

cessively severe, but rather a dull, deep ache, with exacerbations, sometimes in the morning and sometimes in the evening.

Oculomotor palsy occurs at a variable time after the appearance of the pain. It is always unilateral and quite complete, affecting only the side upon which the pain is seated. The most peculiar characteristic of the disorder is its tendency to relapse and to exhibit a periodicity in the relapses. Remak observed relapses at intervals of three months; Von Hasner, every month; Clark, every week; Moebius had a patient in whom the crises returned during the month of August in three successive years; Thomsen, one in whom they occurred in May and October. In time this periodicity gives place to a permanent condition. The author does not agree with Charcot's opinion that these two successive stages of periodicity and permanence are independent. The phase of periodicity lasts for a variable time with accompanying phenomena of malaise, nausea, vomiting, photophobia; in a word, the symptoms of ordinary migraine. The paralytic period follows this at an interval varying from hours to weeks. There is usually a rapid succession in this order: the upper lip drops, the eye turns outwards, the motor feebleness appears throughout the distribution of the third pair; the patient suffers with diplopia, complains of an inability to read at an ordinary distance due to paralysis of accommodation. This second state lasts from hours to months, the phenomena usually disappearing rather rapidly, but not suddenly, to return in the order in which they previously occurred after an interval more or less considerable. The pathological anatomy remains a matter of hypothesis. The suggestion of Charcot was that the disorder was wholly functional, but that by repetition these troubles determined organic alterations at the region of the oculomotor nerves. The treatment suggested is a long course of bromide with the addition of iodide of potash for the circulatory disorders, and electricity in case the paralytic symptoms are persistent.

MITCHELL.

MIGRAINE ALTERNATED WITH METATARSALGIA.

At the French Congress of Alienists and Neurologists, M. Lamacq (*La Médecine Moderne*, Aug. 12th, 1896) described a single curious case in which the patient had a regular alternation of neuralgia of the right foot with right hemicrania. The trouble of the foot is not minutely described in the report, but L. calls it Morton's disease. The duration of the two phenomena was identical, either lasting about twenty-four hours. If the course of the foot-neuralgia was arrested, as by a warm bath, it was replaced in a few hours by migraine. During the attack of metatarsalgia the same general accessory symptoms were present that would accompany a classical migraine: pressure in the head, difficulty in intellectual application, loss of appetite, nausea, etc. A perfect equivalence seems to be made out for the two phenomena.

MITCHELL.

TWO CASES OF MORTON'S DISEASE.

At the French Congress of Alienists and Neurologists, M. Lamacq (*La Médecine Moderne*, Aug. 12th, 1896) describes two cases which he calls Morton's disease, the first of which was rapidly cured by sulphur baths; the second, in which neurasthenic symptoms played a part, disappearing more gradually. There was no relaxation of the plantar arch in either case, and both of them seemed rather to have been ordinary cases of neuralgia, possibly rheumatic in origin, than to conform to the classical type of Morton's disorder.

MITCHELL.

CONCUSSION OF THE SPINAL CORD. Willard and Spiller. *N. Y. Med. Jour.*, March 6th, 1897.

These authors give us the results of a case of fracture of the eleventh thoracic vertebra. The patient received a severe blow from

a trolley car in this region. The lower limbs were completely paralyzed, no involuntary movements were noticed. Sensation lost entirely below Poupart's ligament, except on the front and outer parts of the thighs (ext. cut. nerves). Inability to urinate and defecate was presented. The 11th thoracic vertebra was found elevated, the 12th depressed. Death from exhaustion. The autopsy revealed considerable extravasation of blood into the muscles and connective tissue at the seat of injury, the laminae of the 11th thoracic vertebra were fractured, and there was extradural hemorrhage. No displacement of the vertebral bodies. The dura was intact, and no hemorrhage was observed within it. The cord was firm, of normal shape, and showed no signs of softening exteriorly. No indications whatever were evident macroscopically of pressure on the cord, microscopically were found displacement of fibres in one portion of the cord, numerous hemorrhages, altered blood pigment, masses of granular corpuscles, necrosed tissue, swollen axis cylinders, tumified ganglion cells and round cell infiltration. The spinal roots contained a few swollen axis cylinders, and the medullary sheaths did not stain quite so deeply with haematoxylin as normally. Blood vessels everywhere much dilated. The pathological results are the more important as they occurred early, the patient dying five days after injury. After citing various cases bearing upon their subject, and one recently published by Westphal similar to their own, the authors call attention to the facts recorded in this case. Paralysis of the lower limbs ensued immediately after injury, yet no lesions due to compression through fracture pressure were found. They consider the symptoms due to the pathological changes found in the cord, and the case one of so-called concussion of the spinal cord in which condition we are not wont to await clear structural changes. The communication is of great importance, and contributes not a little to the possible pathology of "railway spine" and the traumatic neuroses. When we consider that cases of this character, unless there be serious damage to the cord which can be determined exteriorly, seldom come to autopsy early after the injury, the changes enumerated above assume more dignity. Their significance for those cases which, after a lapse of time, we usually consider purely functional in nature, *i. e.*, traumatic neuroses, traumatic neurasthenia, etc., should not be underestimated especially as these cases so frequently demand recognition before courts of law.

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TRAUMATIC NEUROSES. A. L. Hall, M.D. (Med. Record, Sept. 26th, 1896).

The surgeon should be an equal authority with the neurologist in determining the sequences of trauma upon the nervous system. Neurasthenia is the usual form under which traumatic neurosis expresses itself, and its symptoms are indistinguishable from neurasthenia arising from other causes. The actual condition of the patient previous to the accident must be known in order to reach a correct estimate of the injury sustained by the nervous system. The type of symptoms manifested, whether neurasthenical or hysterical, is often a question of vital importance in the adjudication of a claim for damages. Traumatic neurosis occurs oftenest at the centres of population, but is by no means rare in country districts. It is probable that traumatic neurosis is dependent upon some definite, yet unknown change in the arrangement and structure of the cellular elements of the nervous system, which gives rise to stable rather than unstable symptoms. A stable, well-organized symptom-complex indicates damage to the nervous structures, while instability of symptoms and want of orderly arrangement denotes trivial injury, and if long continued, simulation is rendered probable. The so-called "objective symptoms" depend upon the psychical rather than the physical state of the subject, and