

nuclei of the nerves which govern these palsied parts. These groups of cells form the conjoined nuclei of the spinal accessory, vagus and hypoglossal nerves and a very localized lesion in this part of the medulla is sufficient to effect them. The involvement of the trapezius and sterno-mastoid muscles is probably due to injury to the nerve supplying them, while the laryngeal symptoms may be accounted for by a paralysis of the stylo-hyoid muscle (due to pressure from an enlarged gland) or by the antagonistic action of the muscles on the left side of the throat over the paralyzed muscles on the right side.

#### A CASE OF COMPLETE ATROPHY OF THE TONGUE WITH OTHER NUCLEAR SYMPTOMS.

DR. GEORGE W. JACOBY presented this case. The patient was a female, aged thirty years, married nine years. She has had three children and two miscarriages. During the past fourteen months she has not menstruated. Her mother died of pulmonary tuberculosis at age thirty-eight. Her husband's sister recently died of consumption, and during her illness the patient nursed her. During December, 1892, the patient was treated for loss of sight, which had come on gradually in both eyes, reducing vision to such an extent that she required some one to lead her. This loss of sight was found to be due to a slight atrophy of both optic nerves, and under internal treatment the symptom disappeared. The patient has also suffered from violent headaches, which disappeared with the loss of sight. Three weeks ago she noticed a difficulty in swallowing and speaking. She vomited every morning on rising, even without eating. At the previous examination it was found that the tongue deviated towards the left and there was marked hemiatrophy of that side of the tongue. The uvula hangs to the left and there is paralysis of the left side of the soft palate. The patient has enlarged glands in the neck. There is at present complete atrophy of the tongue and soft palate. There is also motor ocular paralysis on the left side involving the internal and external muscles. Dr. Jacoby presented the case as one of progressive nuclear paralysis.

Dr. B. SACHS said he saw Dr. Wiener's patient some time ago. The idea of a peripheral lesion was considered for a short time only, and the conclusion was soon

arrived at that the basilar site was the more probable one. The lesion is, no doubt, of tubercular origin. A chronic nuclear condition must be excluded, on account of the rapid progress of the symptoms, and because they have remained strictly unilateral. Dr. Jacoby's case he considered a very interesting one, although he felt rather inclined to doubt the diagnosis, because of the rapid progress of the symptoms. They seemed to indicate the presence of some active lesion, either specific or tubercular.

#### MODIFICATIONS OF RESPIRATION IN THE INSANE.

DR. THEO. H. KELLOGG read an interesting paper on this subject. He gave a systematic description of the various forms of respiratory changes found in the insane. To facilitate the study of these modifications, he grouped them as follows: A. Modifications of respiration as regards frequency, depth, rhythm and sound. B. (1) Spasmodic expiratory modifications, such as occur in laughter, crying, sneezing, coughing and snoring; (2) Spasmodic inspiratory modifications, as in singultus, chasmus, and laryngeal crisis. C. Dyspnoic modifications.

DR. WILLIAM M. LESZYNSKY presented a new form of electrode to be employed for diagnostic purposes.

#### REPORT OF A CASE OF SARCOMA OF THE CERVICAL CORD: AUTOPSY.

DR. C. A. HERTER read the history of this case and presented some photographs and microscopical specimens to illustrate it. The patient was a male, aged twenty-nine, single, a merchant by occupation. He was in good health until the beginning of the present illness, barring occasional attacks of chills and fever, and repeated and prolonged colds which ended in cough lasting several weeks. The patient has never used alcohol and his habits have always been in every respect exemplary. The family history is negative. In May, 1891, the patient noticed a loss of sensation, beginning as numbness, in the ulnar side of the little finger of the right hand. This sensory loss soon extended to the entire little finger and thence to the ring finger and the ulnar side of the middle finger. At the same time there was an upward extension of anaesthesia along the hand. Three months from