taining only 50 centigrammes of urea per 1000 grammes. Now, in the case of our patient, the urine contained 15 grammes of urea per 1000 grammes,—an amount approximating to the normal standard.

Judging from this, gentlemen, the obstacle in hysterical ischuria would not lie in the ureters. Where then does it reside? Should we invoke an influence of the nervous system analogous to that which Ludwig discovered in the case of the salivary gland? In the absence of all information on this point, we are compelled to leave the question in suspense.

LECTURE X.

HYSTERICAL HEMIANÆSTHESIA.

SUMMARY.—Hemianæsthesia and ovarian hyperæsthesia in hysteria. Frequent association of these two symptoms. Frequency of hemianæsthesia in hysterical patients; its varieties, complete or incomplete. Characters of hysterical hemianæsthesia. Ischæmia and the "Convulsionnaires." Lesions of special senses. Achromatopsia. Relations between hemianæsthesia, ovarian hyperæsthesia, paresis and contracture. Variation of symptoms in hysteria Diagnostic value of hysterical hemianæsthesia; necessary restrictions.

Hemianæsthesia depending on certain encephalic lesions. Its analogies with hysterical hemianæsthesia. Cases in which encephalic hemianæsthesia resembles hysterical hemianæsthesia. Seat of the encephalic lesions capable of producing hemianæsthesia. Functions of the optic thalamus; British theory; French theory. Criticism. German nomenclature of different parts of the encephalon. Its advantages as regards the circumscription of lesions. Cases of hemianæsthesia recorded by Türck; special seat of the encephalic lesions in these cases. Observation of M. Magnan. Alteration of special senses.

GENTLEMEN,—There are two points in the history of hysteria, upon which I wish to lay particular emphasis, in this and the following lectures. These are, on the one hand, *hysterical hemianæsthesia*, and on the other, *ovarian hyperæsthesia*. If I set these two

panis)—caused a sudden change in the condition of Marie L—, dating from the 17th September. The vomiting ceased, the secretion of urine resumed its course. Finally, the patient left the hospital, in very fair health, in the course of November. M. Ch. Fernet, in concluding his note, points out the numerous analogies between this case and that of M Charcot's patient.

We may mention also a thesis of M. Secouet, 'Des vomissements urémiques chez les femmes hystériques,' (Paris, Avril, 1873), which contains the report of a case that, though imperfect in some respects, should apparently be classed in the category of hysterical ischuria. (B.)

phenomena side by side, it is because they are generally found associated together in the same patients. With reference to ovarian hyperæsthesia, I hope to render evident to you the influence of *pressure on the ovarian region*—an influence formerly acknowledged, but afterwards denied—over the production of the phenomena of the hysterical seizure. I shall show you that this operation determines, either the premonitory symptoms merely of the hysterical fit, or, in a certain number of cases, the complete seizure. You will thus be enabled to verify the accuracy of the assertion formerly made by Professor Schutzenberger, with respect to this phenomenon, in spite of the contradictions offered by certain observers.

I shall likewise show you a method which I have discovered, or rather re-discovered, which, in the case of some patients, enables us to arrest the course of even the most intense hysterical fit,—I refer to the *systematic compression of the ovarian region*. M. Briquet denies that this compression has any real effect. That is an opinion which I cannot share, and this leads me to make a general remark in reference to M. Briquet's book.[1] The work is an excellent one, the result of minute observation and patient industry, but it has perhaps one weak side; all that relates to the ovary and the uterus is treated in a spirit which seems very singular in a physician. It exhibits a kind of prudery, an unaccountable sentimentality. It appears as though, in reference to these questions, the author's mind were always preoccupied by one dominant idea: "In attempting to attribute everything to the ovary and uterus," he says for instance, somewhere, "hysteria is made a disorder of lubricity, a shameful affection, which is calculated to render hysterical patients objects of loathing and pity."

Really, gentlemen, that is not the question. For my own part, I am far from believing that lubricity is always at work in hysteria; I am even convinced of the contrary. Nor am I either a strict partisan of the old doctrine which taught that the source of all hysteria resides in the genital organs; but, with Schutzenberger, I believe it to be absolutely demonstrated that in a special form of hysteria,—which I shall term, if you please, the *ovarian form*,—the ovary does play an important part.[2] Five patients whom I shall present to you in succession are, if I mistake not, manifest examples of this form of hysteria; you can verify the accuracy of the description I am about to give, by personal examination.

[1] Briquet, 'Traité clinique et thérapeutique de l'hystérie,' Paris, 1859.

[2] Grisolle ('Traité de Pathologie Interne,' 9e édit., t. ii, p. 844) mentions the case of a girl, aged 22, who had neither vagina nor uterus, and yet was subject to most violent fits of hysteria. On autopsy, MM. Chassaignac and Prévost could discover no trace of a uterus, but found, in the ovarian regions, two bodies which were apparently the *ovaries*. The patient had, every month, exhibited all the symptoms of pre-catamenial congestion. (S.)

I.

You are all acquainted with the *hemianæsthesia of hysterical patients.* There would be some ingratitude in not knowing the nature of this symptom, for it has been discovered by purely French investigations. Piorry, Macario, and Gendrin, have each of them, in his turn, described it and dwelt upon its characteristics. Not long after them, Szokalsky made it known in Germany; but nothing remained for him to do save to confirm by observations, which are, however, very meritorious, the facts that had been already declared by our countrymen.

In order to keep within bounds, I shall enter upon a discussion of *complete hemianæsthesia* only, such as we find in intense cases. This will be sufficient for my present purpose. Even in the degree mentioned, it is a frequent symptom, since according to M. Briquet, it obtains in 93 cases out of 400. Considered with respect to position, we find, according to the same author, that in 70 cases the left side is affected, and in 20, the right.

You know what happens under such circumstances. Supposing that the two halves of the body are vertically divided by an antero-posterior plane, one entire side—face, neck, body, &c.—will have lost the sense of feeling; and though this loss of sensibility very often affects the superficial parts merely,—the external tegument,—yet it sometimes also invades the deeper regions, affecting the muscles, bones, and articulations.

Hysterical hemianæsthesia shows itself, as you are aware, under two principal aspects; it is complete or incomplete. *Analgesia*, with or without insensibility to heat or cold, or thermo-anæsthesia is one of the commonest varieties of this species. The distinct manner in which the anæsthetic parts are separated from the healthy parts is also an important characteristic of hysterical hemianæsthesia. On the head, face, neck and body the demarcation is often perfect and very closely corresponds with the median line. Another symptom, well deserving of mention, is constituted by the comparative pallor and coldness of the anæsthetic side. These phenomena, conjoined with a more or less permanent ischæmia, have been many times observed. Examples of them have been given by Brown-Séquard and Liégeois.[1] A difficulty in inducing bleeding by pricking the anæsthetic parts with a pin may, in intense cases, be a characteristic of the ischæmia in question.

I noticed this peculiarity on a former occasion. The matter came under my observation in this way: on leeches being applied to a patient affected by hysterical hemianæsthesia, I saw that their bites yielded very little blood on the anæsthetic side, whilst on the healthy side it flowed as usual. Grisolle, who, you are aware, was a very wise and exact observer, had noted the same phenomenon.

[1] Liégeois, 'Mémoires de la Société de Biologie,' 3e série, t. i, p. 274.

This ischæmia which, indeed, is rather rare when so intense, may furnish an explanation of certain reputedly miraculous occurrences. Thus, it is stated, that, in the epidemic of Saint Medard, the sword-blows given to the "Convulsionnaires" did not cause bleeding. The reality of the occurrence cannot be rejected without examination. If it be true that many of these "Convulsionnaires" were guilty of trickery, we are nevertheless compelled to acknowledge, after an attentive study of the question, that most of the phenomena which they presented, and of which history has given us a naive description,[1] were not entirely simulated, but merely amplified and exaggerated. It has been critically demonstrated that hysteria carried to an extreme, was almost always the active agent in these cases; and in order that a wound, such as that made by a sword, should not, when inflicted on these anæsthetic women, have caused bleeding, it was only necessary, as you may infer from what precedes, that the instrument should not have entered too deeply.

There are other characters also of hysterical hemianæsthesia which are deserving of all our attention, from a clinical as well as from a theoretical point of view. The *mucous membranes* are affected, on one side of the body, in the same manner as the external tegument. The organs of the senses themselves are affected to some extent in the anæsthetic side. *Taste* may have vanished in the corresponding half of the tongue, from tip to base. The sense of *smell* is less acute. *Vision* is weakened in a very remarkable manner, and if amblyopia occupy the left side, we may meet with a most noteworthy phenomenon, to which M. Galezowski has called attention, and which he designates by the name of *achromatopsia*. However, we shall return to this topic.

Hysterical *hemianæsthesia* does not seem to affect the viscera. Thus, to mention the ovary merely, we find hyperæsthesia and not anæsthesia present. That organ may be very painful on pressure, when the abdominal wall is perfectly insensible. Now, gentlemen, there exists a most remarkable relation between the position of the hemianæsthesia and that of the ovarian hyperæsthesia. If the former occupy the left side, the hemianæsthesia occupies the left side, and *vice versâ*. When ovarian hyperæsthesia is double, it is the rule that the anæsthesia shall present itself in a generalized form, and it consequently occupies nearly the whole, or quite the whole of the body.

Not only does such a relationship exist between the seat of the hemianæsthesia and that of the ovarian hyperæsthesia, but a similar relationship exists with regard to the paresis, or to the contracture

[1] Carré de Montgeron, 'La Verité des Miracles opérés à l'intercession de M. de Pâris et autres Appelants,' &c., 1737.

of the limbs. Thus, when the paresis or the contracture supervenes, it always shows itself on the same side with the hemianæsthesia.

The hemianæsthesia, as described, is, in the clinical history of hysteria, a symptom of the greater importance, inasmuch as it is well-nigh permanent. The only variations which it exhibits, are dependent upon degree, on the intensity of the phenomena which constitute it, and occasionally, we should also mention, on the fluctuation of some of these phenomena.

Achromatopsia belongs to the number: it was distinctly and repeatedly observed in one of our patients, a few weeks ago, from whom it has now completely disappeared.

It is necessary to bear in mind that hemianæsthesia is a symptom which requires to be sought for, as M. Lasègue very judiciously remarks.[1] There are, in fact, many patients who are quite surprised when its existence is revealed to them.

II.

I propose now to investigate to what extent hemianæsthesia, such as we have described it, is a symptom proper to hysteria. In reality, it is very rare for it to be reproduced, with the general grouping of all its characteristics, by any other disease. Its well-established existence is, therefore, a valuable indication, one which will often reveal the real nature of many symptoms, which would otherwise remain doubtful. That is a point on which M. Briquet was right to lay great stress. In order to illustrate the importance of this fact, he relates the case of a woman who, after a violent emotion, fell rapidly into a more or less profound coma, with or without premonitory convulsions (*i. e.*, the comatose form of hysteria), and who was seen, on recovering her senses, to be stricken with more or less complete hemiplegia. Here we have a group of symptoms which it is not very rare to meet with in practice, and, on such an occurrence, it may happen that the physician will feel himself placed in a very embarrassing position. Now, the presence of hemianæsthesia, arrayed in all its characteristics which would most probably be found on such occasion, might then, according to M. Briquet, indicate the true path to the observer. This assertion is perfectly accurate; I have no fault to find with it, except as regards one point.

If it be true that hemianæsthesia is an almost specific symptom, inasmuch as it is not found with the same characteristics in the immense majority of cases of material lesions of the encephalon (hemorrhage, softening, tumors), we cannot admit this to be an absolute characteristic. It is, above all, inaccurate to say that *the hemianæsthesia, developed under the influence of encephalic lesions, always differs from hysterical hemianæsthesia, by the fact that, in the former case, the skin of the face does not participate in the insensibility,* or that, *when it exists, it never occupies the same side as the insensibility of the members.* This is an inaccuracy which has been reproduced, almost in the same terms, in the otherwise very interesting thesis of M. Lébreton.[1]

[1] 'Archives Générales de Médecine,' 1864, t. i, p. 385.

I feel some repugnance in again attacking the remarkable work of M. Briquet, but the more estimable the work—and it is justly esteemed,—the more serious become any inaccuracies which may have slipped into it. This reflection will, I hope, justify me in criticizing it.

Gentlemen, there are cases, which, though indeed exceptional, are thoroughly authentic, where certain circumscribed cerebral lesions (*en foyer*), may cause the production of hemianæsthesia with all the signs that characterize it in hysteria—*or very nearly all.* Allow me to discuss this subject, in some detail.

The classic doctrine, at least amongst us,—a doctrine which, besides, appeals to the data of clinical observation, and to those furnished by experiments on animals,—teaches that circumscribed cerebral lesions (*en foyer*), which so profoundly affect the power of motion, especially when they occupy the region of the *optic thalamus* and *corpus striatum*, produce but little effect as regards sensibility. From this point of view, gentlemen, the result is said to be always the same, whether the lesions occupy specially the corpus striatum, the optic thalamus, or the rampart of the amygdalæ (claustrum).

At first glance, when in presence of the suddenly developed lesions which determine an apoplectic fit, and which affect any one of the points just enumerated, the symptom which strikes the observer is a hemiplegia, more marked in the upper than in the lower extremity, and accompanied by flaccidity.

In the face, the paralysis usually affects the buccinator and the orbicularis oris; the tongue also is mostly protruded to the paralyzed side. In addition to motor-paralysis comes paralysis of the vaso-motor nerves, manifested by an elevation of temperature in the paralyzed limb. Occasionally, this vaso-motor paralysis makes its appearance from the outset.

As to sensibility, it is not modified in a perceptible manner, or at least not in a *durable* manner. The special senses present no serious alterations, except some complication supervenes, as where *embolism of the arteria centralis retinæ* occurs (in cases of brain-softening consecutive on the migration of a valvular vegetation), or where *compression*, by contiguity, of the tractus opticus, happens (on occurrence of a somewhat voluminous *hemorrhagic* lesion). Such is a summary of the symptoms which are met with in the

[1] Lébreton, 'Des differentes variétés de la paralysie hystérique,' Thèse de Paris 1868.