Observations
ON
THE EARLY TREATMENT OF THE PSYCHOSES AND PSYCHONEUROSES.*

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WE all want the best treatment at the earliest practicable moment for the psychoses and psychoneuroses, as for all kinds of disease. On that we are agreed, although we may differ as to what that is, as to how best to set about obtaining it, and as to the size and nature of the problem.

The discussion divides itself naturally into two parts: (1) *early treatment in the individual*; and, having evaluated this as to the size of the demand for it, its importance, at what stages it should be undertaken, and so on, to consider, in the event of a decision in its favour, (2) *how we can best attain it.*

The psychoses and the psychoneuroses are diseases which have been much discussed and still have a blurred outline, and this is inevitable, for the pathology is often obscure.

The first proposal I would make towards the attainment of early treatment is to scrap both those unclear words, which Dr. Bernard Hart has done in his splendid little book *The Psychology of Insanity*. It would be far better to revert to the old description by symptoms: depressed, excited, or disturbed, as the Americans have it, maladjusted, anxiety states, phobias, kleptomania, etc. Meantime, as the title thrusts these unwelcome guests upon us to-day, it may be said that under the heading "psychoses" there seem to be included the various forms of insanity, while under that of "psychoneuroses" are grouped the mental disturbances which are not insanity. If, however, we are going to talk of early treatment we must recognize that insanity begins before a person is insane—that is, that the insane paranoiac with delusions of persecution shows signs of this attitude to life, this habit of mind, with its belief that the other members of the herd are against him, for a long time, probably for years, before he develops recognizable delusions or insane behaviour and is regarded as insane. In other words, for a long time he was forming a paranoid adjustment to life, while still sane, which by no means always results in definite insanity, any more than, to use a physical analogy, every case of tuberculous infection develops into fatal tuberculosis. No one doubts that the treatment of tuberculosis should be undertaken at the first sign of it, nay, even before there is a sign, in the pre-tuberculous stage in children. I submit that the same sound line of action should be taken with regard to the onset of mental and nervous disorders.

In demanding early treatment on a wide scale for individuals we may be asked what evidence there is that the need is a great one.

We have evidence in the report of the Board of Control that a large number of persons are suffering from definite insanity—"136,626 were notified insane" and under care in England and Wales on January 1st, 1927. All these patients have been at one time early cases; in some the developing period may have been short, but in many it has been long. Of these, 120,911, or "88.5 per cent. of all notified insane," were rate-aided patients and therefore a serious burden on the community; 874 were criminals (of whom 399 were charged with murder), who are not only now being supported by the country, but who have besides taken a heavy toll in the protective measures, in police and courts, that they impose upon us, and in the anxiety, worry, and loss that they have caused. In addition to the above there were 796 voluntary boarders. If to these are added 35,167 mental defectives "subject to be dealt with," and 25,067 who may become "subject to be dealt with"—that is, 60,234—and it is also recognized that in many cases ascertainment is entirely inadequate, the size of the problem of mental health begins to show itself: insane, mental defectives, and voluntary boarders—197,656.

Admitting that early ascertainment and treatment in the case of mental defectives will not lead to cure, it can in many cases protect the community by helping to make the patients partly self-supporting or less dependent, and by segregation it can obviate the possibility of their bringing mentally defective children into the world and release them from a hopeless battle with life, for which they are insufficiently equipped.

With regard to the insane cases—while there are still some die-hards who are entirely fatalistic about mental disease, believing that, like the wind, it bloweth where it listeth and nothing can be done about it, there is a growing belief that, while heredity and inherent constitution have great influence, in some or many cases they form a fertile ground only, and that if seeds of mental disorder are not planted and cultivated by events and environment there is a reasonable probability of escape. It is possible that the expert safeguarding may have to start in early days, and that the proposed child guidance clinics will be the first line of defence against adjustments to life which may later develop into paranoiac trends, the formation of fantasies to the exclusion of a faithful tackling of life and its difficulties, the acquirement of regressive tendencies leading to fixation and a childish outlook, or the protean forms which may be evolved in the effort to make tolerable what appears to be an intolerable situation. The development of insanity follows the same lines as physical disease—the symptoms are evidence of Nature's effort to cure, or to adapt to an unsatisfactory environment. Fantasy-building, for instance, is a protective and healing mechanism in its proper place. It remakes a sordid world for us, it keeps hope alive, it guards happiness, it favours discovery, even to giving us the wings of a dove—a fantasy held in men's minds for many centuries before realization.

Fantasy (like the unnecessary formation of scar tissue in keloid), out of proportion to life, makes the introvert, passing later into dementia praecox and analogous states. We should see to it that this adaptation, if in faulty degree, is dealt with early. Surely as experienced and as carefully trained an expert is needed for the early stages of these mental cases as is required for treating eyes, throats, or noses. If this be so there is indeed a demand which should be met.

There is other evidence of failure to cope efficiently with the problem of mental health in the reports of the Prison Commissioners. In the last report attention is called to a residue of persons who, though not certifiable under either the Lunacy or Mental Deficiency Acts, "are in medical opinion in an unsuitable environment in prisons" owing to their mental state. "These people form a subnormal group and include the simple feeble-minded and those of borderline intelligence." These include "cases of mental deficiency"; "imperfectly developed states of insanity; mental weakness after attacks of insanity," and so on. Of 77 such men, 41 had six to fifty-four previous convictions. Of 29 such women, 22 had six to 109 previous convictions. Is it too much to hope that with greater facilities for treating such cases they may be dealt with in a way more satisfactory to the community and themselves than is shown by the above figures?

There were 178 girls between 16 and 20 years old under sentence of imprisonment, and, without counting charges dealt with under Section 1 of the Probation Act, 47 per cent. had been previously convicted from once to eleven times or more. There were 2,464 lads between 16 and 20, 50 per cent. of whom had been previously convicted, 16 of them from eleven to twenty times, 2 over twenty. Surely with youngsters such as these it is not beyond the bounds of possibility to devise some psychological or medical approach which, undertaken early enough, should prevent this faulty adjustment to life. The recidivism is marked amongst adults also: 37,237 (64 per cent.) men and 7,000 (87 per cent.) women received during the year had been previously convicted; 2,945 men and 2,978 women had been previously convicted over twenty times. Is this a satisfactory result of the treatment we now accord to criminals, or, as I should

* Made in opening a discussion in the Section of Mental Diseases and Neurology of the Annual Meeting of the British Medical Association, Cardiff, 1928.

like to call these recidivists, mental patients? It is interesting also to note that the numbers of these worst recidivists correspond roughly to the proportion of men and women in the country, and not to the number of the delinquents relatively.

In an appendix in a previous report the medical officer to Birmingham Prison writes:

"All abnormal conduct tends to be antisocial; what we term criminal conduct is only one branch of the tree. . . . The problem of the delinquent should not be envisaged apart from that presented by other mentally abnormal persons. . . . Many of our cases present the problems of social maladjustment. Only the closest investigation will supply the clue for the rectification of them."

The fact that on admission to some prisons wise and humane regard is had to the mental condition of the prisoners, and measures are taken in many cases for ascertaining and treating it, is no valid argument against the necessity for facilities for the help of mental maladjustments outside. These very cases, if capable of being efficiently handled after conviction, would be *a fortiori* cases needing help before the maladjustment manifested itself in such antisocial conduct as to lead to conviction, and it should not be necessary to be sent to prison to secure this help and consequent health of mind.

Still further evidence of the need for expert work is exhibited in the *Criminal Statistics* published by the Home Office, which show that 4,408 suicides occurred in England and Wales in 1926, and 2,194 attempted suicides were known to the police—altogether 6,602. To these must be added a large number, probably the majority of attempted suicides, which have not come to the notice of the police, and some successful suicides which are never found out.

As well as these suicidal cases there are recorded a large number of sex offences known to the police. The total was 4,935. This included 125 cases of rape and 1,961 of indecent assaults on females. The remainder was made up of cases of indecent exposure (1,973), unnatural offences, incest, etc. While in no way minimizing the power of the human being to exert control, it may be suggested that, without straining probability unduly, it is more than likely that many of the above offences are evidence of want of mental balance. Also it is certain that all such cases are not known to the police, and that there are many which are responsible for marital unhappiness and the wreck of wholesome family life short of insanity. No one who has been in practice for long and has the intimate confidence of his patients can fail to have met these cases. All those who are concerned with nervous and mental work will know that they are many. Alcoholism also is often a sign of mental and nervous instability.

I am well aware that in adducing the above as evidence of the size and widespread nature of the problem of mental health, and of the need for the prevention and early cure of mental and nervous disease, I am laying myself open to the accusation that I am an empire-builder in this department, that I seize colonies illegitimately from others, and that some of the territory I have suggested as within the realm of mental medicine is really in that of Jurisprudence, Pedagogical Science, Ecclesiastical Authority, or Religion. Is this so? Is it not truer that all of these must co-operate to succeed, and that a League of Experts with intimate understanding and trust might discover a better way of helping man in his development than has yet been evolved? Has medicine up to now contributed its quota to the solving of these problems? Has mental medicine nothing more to say, no message with regard to these maladjusted people? It may well be that such a league may be a necessary corollary or precursor to the full functioning of the League of Nations.

The above by no means exhausts the numbers needing special help. There exists another, and larger, class of patients, "unwept, unhonoured, and unsung" in any Government statistics. These are the so-called psychoneurotics, who, while not insane, nor mentally defective, nor delinquent, often suffer mental torture to a degree little understood. The patients at the few existing clinics for nervous and mental disorders are largely of this type. Their illness varies in degree from mild forgetfulness of time or things, slight insomnia, nervous dyspepsia, phobias such as fear of a mouse, a cat, or a thunderstorm, up to a state when death may supervene, as in anorexia nervosa, or when suicide appeals as incomparably more attractive than the terror of existence in this world. These are the patients, far more numerous than is thought, for whom most can be done. It would be of interest to know how many of the chronic dyspeptics, gynaecological cases, rheumatic patients, in fact chronic cases altogether, which haunt the out-patient department of any general hospital—inevitable as the weather and quite as tiresome—are primarily or in part due to unsolved mental conflicts, to anxiety states with fear causing dyspepsia or diarrhoea, as it does acutely in many students before an examination.

A question often asked is, What type of patient is it that is meant by an early case and suitable for early treatment? Including in early treatment preventive measures, such as dealing with faulty mental attitudes in children as well as adults, the best definition that I can suggest is: Those who have special difficulty in their mental and moral adjustment to life. All of us have some difficulty, and it is a recognition of this fact which has led us to ignore early maladjustments in the hope, often ill founded, that they will be "grown out of." A tendency to regard such troubles as a dispensation of Providence or domination by the devil, and to struggle unintelligently for a foolish resignation, or submit to a sense of inferiority or a constantly recurring conflict, leads to inhibition, fatigue, and unnecessary expenditure of effort. We have only to consider the results attained by the National Institute of Industrial Psychology to see how important the work of an expert may be from the psychological side. It is easier to prevent a nervous breakdown than to cure one. It is also easier to prevent the strain and stress that comes from these maladjustments and psychoneuroses than it is to cobble up again the destroyed family life or the individual bankruptcy which may be the result of them. It is easier to promote mutual confidence and trust than to mend the tatters in the garments of industrial peace torn by the conflict of a strike. This idea of the connexion between industrial unrest and psychological maladjustments is no far-fetched fad of my own. In the last number of the *Journal of the National Institute of Industrial Psychology* Dr. Myers, after explaining that the methods used "follow precisely the familiar principle of bodily healing," said:

"Is it surprising then that holding these views and proceeding along these lines the Institute has met with such success in increasing both output and contentment in actual practice, and with such widespread approval not only from the more progressive employers . . . but also from the workers and the trade unions of this country?"

The mental readjustments secured (combined with physical ones) are making for trust and understanding. This is surely closely allied to, if not part of, mental medicine.

To sum up so far. Many if not most of the difficulties found in education, criminology, religion, industry, general medicine, and in securing the peace of the world can only be solved with the aid of mental medicine, an understanding of the mind of man, in health and disease. No doctor would admit that an understanding of the body in health was foreign to his purpose of grappling with disease. No doctor should any longer admit that an understanding of the mind in health is redundant, and still less of the mind diseased. The intricacies of its connexion with the body still need elucidating, and are intimate and inevitable.

The psychoses and psychoneuroses in the individual provide useful material for this study. What are the first signs of these diseases? How do we recognize them? Can they be prevented or cured? In other words, are we pursuing a "mad fen fire" ourselves in endeavouring to ascertain and recognize ever earlier signs and symptoms, in the belief that we may be enabled ultimately to prevent their development and to cure them in their early stages? Is it a fact that the psychoneuroses, and to a greater extent the psychoses, are dependent upon inherent or innate factors in the individual which are impregnable to any attack from outside; that we cannot hope to cure or greatly alleviate; and that it is useless and waste of time to try? Surely not. It may at least be claimed that in many alleviation can be gained, and cure also in

some, if by that is understood a capacity for a satisfactory, or passably good, adjustment to life. This is analogous to physical diseases. You do not exactly cure an appendix by cutting it out. The physical condition is not perfect afterwards. You leave a scar and other damage behind, but it is worth it if you get functional success or improvement. In like manner a recovered pleurisy may leave adhesions. Illness and operations on the mind may leave scars, may cause pain, but you may secure functional success or improvement, and it is for a measure of this that we must look.

In searching for evidence that this is obtainable I must refer you to the reports and opinion of those who are engaged in doing this work, and though the number of these is still woefully meagre the widespread nature of the work they are doing in the country is very encouraging. The early treatment of recent cases in mental hospitals has improved immensely of late years. The hospitalization of asylums—a word coined, I believe, by Colonel Lord—is progressing apace, but I must ask you to dwell now not on the certifiably insane treated in mental hospitals, but on the patients whom it is harmful to certify or who are uncertifiable, and the large number of the maladjusted, the patients labouring under obsessions, phobias, inhibitions, and so on. These are the cases for which early treatment is so necessary if we wish to prevent the faulty adjustments, criminal and others, which I have tried to indicate in this paper.

At the Lady Chichester Hospital, established in 1905, nearly a quarter of a century ago, I have had the honour to be senior honorary physician since its start. Here we find that the patients are thoroughly convinced of its value, and continue to apply for help in numbers which, though we have several times increased our number of beds, have proved the hospital to be still inadequate to cope efficiently with the waiting list.

The demand of patients for treatment we share with quacks—it is no necessary proof of value, but the sources from which the patients come are of more significance. We have analysed 100 consecutive cases in 1917 and 100 this last year.

Given that the demand and need for early treatment are urgent and widespread, how can we best attain it?

Facilities for Treatment in General Hospitals.

I submit that the first and most important step now is to establish as soon as possible facilities in connexion with every general hospital in the country. The patients are attending at the hospitals now, and will always be more readily found there than anywhere else.

All the other specialties—eyes, throats and noses, teeth, and so on—have gone through the same initial stage of being obliged to start hospitals of their own, after which the general hospital takes the work on and complains of overlapping. Let us not waste time and money over this.

I suggest that the need for the treatment and its value are established by the work already done in this and other countries.

Dr. Carswell was the pioneer who started wards for borderland patients in connexion with the Poor Law—in 1904, I believe. The Lady Chichester Hospital was the first hospital for these cases.

The pioneer in providing out-patient facilities was the late Dr. Rayner, who with energy and foresight, about 1889, induced the governors of St. Thomas's Hospital to open an out-patient department for early mental cases. He was succeeded there by Dr. Percy Smith, who had in 1900 started the second out-patient department for mental diseases at Charing Cross Hospital.

Since then many others have followed suit, notably Cardiff under your President. There has been a steadily growing recognition of the need by general hospitals both in London and the provinces.

Facilities in Separate Clinics.

The Tavistock Clinic for out-patients, under Dr. Crichton-Miller, opened in September, 1920, and also does fine instructional and propaganda work with courses of lectures for lay and professional people.

The question of beds is a more thorny one, and so far has been largely burked.

The Maudsley Hospital (177 beds), under Dr. Mapother, owing its existence to the late Dr. Henry Maudsley's generosity, aided by the late Sir Frederick Mott, was planned many years before it was started in 1923, after its previous use as a war hospital. It is carried on under very special conditions, and is a centre for training and research of immense value, supported by the London County Council. It would be impossible to have many of such elaborate and complete institutions—though possibly there should be several connected with universities for teaching purposes on the lines of Professor Robertson's scheme in Edinburgh..

The Cassel Hospital, under Dr. Ross, made possible by the grand gift of about a quarter of a million by the late Sir Ernest Cassel, is providing for those who can afford moderate fees. For many years the wealthy have been catered for.

No provision elsewhere can efficiently supplant treatment in the general hospitals. They are well known, convenient, and no one objects to go to them; the patients present themselves there in any case; the earliest cases are to be found there; the general practitioners, who have the best chance of seeing the first mental difficulties, are in close touch with the hospitals, where the appointment of a specialist in this particular work will do more to secure the treatment of this illness on the same lines as others than any other move that can be made. Cases can readily be referred to the mental and nervous department, and easy chat can take place between the members of the staff with regard to them. This co-operation is invaluable on both sides. Moreover, for the teaching of medical students it is essential.

It has been said that there are not enough experts to go round; and, on the other hand, that there is no object in qualifying specially for this work, for there are not enough posts to go round. These are mutually destructive arguments. Meantime, there are good county mental hospitals all over the country, whose staffs are often willing to help if required, and the suggestion of the British Medical Association that no officer already holding a whole-time post should be eligible would presumably only apply if an equally expert applicant appeared. The welfare of the patients comes first. There is little doubt that, given the posts, even honorary ones, suitable applicants will shortly qualify for them.

I submit that there should be no more difficulty in providing a complete department, with facilities for out-patients and beds, for this specialty than for any other. Admittedly it has its own peculiarities, but so have surgery, radiology, maternity, and others. Notable steps have been made in this direction by St. Mary's Hospital, the Middlesex, which has a scheme also for reciprocity in nursing with St. Luke's Mental Hospital, and some others. In my view these hospital departments should be free from any compulsory detention, so that there might be no question of interference with liberty. There should be no locked doors, nor should definitely insane patients be admitted.

Child Guidance Clinics.

Still earlier than those cases we have been considering are those of children who show maladjustments in school life or before, and for them the child guidance clinics offer useful help. They are, as before said, the first line of defence. Two are already in existence in England, and an elaborate one in London is being planned with American help.

Voluntary Boarders in County Mental Hospitals.

Apart from the general hospitals and the institutions in connexion with the teaching universities, we need also to be allowed to send voluntary boarders to county mental hospitals. This is absurdly obvious, and agreed to by almost everyone, and yet has been held up for years because it has formed part of a debatable bill.

Permission to Treat the Early Insane Patient on two Doctors' Certificates.

To compass early treatment another measure is needed also—that is, to allow certifiable patients to be treated on the certificates of two doctors only, for a limited time. It is the legal intervention which the patients and their friends dislike. Many people approve of it in theory, but

in practice—though few object to seeing two doctors and acting on their advice—all would like personally to avoid the magistrate.

These two last suggestions, however, deal with cases more advanced than those suitable for general hospitals, and it is the exceedingly early maladjustment that I am most concerned about.

To those who fear to advocate these reforms on account of the expense I would say that they will come slowly enough, however much we may push for them, and it is probable that measures properly thought out would lead to economy, industrial peace, and a happier race, and justify all expenditure. Early treatment for these badly oriented people is as necessary, and quite as profitable, to the country as for tuberculosis. Why should not funds be forthcoming from the same source?

Summary.

To sum up I would suggest that it is desirable:

1. That every general hospital should have facilities for treating early nervous and borderland patients.
2. That child guidance clinics should be available for the young maladjusted children and be under the charge of doctors.
3. That delinquents should have expert examination with regard to their mental adjustment—on the first offence—repeated if necessary.
4. That voluntary boarders be allowed in county mental hospitals.
5. That early insane patients should be able to be treated on two doctors' certificates.
6. That vocational guidance should be available for all who wish it—as at the National Institute for Industrial Psychology—as a preventive measure against maladjustments and unrest.
7. That every medical student should be obliged to devote some time to the study of all forms of mental disorder.
8. That examining boards should require evidence of knowledge of all forms of mental disorder.

It is better to pay for this than for insanity, delinquency, unemployment, and industrial unrest. May we all live to see a goodly measure of the above reforms in this our beloved and on the whole stable country.

THE HISTORY OF SCARLET FEVER.*

BY

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The study of the history of scarlet fever is beset with two chief difficulties, inasmuch as, not only in the remote past, but until comparatively recent times, it was often almost impossible to disentangle the description of scarlet fever from that of other acute exanthemata, especially measles and erysipelas, on the one hand, and from that of diphtheria on the other.

An attempt has been made by some writers to trace back the history of scarlet fever to classical antiquity. Some, such as Malfatti, Collier, and Clifford Allbutt, have tried to identify it with the celebrated pestilence of Athens which occurred in the year 430 B.C., but the description given by Thucydides (Lib. II, cap. 47–54) indicates typhus rather than any other acute infectious disease.

Sanné remarks that certain passages in Hippocrates have given rise to the belief that the Father of Medicine was familiar with scarlet fever, owing to his speaking of an illness attended with a severe sore throat, though he makes no mention of a rash. As Sanné points out, however, the mere existence of ulcers on the tonsils does not justify the diagnosis of non-eruptive scarlet fever. The same objection applies to writers, such as Willan, who think they have found allusions to scarlet fever in certain passages in Celsus, Caelius Aurelianus, Aretaeus of Cappadocia, and Aetius of Amida, whereas diphtheria was probably the disease in question.

Herodotus, a physician belonging to the pneumatic sect, who flourished at Rome under Trajan about half a century before Galen, is credited by Bateman with having described "with considerable precision" the rashes of scarlatina as well as those of measles and small-pox. Bateman's account, however, is far from convincing.

The Arabian physicians, such as Avicenna, Ali Abbas, and Rhazes, have also been credited with allusions to scarlet fever. Rhazes, for example, stated that measles of vivid coloration was more dangerous than that which was but moderately red. It is but useless conjecture, however, as Welch and Schamberg remark, to regard such sentences as references to scarlet fever.

The first undoubted description of scarlet fever in medical literature is to be found in a work by John Philip Ingrassias (1510–1580), who was first professor at Naples and during his last twenty years lived at Palermo, where he was equally celebrated as an anatomist and as a medical practitioner. In his book entitled *De Tumoribus praeter Naturam*, published at Naples in 1553, he speaks of a disease popularly known by the name of "rossalia" or "rosania," which consisted of "numerous spots large and small, fiery and red, of universal distribution, so that the whole body seems on fire." "Some there are," he continues, "who think that measles is the same as rossalia, but we have often seen that the two affections are distinct, trusting in our own eyes and not merely in the description of others."

Willan has identified the pestilential sore throat described by Wierus as spreading through Lower Germany in 1564 and 1565 as epidemics of scarlatina anginosa. It was particularly fatal to infants, and the sore throat was accompanied by violent fever, vomiting, swelling of the parotid glands, and an erysipelatous rash.

The next most important writer on scarlet fever was Baillou (Ballonius), who, under the title of "rubiolae," described the principal varieties of the disease, including scarlatina anginosa. In an epidemic which occurred in Paris in the winter of 1574–75 there was a very high mortality, and medical art was of no avail.

Jean Cottyar of Poitiers, a contemporary of Baillou, in his work entitled *De febre purpura epidemiale et contagiosa libri duo*, published in Paris in 1578, is generally credited with having given the first description of scarlet fever in France, but Noirot considers his account is far from possessing the importance attributed to it by some persons who have probably never seen it. Cottyar describes the initial symptoms as general weariness, headache, redness of the eyes, sore throat, and fever which may be mild or violent. Some patients, he says, are comatose throughout the disease, while others are wakeful and restless. Purpura appeared on the second or third day, accompanied by delirium and soreness of the throat.

A much more important position in the history of scarlet fever is occupied by Daniel Sennert (1572–1637), who described an epidemic which occurred at Wittenberg in the beginning of the seventeenth century. He identified it with the rossalia of Ingrassias, and described the eruption in similar terms to those used by the Neapolitan writer (in statu vero universum corpus rubrum et quasi apparet ac si universali erysipelate laboraret"). Sennert was the first writer to mention scarlatinal desquamation ("epidermide squamarum instar decidente"), the early arthritis ("in declinatione materia ad articulos transfertur ac dolorem et ruborem ut in arthriticis excitat"), and post-scarlatinal dropsy and ascites ("mox pedes ad talos et suras usque intumescunt"). It is noteworthy that though the occurrence of dropsy was recognized as a sequel of the disease before scarlet fever was given its name, it was not until two hundred years later, after the appearance of Bright's work in 1827, that its connexion with renal involvement was realized. The epidemic which Sennert witnessed was obviously severe and often fatal ("malum hoc grave et saepe lethale est"), and convalescence was protracted ("aegrique non sine magno labore et post longum tempus pristinae sanitati restituuntur"). In more than one passage (De febribus, *Op. omn.*, T. vi, Lib. iv, cap. 12, pp. 483–484; *Epist.*, Cent. II, Ep. 20) he expresses his doubts as to what name he should give the disease. "I should have regarded it," he says, "as

* A paper read in the Section of History of Medicine at the Annual Meeting of the British Medical Association at Cardiff, 1928.