the man then existed. Terror is an emotion which most profoundly disorganises mentality. Further, in their many quarrels, the wife had frequently charged her husband with the loss of virility. That is a taunt that a young man bears very badly. There is no reason to suppose that the quarrelling was all on one side, and that the man responded to the woman's violence and abuse only with love and kisses. On the contrary, the woman appears to have become afraid of the man. On the very night of the murder, she had put on her hat and jacket, packed up her portmanteau, and was about to escape from the house during her husband's absence, when he returned, and forced her to go back. A *juge d'instruction* would have reconstructed the subsequent scene without the aid of psychology.

It must be remembered that we have the man's story, but not the woman's.

Dr. Valtorta's paper is painstaking, elaborate and learned. But is it not after all a clever piece of special pleading? Stripped of accidental circumstances, such as the social position of the murderer, the romantic surroundings of the tragedy, the unusual method of disposing of the dead body, and the question of extradition, the crime is, as I said before, commonplace and sordid. It is sordid. It does not possess the faintest trace of that melancholy charm which is sometimes revealed in a *crime passionnelle*. If the murder had been committed in the slums of London or New York, possibly the termination of the trial would have been different.

J. Barfield Adams.

Hystero-traumatism with so-called "Physiopathic" Syndrome Cured by Re-education [*Hystero-traumatisme avec synarome dit "physiopathique" guéri par la rééducation*]. (*Le Progrès Médical, March 10th*, 1917.) *Ferrand, Dr. Jean, Physician to St. Joseph's Hospital, Paris.*

Attempts have been made to classify the numerous forms of paralysis resulting from wounds in battle. Some are due to direct lesions of peripheral nerves and their roots: others are hystero-traumatic in nature. Between these two extreme varieties there is a particular clinical type which must be isolated from others—paralysis of reflex origin.

Certain neurologists describe a form of paralysis characterised by special trophic, vaso-motor, electric, and reflex troubles in the paralysed limb, such phenomena being sufficient in their eyes to prove the organic origin of the paralysis, which explains their therapeutic failures. They infer from this the uselessness of, even heroic, psycho-therapeutic measures. This inference would seem to be somewhat premature, as observations on a case in point go to prove the contrary. It was that of an infantry soldier who, in May, 1915, was wounded in the right calf. Healing followed a normal course, and was completed in a few weeks. During convalescence he began to walk badly owing to alleged pain in the limb, which assumed the position of equinus with contracted Achilles tendon. A surgeon, believing that the lesion was really organic, severed the tendon, restoring mobility to the foot, which could

now be easily placed flat on the ground. He could, however, walk no better after the operation, and, although the equine phenomenon could no longer be produced, owing to section of the tendon, the leg assumed another vicious position, being semi-flexed on the thigh, with immobilisation of the knee-joint. He could only barely put his foot to the ground, and was extremely lame, walking with the help of a crutch. Again a surgeon, never suspecting a neuropathic affection in the case of a wounded man, did a tenotomy of the flexor tendons of the leg, putting it up in a plaster apparatus to maintain extension of the limb. The result was satisfactory only to a slight extent, but he walked without a crutch when he was sent to a neurologic centre in December, 1916.

He walked with two sticks, the right leg in a position of forced extension on the thigh, and flexion was impossible. The first care was to seek for evidence of a lesion of the terminal branches of the sciatic, and especially of the internal popliteal branch. There was no true motor paralysis, but relative weakness of all active movements. All passive ones were possible except flexion of the knee. There was no sensory trouble; and all the reflexes were normal, a little stronger perhaps on the affected side. Trophic troubles were very marked. All the distal part of the leg was œdematous, cyanosed, almost a violet tint, very cold as compared with the sound limb. The skin was thin, attenuated, and the toes crossed each other to some extent. In the whole foot and lower third of the leg there was well-marked muscular hyperexcitability. The slightest tap on the muscles brought on violent contractions, and even dissociation of movements which are not usually independent in action, such as adduction of the great toe, or abduction of the little one. In a word, the case presented all the troubles attributed to reflex contractures or to the phenomena called "physiopathic."

The mental state was peculiar. A working miner, he weeps at the least examination, manifests absolute terror at the slightest touch of his affected leg, and tremblingly implores one to cure him.

To sum up: here was a wounded patient with a paralysed limb and contraction of the knee, who presented all the signs of the paralyses called "reflex," who has been subjected to a series of tentative therapeutic measures which have failed: a characteristic type.

As to treatment the patient was brought into our re-education ward, and, after having been for a considerable time subjected to fatigue by more or less violent physical exercises, the contracture was, as it were, brutally overcome. After half an hour of passive movements of flexion and extension of the leg, and after showing him how he could bend and straighten his limb, he was induced to do this voluntarily. These active movements were aided and sometimes provoked by galvanic stimulation of painful intensity. In the end he was able to walk slowly, while he bent both knees fully, and, after a treatment lasting about two and a half hours, he was cured.

The case was a particularly bad one, for surgical immobilisation had caused intra-articular adhesions in the knee which it was necessary to rupture. A slight amount of hydrarthrosis followed next morning, but a few days later he walked like any normal person.

This, though a remarkable case, is not a solitary instance of the kind, and Dr. Ferrand has published the general result of his researches on the subject. The clinical type which has been sought to be created does not seem sufficiently differentiated. We need only cite in proof the successive denominations which have been given it. The term "reflex contracture" assumes a condition which very often does not exist, for there is flaccidity in many of these paralyses. Moreover, the term "reflex" implies a pathogenic idea, which is already abandoned by the creators of the clinical type. It has been designated a "physiopathic disorder," a term which is not very precise, and has hardly more significance than the old term "functional." In the minds of the authors this term "physiopathic" would imply the idea of an organic lesion, or at least one not functional in character. And the syndrome thus created is, in their descriptions, opposed not to an organic, but to an hysterical syndrome. In this view Dr. Ferrand cannot share.

He concludes his article with the following summary:

(1) Physiopathic symptoms exist, but they do not constitute an independent clinical syndrome. Many patients presenting these special symptoms, separate or combined, are cases of organic affections with lesions of peripheral nerves; moreover, direct and not reflex.

(2) There is but little relation between the reflex lesions described by Charcot as occurring in chronic arthritic cases and post-traumatic lesions. These latter are, moreover, described by him also amongst the hystero-traumatisms.

(3) The symptoms are not completely new.

(4) They are to be found to-day in many wounded who do not present any organic lesion, but merely ordinary hystero-traumatisms.

(5) They do not constitute any contra-indication to pyscho-therapeutic treatment, even of an heroic kind, and these patients are cured as well as others. In any case, from the fact of a failure of cure it is not to be inferred that they are not the subjects of hystero-traumatism; for some succeed where others have failed, of which the patient whose case has been recorded is an example.

(6) From a medical and military point of view, such patients (when they have not been attacked with organic affections) should be considered and treated as cases of hystero-traumatism. It would be dangerous to make them out to be organically diseased or to treat them as such, for the contagion of example would make ravages in neurological centres.

(7) To cure these patients we must employ all the most energetic means which the authorities have placed at our disposal, from moral suasion to the most painful electric currents. In this way multiple successes are achieved, and the Army recuperated with vigorous subjects.

Such are the conclusions to which Dr. Ferrand and his colleagues have been led by a practice of eighteen months in one of the most important neurological centres in France. T. DRAPES.