LECTURES AT THE BRITISH COLLEGE OF NURSES.

ENCEPHALITIS LETHARGICA.

By Dr. C. Worster-Drought, M.A., M.D., M.R.C.P.

Three very interesting Lectures on Encephalitis Lethargica were given by Dr. C. Worster-Drought, M.A., M.D., M.R.C.P., Physician to the West End Hospital for Diseases of the Nervous System, and the Metropolitan Hospital, London, and Consulting Neurologist, Bethlem Royal Hospital, at the British College of Nurses on November 19th and 26th, and December 3rd.

Notes on Lecture I.

In introducing the subject Dr. Worster-Drought said that we had not yet produced a really satisfactory name for the disease known as encephalitis lethargica. It not only affected the brain (encephalitis) but also the spinal cord (myelitis) in some cases. Nor was the term "lethargica" ideal, as some patients at the onset were very wakeful and others were able to walk about the whole time they were suffering from the disease. Further, "epidemic encephalitis," was scarcely a fair term to apply as the malady was almost always with us, and had therefore become endemic. Neither was the term "epidemic stupor" applicable in a number of these cases. "Sleepy Sickness"—a popular term often applied to the disease—must be differentiated from "sleeping sickness," a tropical disease in which the responsible germ had been demonstrated.

Encephalitis lethargica was a disease which had only been definitely recognised since 1917. At first, cases were mistaken for, and reported as, "Botulism" a very rare disease caused by the toxin of a bacillus (B. botulinus) which had a special effect on the cranial nerves, and was almost always fatal.

Encephalitis lethargica had a seasonal prevalence and was essentially a disease of winter, being most prevalent from November to February, and no age was exempt from the newborn infant to the sufferer from senile decay. The mortality varied from 18 to 46 per cent. the average being 25 per cent.

PARALYSIS OF THE LEFT HYPOGLOSSAL NERVE IN ENCEPHALITIS LETHARGICA.

Note that the tongue deviates on protrusion to the left (the paralysed side) and that the left side of the tongue is atrophied, the mucous membrane being thrown into folds.

With regard to the mode of spread it was very doubtful if the disease was communicated to any extent by direct contact. Evidence had shown (1) small outbreaks might occur in institutions; (2) A woman contracting the disease in pregnancy might infect her newborn child; (3) The development, or otherwise, of the disease was largely dependent upon the power of resistance of the person subjected to exposure; (4) It could be spread by carriers.

The etiology of encephalitis lethargica had been much discussed and when it first appeared it was held by some observers to be a variant, respectively, of poliomyelitis, or polio-encephalitis; others thought it had some relation to the cerebral form of influenza, but the consensus of opinion was rather against its having a connection with this prevalent disease.

No germ of the disease had yet been discovered. Its cause was probably a filtrable virus having an affinity for the grey matter of the nervous system. One other point was that encephalitis lethargica might have some relation to herpes febrilis. Characteristics of the disease were its extremely irregular progress, and the extraordinary and disabling results. It was no longer regarded as an acute illness which might be followed by sequelæ but was usually a chronic and progressive disease, comparable to other diseases of the nervous system. The onset might be sudden or gradual, or the disease might be entirely ambulatory in type. Sometimes the diagnosis was not recognised until it reached a chronic stage.

Symptoms which were often present were, initial sleepiness, "sleep reversal"—the patient might be awake at night, and asleep in the day, and transient double-vision. There might be difficulty in swallowing, change of disposition, prolonged muscular weakness, moral changes and even delusions.

Notes on Lecture II.

At the commencement of his second lecture, Dr. Worster-Drought emphasised the fact that encephalitis lethargica might have an acute or subacute onset, or might be chronic from the first. The patient might be taken ill quite suddenly exhibiting symptoms of lethargy; some patients started with a high temperature, rigors and vomiting, but these symptoms disappeared usually in the first four or five days.

In chronic cases there might be headache at the onset, but this was not a prominent feature throughout the course. The exception proved the rule, however, and occasionally in some cases headache was most intractable. The typical lethargy of encephalitis lethargica could scarcely be mistaken for anything else. There was complete inertia, the patient could be roused with difficulty, there was no spontaneous speech, nevertheless he was not really asleep. In some cases this lethargy lasted as long as five months, but more usually the disease proved fatal before that time.

The colour of these patients was characteristic, the skin becoming a dull yellow.

The exact cause of the lethargy was not definitely known. The theory at first was that it was due to increased intracranial pressure, but cases which had been trephined were far from showing intracranial pressure. Another theory was that it was due to inflammatory involvement of the pituitary gland and that changes in this produced sleepiness. Lastly, there exists deep in the mid-brain a collection of grey matter known as the "substantia nigra," which might contain a sleep-regulating centre and the theory was that a disturbance of this sleep-regulating centre led to sleepiness.

Symptoms of the Disease.

Particular symptoms were affections of the different cranial nerves, so that the pupils of the eyes varied in size and reaction, there might be squint due to paralysis of the muscles of the eyeballs with double vision; the squint usually improved. Ptosis was sometimes present due to paralysis of the muscles of the upper eyelid. There was reduced blinking, and there was often inability of the patient to turn the eyeballs upwards, inability to chew owing to paralysis of the muscles of mastication, and difficulty in swallowing. There might also be paralysis of the lower limbs (paraplegia),

In the acute stage a point of nursing importance was the liability to bedsores owing to the excessive wasting. The mouth should have careful attention as there was a tendency to paratitis.

Other symptoms were herpes, polyuria (ascribed to interference with the pituitary gland), myoclonus (spasm

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