interest because the other tumors had not been painful. It may have been that the previous tumors developed many years before as areas of painful fat.

Another matter Dr. McCarthy mentioned was in connection with syphilis where widespread changes in the lymphatic system occur as an etiological factor in *adiposis dolorosa*. In the case studied by Dr. Dercum and himself there were extensive hemolymph tissues, not only scattered throughout the body, but in the adipose tumors, and he thought perhaps it represented an attempt by nature at compensation for disturbance of lymph tissue elsewhere in the body.

A CASE OF PROBABLE TUMOR OF THE BRAIN OF PARIETO- OCCIPITAL LOCATION.

By Dr. J. W. McConnell.

H., aged 53 years, a plasterer, was admitted to the Philadelphia General Hospital, complaining of loss of power in the left side and staggering.

He gave a history of an attack of unconsciousness occurring seven years ago, preceded by dizziness and an indescribable illness, accompanied by twitching of the left face and followed by transient loss of power in the left upper and lower extremities and persistent numbness of the left hand and forearm. At irregular intervals subsequently he had twitching of the left face, up to one year ago when he had a violent convulsive attack involving the left half of his body without loss of consciousness and without modification of the symptoms residual from the previous attack.

His family history was negative. His personal history contained alcohol, tobacco and probably syphilis. He stated that he suffered for a long time from headache, recently growing worse, especially after the convulsive attacks, from dizziness and occasional nausea without adequate gastric cause.

Examination shows a hemilateral ataxic gait, better brought out by sudden turning. He sways some with eyes open and considerably with eyes closed.

Mentality is excellent, memory good, both for past and recent events. He has not aphasia, word, letter or number blindness, word deafness or agraphia.

There is no difference in the pupils which respond to light, convergence and accommodation. Extraocular muscles are normal. There is no nystagmus, no loss of any associated movement. Examination of vision shows left lateral homonymous hemianopsia without pupillary inaction, with contracted fields, without optic neuritis or atrophy. The motor fifth, the seventh, in fact all the cranial nerves seem to be normal.

The movements of the left upper extremity are weaker than the right, but are of good power, they are slow and ataxic. The reflexes are increased. The movements of the left lower extremity are similar to the upper. The reflexes are increased. Ankle clonus is not obtained. Plantar stimulation gives no response.

The right upper and lower extremities are normal in all respects. Plantar stimulation of the right foot gives plantar flexion.

A convulsive attack observed by the resident physician had for its features a preceding numbness of the left arm. The left hand, arm, face and leg in sequence were tonically convulsed and the patient asked to be laid down. He became unconscious, and the convulsion drew the head upward and to the left, the face was drawn to the left, eyes up and to the left, the body in left pleurosthotonus. Later the convulsion became clonic and general.

Sensation: On the right side is normal to all forms of stimulation. On the left side tactile sense is diminished over the arm and leg, it being almost lost on the hand and forearm. Hypalgesia is found in the same areas. Temperature sense is not disturbed. There is marked ataxia in all movements of the left upper and lower extremities. Pas-

sive movement is not always recognized, especially is this true of the fingers. There is loss of stereognostic conception in the left hand.

The general features of the case are those of a growth, probably of specific origin, located in the parieto-occipital region of the right brain. His previous improvement under treatment and his present betterment under mercury and iodides both suggest the syphilitic nature of the lesion.

ASTEREOGNOSIS WITHOUT MOTOR OR SENSORY INVOLVEMENT.

By Dr. T. H. Weisenburg.

The patient said he was under the care of Dr. R. S. Dorsett, of Philadelphia, with whom he was seen in consultation by Dr. Weisenburg, and subsequently by Dr. Mills.

The man was thirty-two years old, with no history either of alcoholism or syphilis, was perfectly well until three weeks before coming under observation, when he awoke during the night with a pain in the left side of the back of the head and in the same side of the neck, this pain disappearing the following morning. Two days after this, he began to complain of a numb, dead feeling in his left arm, followed in a day by similar sensations over the left chest and abdomen and the left leg. These sensations have persisted. About two weeks after the onset of these sensations he noticed that the grip in his left hand was not as good as before when his attention and eyes were directed elsewhere than to the object grasped. He has never had headache, nausea, vomiting or any disturbance in his eyes.

When examined his eyes and cranial nerves were found to be in a normal condition. The grip of the left hand, when his attention was called away, was not as good as when he was looking directly at his hand, in which case it was normal. The left leg, like the face and arm showed no weakness. The reflexes were somewhat prompt, especially on the left side, but no Babinski was present. Sensation for touch, pain and temperature, and tone sensation were normal over the left side and everywhere. The senses of position and movement were lost or greatly impaired in the fingers of the left hand, the loss becoming less as the thumb and forefinger were approached. To a less extent the sense of location was disturbed, more so, as the radial side of the hand was approached. The sense of pressure was normal. He could not recognize any object placed in or manipulated by his left hand, the astereognosis being absolute. The hardness or softness of an object, or its surface contour could, however, be recognized, but only by the tips of his forefinger and thumb, especially the latter.

The patient was placed upon daily mercurial inunctions with increasing doses of iodides. He seemed to improve almost immediately and in the course of six weeks all of the symptoms above detailed disappeared first, and as the patient improved he was first able to recognize objects placed between the thumb and forefinger, and later on in the other fingers. At the present time, several months after the patient was put upon treatment, no neurological symptoms of any sort can be found.

Dr. Mills said that with regard to the case presented by Dr. Weisenburg, which came under his observation, this man was carefully studied by him. He had taken him into the lecture room and demonstrated the facts spoken of by Dr. Weisenburg, namely, the presence of astereognosis and the absence of motor paralysis and of all sensory symptoms. He said that he had studied the patient on several occasions and the condition remains the same, with the exception that the astereognosis gradually receded until he now is practically normal. He thought the case important from the standpoint which Dr. Weisenburg referred to, that which he had personally held and taught, namely, that there were separate cortical centers for movements for cutaneous and muscular sensibility and for stereognostic conception.