

## Current Literature

### II. SENSORI-MOTOR NEUROLOGY.

#### 2. CRANIAL NERVES.

**Schulte, J. E.** TRIGEMINAL NEURALGIA. [Nederl. Tydschr. v. Geneesk., September 4, 1920.]

Röntgen irradiation is here recommended as legitimate after failure of internal measures and electricity. Alcohol injections or excision are further steps in the process of more radical procedure should the radiations prove unserviceable.

**Härtel, F.** INTRACRANIAL INJECTIONS IN TRIGEMINAL NEURALGIA. [Deutsch. med. Woch., April 29, 1920.]

The author has used the intracranial method for seven years, and as a result in fifty cases a permanent cure of trigeminal neuralgia he believes has resulted. Permanent analgesia of all three branches of the trigeminus assures a permanent cure. Cures of over seven years' standing have followed a single injection. In case only partial analgesia is established, recurrences can be expected. The recurrence can be cured by repeating the injections. In psychogenic cases, which Härtel maintains do occur, and cases of doubtful diagnosis, intracranial injections should not be given. Partial analgesia, omitting the ophthalmic nerve, is technically possible, and is indicated in mild cases in order to spare the cornea, in spite of the fact that this exposes to recurrence. He sometimes determines in advance, by means of a röntgenogram, the size of the foramen ovale and whether there are any anatomic peculiarities in that region. In 41 cases thus treated over six months ago, a complete success was realized in 21 and partial analgesia in 16; 25 have been free from recurrence to date, the intervals since from seven to two years in 13.

**Barlow, R. A.** SPHENOPALATINE GANGLION HEADACHES. [Mich. State Med. Soc. Jl., July, 1920.]

The author calls attention to a sphenopalatine sympathetic headache which may be separated from the migraine medley. Twelve instances are analyzed. The diagnostic criteria are too hazily outlined to permit fidelity in a short abstract and hence reference to the original is necessary.

**Ranzi, E.** EXTIRPATION OF THE GASSERIAN GANGLION. [Wien. klin. Woch., May 20, 1920. B. M. J.]

Trigeminal neurectomy has been performed in sixteen cases at the First Surgical Clinic of Vienna. Three patients died from the operation, one

as the result of an embolism during the operation, and two from meningitis some days later. Thirteen cases recovered, and reports were available in ten, in which the operation had been performed at periods varying from nine years to seven months previously. None of the patients had had a true relapse, and only three stated that they had had slight transient pain from time to time. No ocular damage from section of the first branch was observed. The figures showed that while extirpation of the gasserian ganglion is a more dangerous operation than injection of alcohol into the ganglion, the end results were more satisfactory. Krause's method for exposing the ganglion was at first adopted, but subsequently Cushing's was substituted. The difficulty in the operation depended chiefly on whether the hemorrhage was severe; if so, it usually came from the middle meningeal artery.

**de Lamothe, D.** SIXTH NERVE PALSY ON THE SIDE OPPOSITE TO AN ACUTE SUPPURATIVE OTITIS. [Rev. de Laryngol., Otol., et Rhinol., 1920, April 15, p. 198.]

A girl of nine years had acute right mastoiditis; two days later total right mastoidectomy was performed. Next day headache and incoercible vomiting of cerebral type, but without pyrexia or meningeal signs; spinal fluid normal, no hypertension. Five days later spontaneous horizontal nystagmus to left, with an intermittent pulse; spinal fluid clear under slight tension. Three days later symptoms of acute meningitis, with a turbid spinal fluid under great tension. Two days later lumbar puncture gave relief, but diplopia now disappeared, due to a complete left abducens palsy. The spinal fluid contained a large quantity of fibrin. The patient was treated by daily lumbar puncture (15-20 c.c.) and intraspinal injection of 5 c.c. of electrargol. Complete recovery in about seven weeks. The writer attributes the sixth nerve palsy to the existence of a serous meningitis. As to its occurrence on the side opposite to the acute otitis, he thinks there must have been some special anatomical disposition present, or possibly a constitutional fragility of that particular left sixth nerve which rendered it more vulnerable than its fellow on the side of the otitic lesion. In his case it was the hypertension of the cerebrospinal fluid, and not any infection of it, that was responsible for the palsy. [Leonard J. Kidd, London, England.]

**De Lavergne and Zoella.** SCHICK REACTION IN POSTDIPHTHERITIC PARALYSIS. [Bull. de la Soc. Méd. des Hôp., July 2, 1920. J. A. M. A.]

It is impossible to base a retrospective diagnosis on the findings of the Schick diphtherin test, according to these authors. It may be negative even with pronounced diphtheritic paralysis. To give antitoxin for sequels of diphtheria when there is a negative Schick reaction is contraindicated.