before a nodule develops. In general the patient had the feeling of soreness, rather a paresthesia than pain, unless the nodule was being pressed.

He admitted having had a chancre twenty-two years ago and had been a heavy drinker for many years, principally whiskey. Was married but no offspring. There was double optic neuritis, the pupils were sluggish to light and both Achilles jerks were lost, though the knee jerks were still present. Wassermann reaction strongly positive. There were lues, alcoholism and adiposa dolorosa in the same patient. This may be important when considering the etiology of adiposis dolorosa.

Dercum in 1888 and 1892 first described this disease. It consists of the formation of fat nodules in various parts of the body either in circumscribed or diffuse distribution. There is a variety of the disease in which the discrete nodules become almost generalized. This variety resembles general obesity more than anything else, but the characteristic point is that the nodules are painful to the touch. In many of these cases there is even a relative degree of objective anesthesia. In other cases there is hyperesthesia. Dr. Grinker's patient had hyperesthesia over a great part of the skin of his back. The pain is variously described by different patients as burning, paroxysmal, spontaneous, or may only be elicited on pressure. The lumps never occur on the hands, face or feet, but are found on the trunk, thighs and abdomen, as well as over the arm. A not rare symptom is some degree of mental weakness. Many patients have suicidal tendencies and others mere dementia. Dr. Grinker's patient was not mentally weak but rather emotional which might in this instance be due to alcoholism.

As to the pathology we are still ignorant. The thyroid and hypophysis have been found enlarged in many cases. There was no thyroid enlargement in Dr. Grinker's case and the radiogram showed a normal hypophysis. There was a suspicion, however, of calcified pineal gland, according to the radiograph.

Dercum believes this disease belongs to those caused by glandular disorders, but pathological findings have thus far been indefinite. Increased connective tissue and fat have been found among the contents of the nodules.

In the treatment thyroid tablets have been recommended but thus far no cures have been recorded. For the syphilis the patient was given antisyphilitic treatment.

HYSTERICAL HEMIPLEGIA WITH HEMIANESTHESIA

By Julius Grinker, M.D.

The patient is married and has two living children. Two years ago she was operated on for a perineal tear. She left the hospital well, but later developed gonorrhea and then gonorrheal arthritis, for which complaint she returned eleven months ago. Her right knee was placed in a cast and she recovered. After the cast had been removed she fell in the ward one day and the next day her left side was paralyzed. This paralysis has remained about the same. The left arm and leg were involved but not the face. The gait is typical; a dragging gait, and it does not correspond to any known organic gait, neither to the spastic, the steppage or the ataxic stamping gait; it is the typical hysteric gait described long ago by Charcot. Diagnosis can almost be made from a glance at this gait. Of course, there is no Babinski sign, nor spasticity, nor other evidence of pyramidal tract lesion.

An interesting feature is the combination of hemiplegia with hemianesthesia and hemialgesia beginning exactly in the middle line. This is true hemianalgesia.

In addition there is a contracted field of vision, so-called tubular vision.

The diagnosis in such a case can be made by excluding symptoms of organic disease. Hemianesthesia beginning exactly in the median line and a paralysis that involves only arm and leg, and the fact that this difficulty came on after a slight trauma not sufficient to cause lesion of the brain, leave no room for doubt in the diagnosis.

SYPHILIS OF THE MIDBRAIN

By R. C. Hamill, M.D.

The man is a bartender by occupation, aged twenty-six years. He came into the hospital on the 27th of September complaining of headache and weakness. He first had headache two years ago. It was most pronounced at night, began in the occipital region and passed to the front of the head. During the last attack he had nausea and vomiting, not projectile in type. There were no eye disturbances and no scotoma before the attack. Previous attacks were not accompanied by vomiting. The attacks lasted two or three days at a time.

He had a primary syphilitic lesion three years ago. He has had left middle ear disease for many years and had pleurisy three years ago.

Physical examination at the time of entrance showed that although he could move his eyes in all directions there was a nystagmus in all directions with the slow component towards the position of rest.

On the second of October he complained that his left arm and leg had been gradually getting weak and that he still had a severe headache. At that time the interne noticed a paralysis of the right external rectus with anesthesia and paresis of the left side of the face. Dr. Hamill saw him later in the day, at which time he had a marked diminution of the sense of movement in the left toes and fingers. Both eyes were held to the left, and marked nystagmus was present upon attempting movement to the right.

Lumbar puncture the day of entrance showed 170 cells to the cm. The Wassermann reaction on the spinal fluid was strongly positive; on the blood negative.

Examination October 10. All movements of upper facial are invariably accompanied by bilateral movement of the eyes up and to left. He has left hemiplegia, paresis of movement of the eyes to the left, and paralysis of the right sixth nerve. He smiles more on the left than on the right face. He has complete loss of the sense of movement in the toes and a diminution of the sense of movement in the fingers, and diminished touch sense on the left side.

The reflexes on the right side of the body are much increased.

Smiling is under poor control; he smiles too easily and frequently. The lesion is in the pons, is vascular and syphilitic. It involves the sixth nucleus, the dorsal longitudinal bundle, the lemniscus and the pyramidal tract.

Dr. Charles J. Lewis suggested the possibility of the thalamus being involved. He thought there was less opportunity for a lesion in the fibers of the fillet than in the cell bodies of the thalamus.

Dr. Moyer asked if there was any involvement of the lenticular nucleus.

Dr. Hall thought that if the sixth nerve is involved at the nucleus the seventh might also be involved. Why could not a meningeal involvement account for the sixth nerve on one side and why has he not a multiple lesion?

Dr. Grinker thought of the emotional involvement and the center for mimicry which is pretty generally conceded to be in the thalamus. This man has this to a certain degree, as is manifested by his forced smiling. Inasmuch as he is syphilitic, could we not assume that he has a lesion in the thalamus which may account for his involuntary mimicry?