves is not so difficult, and with our present means of treatment, we are able to limit the duration of the disease. Numerous have been the suggestions for treatment, and yet no specific has been found. The severer kinds of astringents and irrigations have been practically abandoned for the more modern silver salts, which seem to hold sway at present, with becoming benefits, to our suffering patients.

Before going into cursory remarks on the deep complications, I would like to urge the profession at large to give the argyrol treatment a most careful consideration. Used in a 10 to 15 per cent. solution at frequent intervals will modify the pain, lessen the discharge and more rapidly destroy the gonococci than any other remedy at our disposal, without in any way injuring the mucous membrane of the urethra, or causing the later development of the more common complications, which older remedies have produced, such as orchitis, stricture, chronic granulations, and urethral ulcers, or even the passage of the disease to the deeper glandular

*Read at regular meeting of the Nashville Academy of Medicine, Tuesday, October 13, 1908.