discharges of urine, and again this symptom would occur with sudden pallor of the face, without the least loss of consciousness.

Case 5. A man of strong hereditary predisposition to insanity, during a fit of depression, shot himself in both temples, but did not die. Epileptic fits supervened, and his mental condition made his commitment unavoidable. He had very severe seizures, and at times, in connection with them, complained of a peculiar sensation in the left side of the face. Examination disclosed complete anesthesia of the region supplied by the first and second branches of the trigeminus, with blanching of the skin and development of wheals over the affected area. The condition would last several hours and would as quickly pass away. At times it would occur without any convulsion or disturbance of consciousness. The author is inclined to regard this as a case of reflex epilepsy, due to wounding of the trigeminus.

The author follows Binswanger in making three classes of causes of epilepsy, viz., preparatory, predisposing and exciting. Of 741 cases studied, the proportion of males to females was 5 to 4. In the first decennium 53.4 per cent. were found affected for the first time, equally divided between the two sexes; in the second decennium 35.5 per cent. (more females) and only 11.1 per cent. of them were attacked after the age of 20 years. In 386 of the cases a predisposition was in evidence (303 inherited, 83 acquired). Of 303 inherited predisposition, 204 were of neuropathic antecedents, 63 toxicopathic (alcohol, syphilis, etc.); insanity or nervous diseases were present in the ancestry of 59 per cent.; epilepsy in blood-relatives occurred in 61.66 per cent.; epilepsy in parents in 23.75 per cent. The epileptic descent was more often from the mother's side; the father usually transmitted to the son, the mother to the daughter. With regard to acquired predisposition, the following casual moments are cited: Revaccination, 2 cases; alcoholism, 14; trauma, 28; sunstroke, 1, etc. Of determining causes are cited: Dentition, 29; puberty, 15; trauma, 24; intoxication or infections, 30; psychical shock, etc., especially fright, 65; miscellaneous, 18.

Sensory symptoms in Jacksonian epilepsy have always been regarded as accompanying manifestations of the motor phenomena. A. Fuchs attempts in this article to systematize the knowledge on this subject by an examination of the cases quoted in literature and by observations on eleven cases of his own. In regard to the etiology of the paresthesias we must at present assume that they depend upon the general cause of the disease itself. The phenomena of sensory Jacksonian attacks alone or as accompanying symptoms of the motor attack, are found in the following conditions: First, in the prodromal stage of progressive paralysis. They can in such cases appear as the first somatic symptoms of the disease. In one hundred cases their appearance was noted thirty-seven times. In five cases the sensory Jacksonian symptoms alone were present. Second, in diseased conditions of the brain which are limited in extent, such as tumors, abscess, cysts, etc. Third, in encephalomalacia. In this division observations are
limited. Fourth, hemicrania symptomatica. Krafft-Ebing found twenty-one cases in literature and three of his own. The conclusion seems justified that the sensory primary element of the central organ is much more easily acted upon than the motor element by noxious substances, and that in the ganglion cells, which have to do with sensory functions, the summation of stimuli first reach their effect, and by means of mere contiguity the motor explosion takes place. Sensory Jacksonian attacks are always indications of an anatomical central lesion. This symptom obtains a definite symptomatic importance when it accompanies hemicrania tardiva.

Schwab.

129 "Epileptiforme Anfälle in der Reconvaleszenz eines Unterleebystyphus" (Epileptiform Attack During Convalescence from Typhoid Fever). Mühlig (Münchener med. Woch., 1900, No. 7, S. 221).

The author reports the case of a previously healthy man of twenty-three years, who after an attack of typhoid of moderate severity, having been free from fever for twenty days and while upon light diet and apparently doing well, had suddenly, at 3 A.M., a severe epileptiform attack, with loss of consciousness and convulsions, beginning with twitching in the little and ring fingers of the left hand. This was followed during the ensuing day by three similar attacks, after which the patient made an uninterrupted recovery, complaining of nothing more than some tingling of the two fingers of the left hand in which the twitching began. The urine was normal, as was also the heart; the author could find nothing to account for the convulsions. During a period of observation extending over a year he had developed no more attacks.

Allen.


Mirallié reports the history of a man thirty-six years old, vigorous, and having no neuropathic family history, who was trephined unsuccessfully for epilepsy. The man had fallen seventy feet and sustained a fracture of the cranium. Four years after recovery from this injury he developed epilepsy without tangible cause. Before each convulsion he would have an hallucination of seeing his dead friend. Some of the crises had a somnambulistic character; he had both grand and petit mal attacks. There was anesthesia on the right side of the body; special senses also were dulled on the right side. His only seeing eye, the right, was hemiopic (inner side); both optic nerves were atrophic. One hysterogenous zone was found in the right axilla. Cleatix of old fracture was visible and evidences of depression were palpable in line of the old fracture. Patient was first trephined along line of scar; parts beneath depressed bone were compressed, but otherwise normal. A second trephine opening was made over the motor cortical center of the right arm. Bone-disks were not replaced and the meninges were sutured to the skin. There was improvement for five months, there being no major attacks during that time, but at the end of that time the major attacks returned and rapidly became worse than before. Mirallié joins the ranks of those who no longer believe in craniectomy for epilepsy. The case is of special interest from the fact that there was every reason to expect a different result than the one that occurred.

Clark.