the seclusion and quiet of an institution, plus the watchful care of nurses constantly under the eyes of the physician and the family.

Hydrotherapy had been tried in the form of wet packs, but they had had a bad effect, putting the patient into collapse on every trial.

Dr. Riesman thought that physicians should not be bound too much by names. The case, in his opinion, was one of mania but not of the depressive type of psychiatrists. It was an infectious mania as no one who saw the temperature chart could question, and hence the title given to the paper of febrile mania of long duration. In looking through textbooks on psychiatry he had not been able to find a parallel case. He did not think that the mental condition should be called delirium. If one did not see the graphic record and only heard the recital of the patient's psychic state, one could not help classifying the latter as one of mania. It was necessary, he thought, to distinguish between degenerative mania, the maniaco-depressive insanity, and infectious mania. The mental phenomena of the latter differed somewhat from those of the former, but perhaps no more than insanities of the same class often differed among themselves.

Though it might appear that drugs had been given in extraordinary quantities, those quantities had really been the lowest that could have been employed. If he had to treat the case over again he would give even more, for whenever sleep was produced by the drugs the patient's condition was better. He fully agreed with Dr. Dercum in believing it wise to induce sleep artificially if the sleep proved beneficial. He had not seen hematuria produced by the remedies used.

Dr. Dercum remarked that he had not meant to criticise Dr. Riesman's use of the term hypermania. He had himself used it; but he wished, from the purely psychic standpoint, that there were a better term, because it covers cases that are not such as the term mania should be limited to.

A CASE OF SYRINGOMYELIA WITH INVOLVEMENT OF FACE, SCALP AND LARYNX

By Alfred Gordon, M.D.

Mrs. M. McF., aged 45, noticed about five years ago loss of pain and temperature senses in both hands and left arm. Burns or contact with hot or cold objects were not perceived by her. On a number of occasions she discovered burns, ulcerations, erosions on the skin without suffering pain. The healing of these ulcerations would be a long procedure. Gradually the condition extended and paresthesias developed.

At present she complains of a numbness and tingling in her thorax from the waist up to the face, left arm and right hand. She frequently gets headache in the left side of the head. She perspires very little even in the hottest days of summer, but only on the left side of the body. Her arms and hands feel exhausted upon the least exertion. Objectively she presents a distinct syringomyelic dissociation affecting on the left side: hand, arm, thorax (except breast), upper part of abdomen, face along the lower jaw, neck, back as low as the lower angle of scapula, left temporal region, vertex and occiput. On the right side: arm (except deltoid region), hand; on the neck there is only a diminution of sensory disturbances for pain and temperature. Touch is preserved everywhere. Tongue, pharynx and larynx are also anesthetic on the left side. The

left vocal cord is decidedly anesthetic. Within the last two to three years a hoarseness developed which at times becomes very marked. The hands show slight wasting, the grip of both hands is poor. The lower extremities are not involved except that the knee-jerks are increased. The eyes show a somewhat sluggish pupil on the left and a certain degree of neuro-retinitis with choroiditis. The chief interest of the case lies in the involvement of the face, scalp, larynx and pharynx. There are in the literature only 27 cases according to the statistics of Egmont-Baumgarten (*Berliner klin. Woch.*, 1909, No. 34) with involvement of the larynx and with hoarseness as a symptom. The case is therefore one of syringomyelia and syringobulbia.

A CASE OF PSEUDOHYPERTROPHY AFFECTING THE LOWER AS WELL AS THE UPPER EXTREMITIES

By Alfred Gordon, M.D.

A colored boy twelve years of age presented from early childhood some weakness in the lower extremities. At present he shows very much enlarged calf muscles which contrast strikingly with the rest of the limbs. He presents also the typical difficulty of sitting down or getting up, climbing on his four limbs, marked lordosis of the spine, protrusion of the abdomen, recession of the scapulæ—all characteristic of the pseudo-hypertrophic form of myopathy. The biceps muscles of the arms when the latter are not flexed present an unusual hardness, and when an attempt is made by the patient to flex his arm, viz., to contract the biceps, the latter becomes unusually soft. Evidently the dystrophy or rather pseudo-hypertrophy affected also the biceps muscles. The latter observation is rarely observed.

A CASE OF PERIODIC PARALYSIS

By Charles S. Potts, M.D.

F. E. aged 17 years, single, stenographer by occupation. Family history negative. Until eighteen months previous to July, 1909, the patient has always been a healthy active boy. At that time about once weekly he began to have spells in which the legs would become weak, so that while he could stand and walk with difficulty, he could not raise the leg sufficiently to go up steps or over a curb. These spells seemed to come on after unusual exertion and lasted about a day. For some hours before the spell would appear he would feel tired. He was first seen by Dr. Potts on July 9, 1909, previous to which date the patient had not had a spell for six weeks. This attack began the previous day and when examined he could neither stand nor walk, although all movements of the legs and feet could be made slightly. Dorsal flexion of the foot was most impaired. All movements of the arms and hands were present but impaired, but not to the same extent as those of the legs. Cranial nerves were not involved. The action of the sphincter was normal. Tendon jerks were all lost and when the soles of the feet were irritated the toes moved in neither direction. (Other skin reflexes were not tested.) Faradic contractility was absent and there was no pain or tenderness. Tactile and pain senses were normal. The next day he went to his business, feeling perfectly well, except as he described it "a little stiff." Re-