Society Proceedings

PHILADELPHIA NEUROLOGICAL SOCIETY

October 24, 1905.

The President, DR. JOSEPH SAILER, in the Chair.

Atrophy of One Lower Limb, following Specific Urethritis.—This case was exhibited by Dr. J. W. McConnell.

Testing the Iris Reaction to Light.—Dr. Pickett said that in testing the light reaction it is customary to have the patient look into infinite distance, that is, at some object about 200 feet away, while the examiner covers one eye with the hand or with a piece of card-board and then quickly uncovers it, observing the change in the size of the pupils. Dr. J. W. McConnell, last summer, was in the habit of using a pocket electric lamp for illuminating the eye, and making the contraction of the iris more complete. This brought to Dr. Pickett's mind the use of this apparatus in a particular way. He mentioned some objections to the use of this apparatus, as of any artificial light, in the ordinary way. When the light is flashed at one side the patient thinks of that light; and if there be such a thing as Haab's "psychic reflex" a part of the contraction of the iris must be accredited to it. Certainly a fallacy of the ordinary method is that the patient tends to accommodate for some near object when his eye is uncovered, and the contraction of the pupil which occurs is partly a contraction in convergence and accommodation. The average patient is apt to look at the examiner's face or hand.

Now in this particular method having the patient fix upon the bulb of this handlamp both pupils contract, representing a combination of the reaction in accommodation and convergence with the so-called Haab's psychic reflex. The patient still fixing upon this bulb, Dr. Pickett flashes the light and a further contraction of the pupil occurs, which must be a pure light reflex. Some one may say that the pupil being already contracted in convergence, the further contraction, by flashing the light, must be only a partial reflex to light. His answer to this is that where the light reflex was doubtful by the usual method, it became very striking by this method; and while it is perhaps a residual light reflex, it is so distinct that Dr. Pickett thinks it has some advantage over the usual methods. An objection which Dr. de Schweinitz has to this method is that the moment a light is flashed in front of the patient's eyes, he squeezes the lids and what is known as the Westphal-Piltz reaction enters into the contraction observed. However, as the Westphal-Piltz reaction is a momentary phenomenon the pupil must return quickly to the size determined by the other factors named.

The case Dr. Pickett presented was one of tabes in which the light reflex by the ordinary methods was not distinct. Having him look at this bulb, however, it was seen what a strong reaction there was to light.

Dr. Dercum thought the method had a distinct value. He thought the fact of eliminating the reactions of accommodation and convergence a distinct gain. He did not think that the objection in regard to the Westphal-Piltz reaction is of much moment. He thought it might interfere with a very delicate test, but in such cases the test for the consensual light reflex would aid in settling the question. In studying doubtful cases of light reaction, he thought we should take both the

consensual and direct light reflexes. For the relative presence of light reaction, however, he thought the method of Dr. Pickett a valuable one.

Dr. Weisenburg thought the method a very valuable one. He stated that he had never seen a pupil contract in accommodation and did not believe accommodation had anything to do with it. He called attention to a new pupillary reflex. He stated that the Westphal-Piltz reaction was demonstrated a number of years ago, and consisted in contraction of the pupils by attempt to close the eyes. He stated that he had never seen this without at the same time noticing a movement of the eyeball, and it struck him that this contraction of the pupil is really an associated movement. When the eyeball moves upward, the pupil contracts. This contraction he did not believe to be a reflex at all, but an associated movement. If, while the eye is closed, the eyelid is suddenly lifted a contraction of the pupil occurs. He stated that he had examined many cases of facial palsy, and upon lifting the eyelid upon the affected side, he did not get this reaction, which would indicate that the seventh nerve forms part of the arc. He believed this to be a new reflex, and that the seventh nerve as well as the third took part in it, because it is absent in seventh nerve paralysis. To explain this, it is necessary to consider the seventh nerve as partly sensory, and Dr. Weisenburg believed it to be such, this belief having been borne out by many reported cases.

Dr. Pickett, in answer to Dr. Dercum's remarks, stated that in studies on cases of paresis at Blockley they had decided that the consensual reflex was no more delicate than the light reflex and corresponded to it. He said that the advantage which he and Dr. McConnell claim for this method is that it appears to be more delicate than the light reflex by the ordinary method.

In cases of tabes in which the light reflex was very slight by the ordinary method and the residents declared it was absent, it was strong by this method, and if there was no grave fallacy in the method, it possessed a decided advantage over the old one.

A Case of Double Ego.—This paper was read by Dr. Alfred Gordon.

Dr. Pickett said he had reported a similar case about a year ago. He believed the guiding phenomenon to be motor hallucinations, as described by Séglas, Ballet and others rather than sensory hallucinations. The motor speech center being active, there are voices speaking in the patient, and by other motor centers he is led to do things independently of his will. This long continued control of the patient by forced movements leads to the idea that he has a double personality. These belongs to a different class of cases from those of double or alternating consciousness.

Dr. Lloyd thought there were three conditions in which this curious affection of the sense of personality existed, namely hysteria, epilepsy and delusional insanity. He thought hysteria could be excluded in this case and that it was most probably an epileptic condition. He did not attach much importance to the attempts of the patient to explain his own symptoms. He thought the patient had heard too much scientific talk at clinics, and he attempts to use terms which he has heard doctors use in explaining his condition. He considered that the loss of consciousness and the long sleep afterward led to the diagnosis of epilepsy. Gowers thus explains the case of a cabman who in a state of epileptic automatism would drive through crowded streets without an accident and remember nothing about it afterwards. Dr. Lloyd thought there were some things about Dr. Gordon's case that would suggest delusional insanity, and it was possible for the two diseases, epilepsy and delusional insanity, to go together. All things considered, however, he believed that epilepsy would best explain the condition.

Dr. Riesman recalled the case of Mrs. Piper, a sort of medium,

who had a triple personality. In the beginning of her career she was controlled by a Frenchman. She did not understand French, but in her séances would speak French fluently. She later became controlled by another personality. Sometimes one personality would express his ideas in writing, while another would speak through the mouth, and she could thus answer two sets of questions at once. While not a case of epilepsy or insanity, this case was brought to his mind by Dr. Gordon's paper.

In closing the discussion of this paper, Dr. Gordon stated that his reason for calling this a case of double ego were as follows: Cases have been reported of double personality, but none of them resemble this: here is a man who is perfectly conscious of what is going on about him and he is convinced that he like any other individual is divided into two. Dr. Gordon did not believe, therefore, that this could be called a case of double personality. He did not believe the case could be one of paranoia. He stated that he had looked up the literature for a period of seven years and had not found a case like it. The fundamental difference between his case and those recorded is in the fact that in the recorded cases the patients passed through the different states alternately, while in this case the two egos coexisted at the same time. In regard to the diagnosis, he believed that the case was probably a post-epileptic psychosis.

A Case of Crural Monoplegia probably Representing the Early Stage of a Unilateral Ascending Paralysis due to Degeneration of the Pyramidal Tracts. This case was reported by Dr. C. K. Mills.

Dr. Chas. K. Mills exhibited a brain showing arteriosclerosis and two areas of necrosis, one cortical precentral and the other in the pons near or involving the dorsal longitudinal bundle. The main feature of the symptomatology were Jacksonian epilepsy and paralysis of associated movements. The case will be later reported at length.

Dr. McConnell said in summing up the case, the cortical lesion only became active because of the attack of uremia, this part of the cortex being the place of least resistance.

CHICAGO NEUROLOGICAL SOCIETY.

October 26th, 1905.

The President, DR. HAROLD N. MOYER, in the Chair.

A Case of Brown-Séquard Paralysis.—This was presented by Dr. Julius Grinker.

J. S., an Austrian laborer, aged 24, entered Cook County Hospital, September 14, 1905.

About five months ago, during a quarrel in which knives were used, he sustained a stab wound in the middle of his back and several large and small flesh wounds upon the posterior portion of the right thigh, almost immediately thereafter a complete paralysis of motion appeared in the right lower extremity, which compelled him to remain in bed three months. Improvement was slow, but he gradually began to use his limb, so that now he is able to walk without a cane. Almost from the beginning he complained of pains in his right thigh and leg, which still persist, although in a mild form. The entire left lower extremity feels cold since the accident, and sensation in this limb is either perverted or entirely abolished. At no time have the sphincters been involved.

Dr. Grinker said that upon examination the patient was well nour-