its entire clinical course. These were cases resulting from tangential projectile wounds in the region of the sagittal suture resulting principally in paralysis of both lower extremities. Of these the author here gives eighteen cases, which present the clinical picture of what may be most fittingly called cerebral polyplegia. The initial phenomena were nearly always of stormy character, paralysis of the lower extremities, paralysis or paresis of one or both of the upper extremities, disturbances of speech. The author divides these cases into four groups: 1. Those cases in which the clinical symptoms, after the lapse of several months or even years, showed no signs of improvement (these being usually the cases which were at first characterized by pronounced paralysis of both lower limbs and one or both of the upper). 2. Cases which presented the picture of a hemiplegia or hemiparesis, but where more careful examination revealed pronounced traces of lesions in other psychomotor regions. 3. Cases where, notwithstanding alarming initial phenomena, the recovery was sufficient to permit the patients relatively free use of the limbs. 4. Cases of so-called transverse polyplegia. The author discusses the various theories on restoration of function of movement both from phylogenetic and other points of view, giving examples where recovery seemed to be due to compensatory activity of centers on the side of wound and adding: "It must be confessed that the cerebral polyplegias here described seem to offer evidence in disproof of homolateral cortex compensation, because, in many of the cases the centers on both sides were destroyed and, notwithstanding this fact, recovery, to a great extent, took place." The author is of the opinion that in some of these cases, the centers were only temporarily injured—by subdural hemorrhage, diaschisis, concussion, etc., and that later they were again brought into activity. He calls attention to the differences in the final results in these soldiers wounded in the field compared with the similar cases usually met with in peace times. These latter are nearly always forms of hemorrhage or encephalomalacia in the brains of syphilitics and alcoholics where the whole organism is suffering from serious pathological processes. Here the cases were all young men, in the very best condition physically, and with high degree of education in coördinated movements because of gymnastic exercise, marching, target practice, etc. In these patients, even where they presented an initial picture resembling that of most severe pseudobulbar paralysis there was a steady recovery of function, while in the ordinary hospital cases there would have been decline into complete helplessness.

Pfeifer, B. CONCERNING HOMOLATERAL HEMIPLEGIA FROM A SHELL WOUND OF THE BRAIN. [*Archiv f. Psych.*, 1919, Vol. 59, p. 687.]

The author describes a case of homolateral purely motor hemiplegia after a shell wound of the brain. The Roentgen picture revealed that there was a splinter of the shell in the cerebral peduncle of the side

opposite to the wound, thus explaining the paralysis on the homolateral side. The author remarks that this case shows anew what mistakes may arise from an incautious assumption of a congenital absence of the decussation of the pyramids. He reviews cases of homolateral paralysis to be found in the literature expressing the opinion that they can all be explained as due to some such cause as secondary injury of the contralateral pyramid through pressure or hemorrhage, etc. Homolateral hemiplegia can also be counterfeited by functional paralysis, by multiple foci in organic brain disease, etc. A true homolateral hemiplegia as consequence of congenital absence of the pyramidal decussation could only be assumed if it were proved by unequivocal clinical signs, confirmed by the most careful anatomical examination of both hemispheres from the motor cortex to the crossing of the pyramids.

Schmidt, Adolf. HOMOLATERAL HYPERESTHESIA WITH HEMIPLEGIA.
[Archiv f. Psych., 1919, Vol. 59, p. 501.]

The skin and deeper parts are often found to be abnormally sensitive, in new cases of hemiplegia, on the side which is not paralyzed. Even when in an unconscious condition the patients make motions of defense indicative of the hyperesthesia. The author describes two cases from his own experience. In one there was complete paralysis of both legs and arms on the right side, while the motility of the left side was not affected. There was, however, extreme hyperesthesia on the left. The section revealed apoplexia sanguinea on the left. This hyperesthesia is not merely a phenomenon of contrast for it is observed in cases where there is no impairment of sensibility on the paralyzed side. The hypoaesthesia on the paralyzed side and the hyperesthesia on the non-paralyzed are not connected phenomena; one may occur without the other, both being dependent, not on the severity, but on the localization of the lesion. According to the author this indicates that the centers controlling sensibility must be situated near the point where motor paths of the contralateral side are most usually found affected, *i.e.*, in the medullary layer below the motor cortex region and in the internal capsule. In lesions situated in the brain stem the conditions seem to be otherwise; at least the author observed a case of hemorrhage in the pons in which there was very pronounced hyperesthesia of the skin and muscles on the side of the paralyzed extremities. The author believes that the homolateral disturbance of sensibility must be due to the stimulation of special paths in the brain which are distinct from the cortico-thalamic paths. It is known from other experiences that probably each half of the body is not exclusively connected with the cerebrum cortex of the other side, but that in some instances centripetal impulses from the homolateral side stimulate the cerebrum cortex. It could be assumed that in lesions of one of the cerebrum hemispheres, sensory fibers which lead from this to the other hemisphere are stimulated and that