In six years study of the case there was no noticeable change in the patient's system of delusions, nor did he display any emotional disturbance except those of anger and vexation, such as might be found in a normal man.

Dr. Douglas Singer said that he had once visited the man whose case Dr. Leonard had reported, but never examined him. The subject of paranoia is really one of considerable interest in many ways. It depends on the way in which one looks at these disorders. It seems to him that the views of most people are extremely vague as to what paranoia is. It is one of the oldest and most honored descriptions we have in the whole of our nomenclature, but to-day it is gradually losing its various strongholds. It is perfectly true that Kraepelin has attempted of late to define a paranoia which shall be separated from dementia præcox, and from a new group, described as paraphrenia, but so far as Dr. Singer can understand, his attempts at distinction between these are not convincing, especially from the type of paraphrenia. The chief point in regard to the definition, however, is that true paranoia is a condition in which the individuals are abnormal all the way through, from the beginning of their lives. In other words, it represents a progressive development from the time of birth. When one reads Kraepelin's description of the paraphrenic disorders, one finds that same feature still present, at any rate. And it is for that reason that a great many people have dropped the use of the term altogether. We tend rather to speak of them as paranoiac conditions, without attempting to say more about them. But it is perfectly true that now and again one comes across an individual of this type, in whom there seems to have been throughout life a slow, steady, building-up of a system of delusions of this kind—more or less fantastic. However, Dr. Singer would not express a very definite opinion as to whether it is a separate group.

Dr. Leonard said that the case he had reported was very interesting. The man had quite a following, so to speak, in the town near the asylum. The speaker believes that a great many forms of religions, on the order of Dowieism, are just forms of paranoia, and that if this man had been allowed his freedom he could have had a very large following. After he died a couple of patients in the asylum tried to imitate him.

CLINICAL CONFERENCE OF THE NEUROLOGICAL INSTITUTE OF NEW YORK

January 7, 1915.

DR. J. RAMSAY HUNT in the Chair

ANEURYSM OR OTHER LESION CAUSING THIRD NERVE PARALYSIS, TITUBATION AND HEMIANOPSIA

By Edwin G. Zabriskie, M.D.

The case was presented from the First Division. The patient was a widow, 45 years old. Since childhood she has had periodic headaches, migrainous in character. Menses began at 20 and still persist; had one miscarriage at five months twenty-three years ago. Her husband, mother

and two sisters died of tuberculosis. On Wednesday, December 23, 1914, she awakened with severe fronto-occipital headache. The headache was quite unlike the migraine she had had. She felt very dizzy, lay down and took some homeopathic medicine. In the afternoon she felt better and got up and worked. Suddenly a mist came before her eyes and when she attempted to walk and stand she staggered like a drunken woman, lay down, got up again, staggering worse. Lay down again and fell asleep, became unconscious and remained so for four or five hours. She said they tried to waken her but were unable to do so until 2 A. M. She had been there since 7 P. M. On first awaking she did not know where she was for a few minutes. She then tried to get up but fell sprawling to the floor; after a few minutes went upstairs, staggering worse than ever. She felt better by the afternoon; staggering was not so bad and the headaches were less severe.

Two days later the right eyelid drooped suddenly and she saw double. She had many waves of strange feelings over whole body, as though she were going to faint, the headache gradually diminished, and there was no nausea or vomiting.

Examination December 31, on admission to the hospital, showed paralysis of the right third nerve with ptosis, and inability to turn the eye upward, and limitation of movements inward and downward. The pupils, about $2\frac{1}{2}$ mm. in diameter, reacted promptly to light and accommodation, slightly irregular in outline. The station and gait were decidedly unsteady, the feet being wide apart, with an inclination to fall to the left. The squeezing power was slighter of the left hand than of the right and the flexing and extending power of the left lower extremity seemed to be somewhat less than of the right. It might possibly be said that she had a slight left hemiparesis of the extremities. There were no sensory or motor disturbances of the face. The tendon jerks of the lower extremities were lively, with an exhaustible ankle clonus on the left side. The pulse varied from 90 to 120 and was very susceptible to accentuation by effort. Occasionally there was intermission of a beat. The blood pressure varied from 115 to 125 and was equal on both sides. The Wassermann reaction of the serum and the cerebrospinal fluid was negative; the latter reduced Fehling's solution, and contained 30 cells to the cubic millimeter. No abnormality of the viscera was made out. On January 4 she was examined by Dr. Ward A. Holden, ophthalmologist to the hospital, who reported, in addition to the ocular findings above mentioned, a slight but distinct contraction of the left halves of the visual fields for red; the optic discs were normal. The ptosis was not quite so complete as it had been. There is inability to turn the eye upward and mobility is limited inward and downward. The gait is decidedly broad based and titubating; she always falls to the left. Barany's pointing test is correctly executed with the eyes open and shut, no ataxia of the hands or legs. Deep muscular sensibility does not seem to be disturbed, knee jerks are exaggerated, left ankle clonus, no Babinski (this is possibly obscured by defense movements). Pulse 120.

We have therefore a woman subject all her life to migraine who developed suddenly paralysis of the right third cranial nerve, a slight left hemiparesis and a slight left hemianopsia and in whom these conditions persist. The question is where and what is the lesion that is producing these symptoms. The seat of the lesion must be at the base of the brain where the third nerve and the optic tract wind over the cerebral peduncle.

The lesion may be vascular, such as an aneurysm or a thrombosis, it may be a tubercle or possible luetic or may be one of those rare conditions that occur rarely with migraine, a migrainous ophthalmoplegia, and whose pathology is unknown.

The most probable diagnosis is aneurysmal dilatation of one of the posteromesial branches of the posterior cerebral artery. Such lesion best explains the symptoms and their conduct. Were the lesion in the peduncle itself the syndrome of Weber would be present, *i. e.*, alternating superior hemiplegia: complete paralysis of one side of the body, including the face and paralysis of the third nerve of the opposite side. We may be right in assuming that the weakness of our patient's left side is the expression of a slight encroachment on the peduncle by a lesion such as aneurysm, tubercle, or gumma even, and that her symptoms constitute therefore the Weber syndrome not fully developed. In view of the fact that the Wassermann reactions are negative even after the administration of what has been called a provocative dose of salvarsan (0.4 gm.) and that there are no somatic evidences of syphilis that diagnosis may be excluded. A local tuberculous deposit cannot, however, be so safely excluded. The existence of 30 lymphocytes to the cubic millimeter in the cerebrospinal fluid suggest tubercle and the patient's history of exposure to the infection must be kept in mind.

There are many reasons why the case was not believed to be an example of ophthalmoplegic migraine. In the first place, it is improbable there are any cases in the literature since Charcot first called attention to the remarkable occurrence, *viz.*, oculo-motor palsy occurring in the course of an attack of migraine, and recurring, in which the paralytic accompaniments of the attack came on when the patient was as old as this one is. In the second place her present symptoms were not ushered in by phenomena of migraine, and in the third place the symptoms other than the third nerve symptoms, namely, the reeling, the hemiparesis, and the hemianopsia are not features of ophthalmoplegic migraine.

CONGENITAL CEREBELLAR ATAXIA

By Henry K. Marks, M.D.

The patient, from the First Division, is 5½ years old. His father is healthy. His mother for the past few months has been complaining of headache and constant dull pain in the right shoulder and arm. Her serum Wassermann has been reported positive and she is under treatment in the hospital. There is no history of hereditary or familial diseases. No consanguinity exists between the parents. A maternal aunt has paralysis agitans.

There are three other children besides the patient, all older than he. They were full-term babies and are healthy and thriving. The eldest is now 18. The mother had one miscarriage after the birth of the patient. The patient himself was a full-term 7½ pound baby. Labor was prolonged and difficult. After thirteen ineffectual hours it was discovered that he was a transverseling. Instruments were resorted to and the child was born asphyxiated. For two hours he gave no sign of breathing. Soon after he began to breathe, he was fed by spoon and swallowed naturally without regurgitation. From the time of birth till two weeks later