Society Transactions

NEW YORK NEUROLOGICAL SOCIETY

The Three Hundred and Eighty-Fifth Regular Meeting, Jan. 4, 1921

WALTER TIMME, M.D., *President, in the Chair*

CASE OF LETHARGIC ENCEPHALITIS WITH UNUSUAL OCULAR SYMPTOMS AND NEARLY BILATERAL IMMOBILITY. DR. B. ONUF.

Dr. B. Onuf presented a case seen by him in his consulting service at Ellis Island, and diagnosed as lethargic encephalitis with resulting bilateral ophthalmoplegia and a slight titubation of gait, besides some muscular disturbances, of which later he expressed some doubt whether they were the result of the encephalitis or due to a juvenile muscular atrophy.

The data of anamnesis are somewhat meager: While coming from Italy to the United States, patient was taken with headache and what he called weakness of the lower extremities, being unable to stand and walk without support, and for three days he wanted to sleep day and night. He had also loss of appetite, but no fever. On Dec. 22, 1920, he was admitted to the Immigrant Hospital on Ellis Island, where Dr. Faulkner and Dr. Brown recognized the ophthalmoplegia and swaying gait and referred the case to the speaker for further neurologic examination and opinion. The patient on admission showed a slight elevation of temperature.

Neurologic Examination.—A neurologic examination was made on Dec. 24, 1920. The patient presented an ophthalmoplegia of both eyes. The eyeballs appeared to be quite immobile. Only when the patient looked into the mirror was there a slight convergent movement of both eyes, the right eye also moving slightly outward when following the mirror to the right side, while in the left eye only the convergent movement was noticed. There was a slight ptosis of the left side, but none on the right. Pupils showed slight inequality—the left was smaller than the right. Some light response was present in both eyes, but decidedly diminished in extent. Accommodative response was practically absent. Consensual reaction present in the right eye, but diminished, and was still more diminished in the left eye. There was no distinct asymmetry of facial innervation, but occasional twitchings on either side, more of the character of choreic tic than peripheral twitchings. The tongue was put out straight and showed no atrophy. The speech was of somewhat nasal character and was a little indistinct. The gait was swaying, with no preference to one side. There was a slight Romberg sign. The patient could not walk on a straight line on the floor, heel to toe. Knee, ankle and wrist reflexes were absent. The epigastric reflex was present on both sides and was fairly lively. The cremasteric reflex was slight on both sides. Plantar reflex caused flexion of the small toe and the one next to it on either side. The motor power of upper extremities was well preserved but there was a slight deviation in the index to index pointing test with eyes closed, also the index to nose

pointing test. There was slight adiadokokinesis. Touch, pain and localization were preserved everywhere. No areas of hyperalgesia were present. There was a slight degree of winged scapulae and lordosis which disappeared on sitting down. There was no pronounced atrophy of any group of muscles.

Mental Condition.—The patient appeared serious, perhaps slightly depressed, but prompt and to the point in all his answers to sensory tests. He gave promptly the day of the week, month and day of month. He said he was in a hospital, and that he came there two days ago (correct). He was intelligent and cooperated well.

Eye Grounds.—He had no optic neuritis, but the disks were perhaps slightly grayer on the temporal side.

Examination.—About 12 c.c. of cerebrospinal fluid were withdrawn by lumbar puncture. The fluid was clear and under normal pressure. This was made by Dr. R. P. Sandidge. It revealed: cell count, 4 cells per c.mm.; globulin, slightly positive; Wassermann reaction, negative. Dec. 30, 1920, the Wassermann test of the blood was reported negative. The urine was amber in color, acid, with a specific gravity of 1.025; no albumin; no sugar. Jan. 4, 1921: Blood count, by Dr. J. F. Paulonis, showed: red blood cells, 4,800,000; white blood cells, 7,800; polymorphonuclears, 71 per cent.; small mononuclears, 23 per cent.; large mononuclears, 4 per cent.; eosinophils, 2 per cent., and hemoglobin, 95 per cent.

In conclusion, Dr. Onuf expressed his gratitude to the medical staff of Ellis Island for the help given in working up this case and for the privilege of presenting it to the society.

DISCUSSION

DR. I. ABRAHAMSON said that at present he knew of no lethargic encephalitis cases, except chronic and remitting cases. Poliomyelitis and poli-encephalitis were in existence, presenting certain features of poli-encephalitis, but belonging to the group of poliomyelitis. Severe and complete ophthalmoplegias were unusual in lethargic encephalitis. The loss of knee jerks might be either of spinal origin or from lesion in Deiter's nucleus. The history of unsteady gait would indicate that the case might fit into the latter category. He had lately seen patients in whom there had been lethargy and diplopia, and finally total focal paralysis, whose cases he regarded as poli-encephalitis.

DR. WALTER TIMME said that there had been a recrudescence of lethargic encephalitis early in December. In the case presented, the number of cells was small for poliomyelitis.

DR. B. ONUF stated that he had thought of poliomyelitis, but the history of the lethargic condition decided him in favor of encephalitis. The patient had been taken ill on the boat coming from Italy, which might make a difference in the possibility of the condition being lethargic encephalitis.

DYSPITUITARISM WITH HYPERTENSION. DR. E. DAVID FRIEDMAN.

Dr. Friedman presented a student, aged 19, who for nine years had shown dwarfism and obesity, hypertension, and recently, recurrent pains in the region of the spine. The lad was the third of seven children. The parents and one sister were short and stout. One brother suffered from petit mal. The patient's history included measles and scarlet fever, but it was not known

whether the kidneys were involved at that time or not. The birth was normal and development normal up to the age of 9 years when he began to grow stout. There had been little gain in height since that time. The abdomen became pendulous, the fingers stubby, the feet remained small and the face became ruddy. Thyroid extract was administered in 1915 for over a year, and he grew 2 inches in height. The treatment was then stopped. The patient felt well and went to college. About six months ago he complained of shooting pains in the region of the spine and chest. Examination of the urine showed "kidney involvement." When presented he had shortness of breath and palpitation of the heart after exertion. Speech was somewhat hesitant and some impairment of memory had made itself apparent. Dimness of vision had been reported during the last two months and occasional headaches. There was nocturia but no polydipsia.

The physical examination revealed a short, obese man, 136.5 cm. in height (normal for his age, 175 cm.); the weight was 46.4 kilograms. There was erythema of the face and a pendulous distended abdomen. The teeth were somewhat spaced, the approximation poor, the lateral incisors projecting at a marked angle. The pupils and fields were normal. No sclerotic changes of the vessels of the fundus were reported. There were two pinpoint hemorrhages in the left fundus at one time. The thyroid was not enlarged. Examination of the lungs was negative; the heart was somewhat enlarged to the left and the aortic second sound was accentuated. The blood pressure was increased to systolic, 198; diastolic, 110. The genitals were small. There was an overgrowth of hair at the bridge of the nose, and the body was covered with fine lanugo hairs. The only pathologic neurologic findings were the slightly diminished deep reflexes, which may possibly be accounted for by the existent glycosuria and hyperglycemia. Other laboratory findings were normal. There was perforation in the septum of the nose, and the tonsils were moderately enlarged. The skin was dry and presented three distinct peculiarities: ringworm of the axilla and pubis, erythema and telangiectasis of the face, and striae distensae of the abdomen. Roentgen-ray examination showed undeveloped sinuses, the left being opaque. The lower molars were unerupted and impacted. Examination of the skull revealed a normal sella. The posterior clinoids, as well as the bones of the body and sphenoid bones were markedly atrophic and thin. A dense shadow was seen in the middle fossa, and a shadow at the root of the neck, extending up from the aorta, probably due to the large vessels. The roentgenograms of the hands showed bony development, such as is usually seen in a person of 13. Epiphyseal lines were still present. Libido was absent. The urine showed glycosuria. An electrocardiogram showed a left ventricular preponderance, and there were tachycardia and sinus arrhythmia. There was slowing of the rate on holding the breath and after vagus pressure. A slight alteration of the size and shape of the pulse wave revealed instability of the cardiac pacemaker. There was an unstable vagus and sympathetic balance. Intramuscular injection of atropin and pilocarpin produced no striking results. Epinephrin was not tried on account of the high blood pressure. The conjunctival epinephrin test of Loewi was negative. The title for the presentation was chosen to indicate the predominating features; but other glands were involved as well. The stunted growth points to a deficiency of the morphogenetic principle of the anterior lobe of the pituitary gland. The glycosuria and the hypertension might be interpreted as a hyperactivity of the posterior lobe. (The absence of a pathologic blood chemistry aside from the increased blood sugar and the presence

of a normal phthalein output would seem to exclude true interstitial nephritis.) The hypertrichosis and the increased cholesterol content of the blood indicate some involvement of the suprarenals. The dry skin and delayed ossification of the bones show that the thyroid was not functioning normally. Reichmann¹ has designated a new pituitary syndrome differing from the two characteristic types hitherto described, hyperpituitarism producing acromegaly and hypopituitarism causing the dystrophy adiposogenitalis of Frölich. Reichmann's case resembles ours very much with the exception that his patient showed exophthalmos and bradycardia instead of the tachycardia seen in this case.

DISCUSSION

DR. WALTER TIMME asked whether the abdominal viscera had been examined. Dr. Friedman replied that with the exception of the palpation for the liver, the edge of which could just be felt, no examination had been made. Dr. Timme also asked whether the shadow of the chest had been considered from the point of view of a possible thymus shadow, to which Dr. Friedman answered that this point had been carefully considered and the possibility excluded. There was an absence of relative lymphocytosis characteristic of thymic cases. It was of interest, Dr. Timme also noted, that the genitals showed lack of differentiation.

DR. E. D. FRIEDMAN, in closing, said that the treatment had consisted of anterior lobe pituitary and thyroid extract for the past six months without any real change. The patient had received thyroid extract more or less constantly since 1915, the dosage varying from one-half to one grain three times a day.

JUVENILE TABES AND CASE REPORT TO ILLUSTRATE THE CONDITION. DR. CHARLES ROSENHECK.

Dr. Rosenheck sketched the development of the recognition of juvenile tabes as a distinct clinical entity from the day when Remak first reported three cases in 1885 and cited a discussion ten years earlier.

The difference between juvenile tabes and Friedreich's hereditary ataxia was not always apparent to earlier observers, and Hildebrandt first called attention to the error, drawing the distinction between such cases and those that might be considered true juvenile tabes. The diffidence of observers in accepting juvenile tabes as a true clinical entity is thought to have been due to the fact that up to 1910 no necropsy examination had been recorded to prove the existence of such a disease process.

The various factors that create the syndrome in the young and the respects in which it differs from the accepted orthodox type as observed in the adult are: The average of incidence is placed at 15 years. Mingazzini and Baschieri-Salvadori report an onset at 3 years of age as the youngest recorded case. Hereditary syphilis is responsible for the development of tabes in the young in the majority of cases. A few cases of infection in infancy are reported. According to Cantonnet's analysis, nearly twice as many females as males are affected, a striking reversal of conditions obtaining in later life. The mode of onset in a large number of cases was an early visual difficulty rapidly proceeding to optic atrophy and blindness. The percentage of this form of onset

1. Reichmann: Deutsch. Arch. f. klin. med. **130**: Nos. 3 and 4.

is much higher than in adults. Lancinating pains come next in order of frequency, 25 per cent. of the patients showing these as compared to 70 per cent. of adult patients. Bladder disturbances and gait defects were observed in fewer cases. Cantonnet remarks that ataxia in juvenile tabes is conspicuous by its absence, and the absence of marked gait disturbances in the tabetic blind has been commented on by all writers on the subject. Crises and girdle-like pains have not been observed at any time, nor have trophic phenomena been reported.

Thorough neurologic study renders the diagnosis a matter of simplicity. Cerebrospinal syphilis and Friedreich's ataxia are the only conditions that simulate it to any serious degree. Scoliosis, foot deformity, pyramidal signs, nystagmus, speech defects, etc., are never found in tabes, however; and the syndrome of cerebrospinal syphilis is somewhat different.

A young woman, 18 years of age, was next presented. She was the second of five living healthy children. Pupillary inequality was observed at the age of 12 by a school physician, and she was advised to wear glasses. The first subjective disturbances appeared at the age of 15 and took the form of severe lancinating pains. This was the only symptom for two years. Paresthesias, variable in character but always affecting the lower extremities, principally the toes, have been noted in the past year. There have been no visual difficulties during the period of the development of the malady. Examination of the patient revealed no abnormal attitudes of the voluntary motor system. The gait was somewhat disturbed by an ataxia which varied. In general, all coordinative activity was performed in a fairly creditable manner. Skilled test acts showed no gross defects. Deep reflexes were completely abolished; superficial reflexes were present and equal. No pathologic reflex could be elicited. The peripheral neural apparatus showed no pathologic alteration or impairment. Examination of the cranial nerves revealed that the pupils were fairly regular, markedly unequal and not responsive to light. Accommodative and consensual reactions were likewise abolished. The fundi showed a narrowing of the larger vessels and indistinctness of the smaller ones; the disk was grayish and showed clear evidence of early atrophy. Systemic examination revealed general deficiency in growth and development. Hutchinsonian teeth were present. Laboratory examination showed a positive blood Wassermann reaction. The spinal fluid contained 130 cells per c.mm.; globulin was increased; the Lange colloidal gold reaction was 5544334555, in addition to the positive Wassermann reaction. The prognosis in general, Dr. Rosenheck said, after summarizing the main conclusions reached, was excellent for life, but extremely poor for vision.

DISCUSSION

DR. D. J. KALISKI (by invitation) said that he wished to supplement the report by findings in an interesting case recently seen. There had been no diminution in vision until about the middle of last August, when the patient had suddenly become blind. Investigation showed that there had been symptoms soon after birth, but no treatment had been pursued after the child was 1 year old. There were many stigmas present, such as hutchinsonian teeth, complete optic atrophy, the Argyll Robertson pupil, which also reacted sluggishly, a positive Wassermann reaction and a positive cerebrospinal fluid. Cells were not greatly increased, but there was increased globulin, and a paretic curve resulted with gold solution. The child was becoming more and

more unruly, and the outcome will probably be taboparesis. A similar case was seen four or five years ago, in which the signs of tabes were clear. Taboparesis developed, and the patient died. .

DR. ROSENHECK said that such cases were so rare, his being only the second that he had seen in twelve years, and the first certain one, that he regretted that fuller discussion had not been opened.

DR. ABRAHAMSON said that it would be interesting to study the endocrinous glands in the patient's family, to try to determine why one child was affected and the others spared.

DR. TIMME remarked that the girl showed numerous glandular disturbances, and the teeth especially were very small.

INCIDENCE OF ALCOHOLIC AND SYPHILITIC PSYCHOSES. DR.
GEORGE H. KIRBY.

Dr. Kirby drew attention to the fact that until recently one often encountered the statement that alcohol and syphilis together were responsible for from one quarter to one third of all cases of mental disease that required hospital treatment. During the past decade there have been certain developments which must exercise great influence on the prevalence and potency of these two important causes of mental disorder.

There can be little doubt that during recent years there has been a general movement against the intemperate use of alcohol. The federal prohibition amendment is but one indication of this movement. A striking reflection of this trend against inebriety is seen in the admission rate to the Bellevue Hospital alcoholic wards for the past eleven years. During this period the total number of cases of acute or chronic alcoholism (exclusive of the psychotic types) was 75,333. The high point was reached in 1910 when nearly 32 per cent. of all admissions to Bellevue Hospital were diagnosed as cases of alcoholism. Since then there has been a persistent decrease, the low point being reached in 1918 when a little over 6 per cent. of the cases were diagnosed as alcoholism. A slight upward turn of the curve in 1919 was due to a relative falling off of the general admissions to the hospital. The actual number of alcoholic cases in 1919 was less than in 1918. The figures for 1920 are not yet available, but preliminary estimates show a smaller number of cases than in 1919.

Dr. Kirby regarded the continuous decline in the ratio of alcoholic cases as all the more significant when one takes into consideration the increasing population of New York and the fact that there has been apparently no important shifting of alcoholic patients to other hospitals or institutions for treatment.

The percentage distribution of alcoholic psychoses admitted to all of the New York state hospitals also shows a decline for the past twelve years. A marked fall has occurred from the high point in 1908 (when nearly 11 per cent. of the state hospitals' admissions were diagnosed as alcoholic psychoses) to less than 2 per cent. in 1920. It was thought that the diminishing number of alcoholic psychoses reported might be accounted for in part by a change in diagnostic attitude; but the separate listing of the Korsakoff cases, which presents little room for diagnostic error, gave a curve which showed a decline similar to that for the other psychotic types.

Turning to the syphilitic psychoses, Dr. Kirby remarked that during the past ten or fifteen years a number of forces and influences have come into play which may possibly be lowering the incidence of syphilis as a disease or modi-

ying its later manifestations, especially the neuropsychotic forms. During recent years the public interest in syphilis, its prevention, consequences and treatment has been vastly increased. The therapy of syphilis has been revolutionized since the introduction of arsphenamin in 1910, and the lessened amount of alcoholism may perhaps also be reckoned as a favorable influence. Possibly it is too soon to expect to see results on account of the time which usually elapses after the infection before neurosyphilitic lesions become manifest.

Dr. Kirby showed a chart drawn up from state hospital data on cases of paresis admitted during the past twelve years. The ratio of these cases has held fairly uniform at about 13 per cent. of the total admissions. There has, however, been a slight fall during the past two years from the relative high point of 13.4 per cent. in 1918. Moreover, by using the recent census and calculating the rate of paresis per hundred thousand of the state's population, it appears that there has been a decline from 9 per hundred thousand in 1918 to 7.9 in 1920, the lowest figure on record. The actual number of cases of paresis admitted to the hospitals has also declined since 1918. This reduction may be somewhat significant in view of the steady increase in the population of New York State.

The data at hand would seem to justify the conclusion that alcoholism has declined perceptibly in recent years, and coincident with this decline there has been a marked fall in the number of alcoholic psychoses.

Mental disorder (paresis) due to syphilis reached a high point in 1918 with a subsequent decline in the relative and actual number of cases entering the hospitals.

DISCUSSION

DR. L. PIERCE CLARK opened the discussion of Dr. Kirby's paper with the suggestion that since dermatologists so frequently report that they see the early signs of syphilis at skin clinics, this would seem an excellent field for therapeutic work. If preventive workers would concern themselves with the earlier stages of the disease better prophylaxis would be obtained.

DR. B. ONUF asked how the diminution in syphilis and alcoholism has affected other psychoses. He thought it would be interesting to find out whether substituted drug habits, if such occurred, would also result in psychoses.

DR. L. P. CLARK asked whether the information collected by Dr. Kirby might not be turned over to mental hygiene publications so that the reading public might have correct data concerning the incidence of alcoholic psychoses and syphilitic psychoses and the relative decrease.

DR. B. ONUF said that Dr. Brill had spoken of a case of alcoholism treated by psychoanalysis with entire cure. The patient then proceeded to forge checks, so that Dr. Brill did not feel proud of his achievement and thought that the patient might have been better off as a drunkard. Dr. Onuf also said that Dr. Gregory had reported a recent great increase in cases of alcoholism admitted to Bellevue.

DR. IRVING J. SANDS said that his experience at Bellevue would lead him to believe that there was no such thing as a new form of psychosis resulting from prohibition. Furthermore, he stated that he had discussed that question with Dr. Barnes, and many of the older men who had charge of the alcoholic service in years gone by, and it was their impression that the old alcoholic repeaters were not now coming to Bellevue with a psychosis. It was true

that admission in general to the psychopathic ward was increasing, but that was due to other factors, and not to prohibition. He felt that prohibition had helped considerably.

Regarding the problem of general paralysis, he felt that the early recognition of neurosyphilis and the favorable impressions made by intensive treatment on mesodermic syphilis helped materially to lessen the number of paretic patients. He referred to Dr. Gregory's work on the modern conceptions of inebriety, which was published in 1917.

DR. D. J. KALISKI (by invitation) asked whether the decrease in paretic admissions to state hospitals had been brought about by the increase in facilities for treatment in other institutions. The state hospitals used to be the only refuge. Now more widespread and better known treatment centers and clinics, and the increase in treatment in private practice may have helped to lessen the admissions.

DR. KIRBY, in closing the discussion, said that he had seen no signs that other psychotic types were appearing as substitutes for alcoholic psychoses. The total admissions to the state hospitals have diminished, due, he thought, chiefly to the falling off of alcoholic psychoses. There has been no increase of drug psychoses; in fact, the number admitted to the state hospitals has decreased, although drug psychoses have always formed a relatively small group among the admissions to the state hospitals.

The suggestion that the decline in the number of syphilitic psychoses admitted might be due to more frequent treatment of these cases in general hospitals and in private practice, especially early cases of paresis, should be taken into consideration. Dr. Kirby did not feel, however, that this factor would modify greatly figures for the entire state over a period of years, unless actual curative results were being obtained in the treatment of early neurosyphilis. Unfortunately, experience shows that many cases of paresis that have been treated in general hospitals or in practice eventually reach state institutions.

REMARKS ON CONSCIOUSNESS IN THE EPILEPTIC FITS. DR. L. PIERCE CLARK.

The ordinary definition of the epileptic fit, Dr. Clark said, is a loss of consciousness with or without a convulsion. This accepted loss of consciousness, Dr. Clark finds, from patients' reports, to be questionable. One patient states: "When a petit mal occurs, I can usually control myself and go on talking or continue whatever I am doing. . . . There is a sort of turmoil in my mind. This would last only a second." Another says: "I feel intensely aware of myself." A third patient reports: "During the confused spell I have a feeling that I must not let any one know there is anything unusual, and that I must retain my poise at all costs. . . . Consciousness so far as outside affairs are concerned is suspended and my attention is directly turned in on myself." Another patient says: "I could always control these attacks if I really wanted to, but I let them come up. It was a gratification, I think, to something inside me."

From these statements, Dr. Clark infers that instead of there being a loss of consciousness in totality, the subject consciousness is increased. Awareness of surroundings may be greatly or entirely lost, but there is in its place heightened awareness of self. In more severe epileptic reactions the person may not be able to report his subject awareness; but from his appearance and manner it is apparent that he is in a state like that experienced by persons

able to record twilight states. Still more complete submergence of self to a condition resembling that of birth or earliest infancy is met with in deeper grades of disordered consciousness. The patient may answer questions and will always answer in disjointed sentences in the optative mood, such as "I am trying to," "I'd like to," etc.

The state of epileptic reaction, then, said Dr. Clark, is an involution of the normal development of consciousness. This latter is gradually evolved out of egoconsciousness to a rich combination of subject and object consciousness or to a unified composition of both. The epileptic reaction then has an enormous psychic importance, principally in the deteriorating influence on the power of sustained interest and attention, and the orderliness of normal objective life. Each attack refreshes and satisfies the patient's cruder egoconsciousness and enriches his egoistic interest. It is therefore to be expected that he will not be interested in recovering from his disorder and in foregoing his unconscious self gratification. To appeal to him, his personal satisfactions in everyday life must be increased beyond those obtained from his habit.

DISCUSSION

DR. JOHN T. MACCURDY thought that Dr. Clark had brought out an important clinical point in regard to the mental state of many epileptic patients. He agreed with Dr. Clark that particularly in cases with a prolonged aura a heightened sense of personal awareness was a frequent phenomenon. This is well illustrated in the account of an epileptic attack given by Dostoevsky in the "Idiot." On the other hand, Dr. MacCurdy wished to take exception sharply to Dr. Clark's contention that such heightened sense of awareness was in opposition to the loss of consciousness so generally recognized as pathognomonic of epilepsy. He insisted that consciousness was used in two senses. In the sense in which Dr. Clark was now using it, it meant a direction of attention to the patient's own ego. Clinically, however, consciousness usually means the reciprocal function of attention to the environment—objective consciousness, as Dr. Clark said. With any weakening of consciousness in the clinical sense there was always a tendency to an increase in the attention to the patient's own personality. In fact, this is the essence of introversion. A good example is seen in the normal phenomena of dreams. In them there is usually a heightened sense of the dreamer's personality, while objectively the subject is unconscious.

DR. GREGORY STRAGNELL (by invitation) said that in discussing the consciousness of the epileptic patient, the conscious, introverted attitude of the patient must be looked on as an escape from his obligations. It would hardly be analogous to unconsciousness. Two characters, famous in history, who were addicted to epilepsy, Napoleon and Dostoevsky, illustrate this. From the journals and letters of both of these, it is seen that both at about the age of 12 wrote home and threatened to simulate insanity to compel the state to look after them if they were not forthwith supplied with funds to maintain the position which they felt was their due. Each of these men found a compensation for an initial inferiority and the same form of retreat in later life when the carrying out of the compensation became too difficult. The mechanism in each of them was first the recognition of an initial inferiority of the ego which the one sought to compensate for by war, the other by literature; and if the

struggle became too difficult, they sought a retreat in the epileptic attack. This should give a clearer concept of the struggle going on in the consciousness of the person.

DR. C. P. OBERNDORF said that epilepsy was caused by many things and cured by many things. The term epilepsy does not mean very much. All stages of it may exist. In using the term, every form of convulsive attack is included. A case seen recently was that of a woman 42 years of age, the mother of ten children, who has attacks daily. In her case the epileptic attacks were due to an organ deficiency. Unless Dr. Clark can limit idiopathic epilepsy, due to a special type of physical disorders, his discussion will lead too far afield. To draw up a psychogenetic group will be undertaking something too misleading and will confuse the therapy.

DR. IRVING J. SANDS said that he considered Dr. Clark's contributions to the epileptic problem epoch making, and that all students of mental disorders were indebted to him. However, epilepsy, in his opinion, was an organic condition, and the fit was caused by the reaction of the brain to some stimulus. In his opinion there were definite structural (cerebral) alterations, macroscopic, microscopic or physiochemic in nature, caused by endogenous or exogenous toxins. He had had an opportunity to conduct an intensive study of epilepsy at the Manhattan State Hospital. The results obtained there by the administration of proper drugs convinced him all the more that epilepsy was an organic condition. In May, 1919, when sedatives, such as chloral, bromids, hyoscin and paraldehyd were used in controlling the psychotic epileptic patients, there were 502 recorded seizures; while in May, 1920, after the system of luminal therapy had been worked out, there were only eight seizures in the same ward. He stated that he had been able to follow up this therapy in Bellevue Hospital, where many of the epileptic patients had been sent because of some postepileptic unfavorable complications, and there too had obtained satisfactory results on that drug. There was no doubt but that psychogenic factors played an important part in many of the epileptic patients, especially in those having epileptic equivalents. Recently he had seen a case which might well fit into the group described by Dr. Clark. It was that of a 28 year old woman, a nurse, of unusual intelligence and ability, who was in charge of a big ward of mental cases. For the past four years she had been having attacks lasting one or two days, once every six months or so, which had been characterized by intense hemicrania, nausea, vomiting and scintillating scotomas. She was seen two weeks ago in one of these attacks. She left the ward suddenly, packed her trunks and cabled that she was coming home. She had had intense unilateral headache, nausea, vomiting and scintillating scotomas characteristic of migraine. After three days she felt greatly relieved. She stated that during this time she had thought only of herself, had had a sense of heightened self consciousness, and felt that several distressing conflicts that had been troubling her for a few weeks had been solved. She also added that all the other attacks would come on whenever confronted by some perplexing problem, and following these attacks she felt a sense of security in employing the mode of procedure indicated by her subconscious trend. This case Dr. Sands regarded as more or less of an epileptic equivalent associated with migraine.

DR. B. ONUF inquired concerning the relation between the injuries sustained during the attacks, and the theory of the wish of the person to escape from consciousness and to return to intra-uterine life.

DR. CLARK closed the discussion by stating that he emphasized time and again that he considered there was a definite group of essential epilepsy exclusive of groups involving organic conditions. He had always limited his remarks to cases in which no specific cause could be found. The epileptic fit essentially does not differ from conditions seen in the psychotic ward, and is a pure retreat to gain a certain result. Essential epilepsy is a mental disease with physical objective manifestations. Any diagnostic critique must keep this in view. It has been practically agreed that essential epilepsy may be considered a definite clinical phenomenon.

In replying to Dr. MacCurdy's comment, Dr. Clark said the sleep phenomenon was analogous but not parallel. As to medication, speaking from his own experience, he felt that luminal was probably the most insidious and destructive drug we have ever used. Its disastrous effects can be appreciated only after several years, whereas bromids reveal the harm they do on the surface after a short period. Luminal is deadly because of its character deterioration. It is worse than bromid medication since the mere stoppage of the drug does not do away with apparent deterioration, as in taking away bromid after prolonged use.

Epileptoid attacks, tabetic convulsions, etc., do not concern the idiopathic group. Their pathology may have been demonstrated, but until we obtain more data, every possible investigation should be continued.

COLORADO NEUROLOGICAL SOCIETY

Regular Meeting, Jan. 22, 1921

HOWELL T. PERSHING, M.D., *President, in the Chair*

Dr. Pershing thanked the Society for the honor of being chosen its first president; he predicted for the organization success and the accomplishment of much good for those interested in neurologic work.

A draft of the constitution and by-laws was presented and adopted.

ANXIETY NEUROSIS. DR. GEORGE E. NEUHAUS.

Dr. Neuhaus gave a brief review and history of anxiety neurosis as viewed originally by Freud and his successors, calling attention to the prominent characteristics which identified this clinical state. Four cases were reported, all of which were traced to sexual complexes, instancing recovery when the complexes could be brought out as the result of psychoanalysis.

DISCUSSION

DR. SAMUEL GOLDHAMMER referred to the cardiac type, comparing this to the neurasthenic, postinfluenzal and "gas" types, as observed in the army.

DR. EDWARD W. LAZELL said that the followers of Freud were making the same mistake as the older observers, and that while Freud was a clinician, that the phenomena he himself observed were not thoroughly interpreted. Quoting Kempf further that "the hormone is the messenger of the mind and not of the body," he expressed an opinion that all anxieties were regressions and the basis of the physical symptoms were the glands of internal secretions. Over-compensation of inferiorities is the chief cause of anxiety.

DR. C. S. BLUEMEL thought the type of individual was too often overlooked. Sexual complexes, he thought, were probably as frequent in other states if looked for.

DR. HOWELL T. PERSHING believes that these patients are subject to fear without a rational cause for the fear. All of us have the inherited mechanism which makes possible the development of fear. That these anxiety cases become especially sensitized depends on a neurotic inheritance, and some accident, shock or dynamic illness sets the matter off. Among the many other causes, the sexual may become operative, and in any such case the person may revert to what are regarded by him as errors, or indiscretions of youth in the same way as it may be developed in melancholia.

EPIDEMIC ENCEPHALITIS. DR. EDWARD. DELEHANTY.

Dr. Delehanty spoke generally of the epidemic of encephalitis, referring to the wide discussion given the subject. In his opinion, it was a new disease; he had no recollection of seeing similar syndromes in previous years of practice. Several cases were related of rather atypical course.

DISCUSSION

DR. PHILIP WORK reported having seen six cases in which the pleocytosis ranged from twenty to sixty. In one of his cases a typical bulbar paralysis developed with a rapid course.

DR. HOWELL T. PERSHING referred to the previous epidemic of encephalitis in which he recalled cases which were regarded at that time as cases of meningitis; when the patients recovered the true nature of encephalitis was identified. He was impressed by the diversity of symptoms in the present epidemic. His first case resembled a Landry's type of paralysis until recovery began to appear in the reverse order—that is, the face recovered first. Another case was mistaken for melancholia; later a typical bulbar complication led to a correct identification. The third case appeared to be a poliomyelitis. Choreic and mental cases were also mentioned. The relationship of influenza is doubted.

DR. GEORGE A. MOLEEN called attention to a syndrome which he thought might be a form of noninflammatory hemorrhagic poli-encephalitis. He had found only one reference in the literature to this syndrome—this appeared in the *Revue Neurologique* under the caption "Syndrome of Tapia." Three cases were mentioned in all of which the left side was involved. A striking characteristic of all cases was the severe pain over the trigeminal area extending back to the occiput, which precedes the degenerative symptoms. This has been so severe as to have led to attempts at suicide in two instances. Shortly after the appearance of pain, atrophy was noticed in the same half of the tongue with marked furrowing and fibrillary twitching (of which photographs were shown); paralysis of the soft palate, the vocal bands and more or less weakness of the muscles of the neck was common in all cases. The paralysis of the ipsilateral vocal band was absolute. In one case only was strabismus noted. In one case there was a previous syphilitic basal meningitis from which the patient had recovered and negative Wassermann reactions of the blood and serum had obtained for a year; this was also true in the case reported from Brazil in the French literature. The other cases mentioned were free from syphilitic evidence. The treatment was similar to that for acute infec-

tions—symptomatic for the most part and with free alkalization and elimination. Complete recovery is the rule with the restitution of the tongue and restoration of the vocal power.

SAN FRANCISCO NEUROLOGICAL SOCIETY

Regular Meeting, Feb. 4, 1921

MILTON B. LENNON, M.D., *President*

A CASE OF SUBACUTE MYELINIC DEGENERATION. DRs. E. W. TWITCHELL and R. W. HARVEY.

Drs. Twitchell and Harvey related the case of a man 52 years old with negative venereal history. In 1918 he had a severe attack of influenza. Four years ago he began to have tingling and a clammy feeling in his hands and feet. When examined on Aug. 15, 1920, he was so weak that he could not walk without a cane. Marked ataxia of the hands and feet was present. The tendon reflexes in the arms were diminished; those in the legs were absent. The lower abdominal reflexes were absent; the cremasteric reflexes were present but feeble. Blood count: red blood cells, 2,660,000; white blood cells, 5,800; hemoglobin, 82 per cent.; there were moderate poikilocytosis and anisocytosis. The blood Wassermann reaction and all spinal fluid tests were negative. A month later the patient was unable to stand or to feed himself. His hands ached so that he "wished they could be cut off." The entire body was very sensitive. In spite of this increasing weakness, the red count went up to 4,760,000 after a course of Fowler's solution and two doses of neo-arsphenamin. The patient died on Oct. 2, 1920.

DISCUSSION

DR. G. Y. RUSK reported that the brain showed a diffuse atrophy involving both frontal lobes and adjacent portions of the parietal and temporal lobes. The spinal meninges were normal, but on section the posterior columns showed a broad V-shaped brownish-yellow area of degeneration. Farther up the presence of chronic inflammatory changes suggested the possibility of syphilis in spite of the negative serology.

DR. E. S. DUBRAY, speaking from the internist's standpoint, said that he did not know of any particular group of cases that bring the internist, neurologist and psychiatrist so closely together as the group of which this case was an example. He discussed the spastic, ataxic and mixed forms and called attention to the fact that a review of all of the primary anemia cases at the Mayo Clinic had revealed the presence of neurologic signs in 80 per cent. The most valuable clinical sign that rules out syphilis is a stocking and glove anesthesia. He also cited a case of the kind under discussion which first had been thought to be one of multiple sclerosis.

DR. J. N. WOLFSOHN related a case of this disease in an alcoholic woman, seen by him in 1914, when he made a diagnosis of multiple neuritis. Three years later her symptoms persisted and blood examination revealed a red cell count of 800,000, with a color index of 1.4. After four months of arsenic therapy the red count rose to 4,000,000, but she had a flaccid paralysis with a positive Babinski sign and other features of beginning sclerosis of the cord.

DR. W. F. SCHALLER said that he had frequently found cases of this disease. In 1917 he reported twenty-three cases with four necropsies in which the central nervous system was studied. None of his cases showed the unusual findings of this case, consisting of the perivascular and meningeal infiltrations rather than the cortical changes. His patients presented paresthesias rather than the pain complained of in this case. Many cases of this disease do not show anemia; frequently they show a high* color index. Dr. Schaller said that when he has a patient with a spastic paraplegia and impaired sensibility, he watches the blood closely. He believes that if these patients are seen early enough something can be done for them. He tries arsenic and iron and colonic flushings, on the theory of intestinal intoxication. He said that he did not know of any disease that is so difficult to diagnose as combined sclerosis.