

Granting syphilis in the mother at time of conception, granting congenital syphilis in the child—unfortunately neither examination of his blood or spinal fluid has been done as yet—we have a favoring etiological factor for any one of these three conditions—agenesis, vascular accident or cerebellar encephalopathy. The prolonged difficult labor, the transverse position of the child, the use of instruments might well have produced hemorrhage with secondary porencephaly. Even the report of positive syphilitic findings in the spinal fluid cannot allow us to differentiate with absolute certainty. Further, whether congenital cerebellar ataxia in the strict sense of agenesia or cerebellar infantile palsy, the course of the diseases need show no particular differences.

POLYNEURITIS OR POLIOMYELITIS

By J. L. Joughin, M.D.

This patient, from the First Division, is a bright young Jewish girl, aged 12. When very young she had measles and whooping cough. She had mumps three years ago and either two or three years ago suffered from an attack of grippe. She has never had sore throat, her health for the past few years has been excellent, and she has regularly attended school, during that period never having absented herself on account of illness.

On Wednesday, eleven weeks ago, she complained of severe pain in the calf of the right leg which occurred only on walking. This was the only symptom characterizing the onset. On Thursday the intensity of this pain diminished, but she noticed a rapid decrease of the motor power of both legs. In spite of this, however, she walked eight blocks to school and ascended four flights of stairs to gain her class room. Near the top of the fourth flight her legs gave way entirely, she fell and was unable to regain her feet without assistance. At this time she noticed that she could not get up from her chair without placing her hands on the arms of the chair and thus partially supporting the body weight while in the act of arising.

Friday she went to school in the morning but in the afternoon became unable to walk and since that time she has never been able to resume attendance at school. By Saturday all pain had left her. On Sunday the motor loss increased to complete disability when she entered the Jewish Hospital, Brooklyn, and remained there for six weeks. She says at this time she could not stand alone even momentarily, nor walk, and any movement of the toes or of the foot as a whole at the ankle joint was quite impossible. The mother of the child confirms these statements. There were not at that time nor had there ever been any paresthesias nor does she recollect that she ever felt pain on deep pressure of the muscles of the calves or thighs.

A day or two after entering the hospital she began to fumble in picking up objects and this difficulty became very marked, though it never increased to complete impotence. A definite loss of power developed in the upper extremities, the fingers became partially flexed and it was only after passing approximately two weeks in the hospital that she became able to extend them. Apparently there have been no subjective sensory

disorders in the arms. There has been nothing at any time in the history which would suggest that there has ever been any cranial nerve involvement. The sphincters have been quite intact.

Status præsens.—The patient falls when standing in the Romberg position. The gait is uncertain, rather broad-based, and of steppage type. There is a paresis of both upper and lower extremities and this is most marked in the distal portion of the limbs. Apparently the flexors are more affected than the extensors and the left side of the body more than the right, but this difference is slight. The forearms, the lower third of the thighs, and the legs below the knees are distinctly atrophic. This is apparently an atrophy en masse and not of isolated muscles. The thenar and hypothenar eminences of the hands are flattened and soft, the left more so than the right. Though the interossei do not appear atrophied, their muscular force is almost nil. All the muscles of the extremities are flabby and there is some hypotonus. There is no fibrillation. At the time of the first examination there was distinct violaceous mottling of the skin of the legs, but this is less evident now.

The special senses, speech and sphincters are unaffected. The sensory examination is negative and there is no astereognosis. The pupils and extrinsic muscles of the eyes show nothing abnormal. At the cardiac apex is heard a slight soft systolic murmur which however is not constant and is limited to this area.

The knee jerks are present, the left greater than the right. The ankle jerks could not be obtained and there is no ankle clonus. No cutaneous reflexes could be elicited. The examination of the cerebrospinal fluid revealed no abnormalities.

There is here, therefore, occurring in a child of twelve a purely motor paralysis, most marked distally, symmetrical, and of a rapid and afebrile onset. This in a few days attained its maximum intensity, began rapidly to improve and has uninterruptedly continued to do so.

The etiological factor so far as the speaker had progressed in search for it is still undetermined. The condition certainly does not coincide with any of the classical types of neuritis usually described. The development of complete paralysis within the space of four or five days and the subsequent rapid improvement, along with the absence of sensory disturbances, suggests to him a diagnosis of poliomyelitis. However, to him, at least, the marked symmetry of the atrophy, the paralysis so marked distally and the afebrile onset exclude this diagnosis. He regards this as a case of polyneuritis presenting several interesting atypical symptoms, the etiology of which is at this time in doubt.