severe. Examination showed diminution of both knee jerks with irregular pupils which reacted very sluggishly to light. The spinal fluid showed a cell count of 10 lymphocytes on the first and 40 lymphocytes on the second examination with a faintly positive Nonne and Noguchi. The Wassermann reaction was negative upon the serum, but three plus positive on the spinal fluid. The patient gave a history of drinking liquor to excess for a great many years. Dr. Hall thought the case one of both gastritis and gastric crises of tabes.

Dr. Grinker said that the specimen which was passed for examination reminded him of the fact that in gliomata hemorrhages are not at all uncommon. In his own experience he recalled a case which was almost as interesting as this one, in a patient who was secretary of a labor organization. He received a trauma from a brick which fell upon his head, causing a scalp wound, and what was considered at that time an abscess of the brain was the result. He was treated and a month later developed a rightsided hemiplegia with aphasia. He was in a stuporous condition and the diagnosis in that case appeared to be a cerebral abscess, considering the fact that only a month previously he had sustained the trauma to his head, which was suppurative in character. He was operated upon but the surgeon failed to find the abscess and the patient died. A post-mortem was obtained and a hemorrhage was found which involved the internal capsule, the motor tracts, and extended outward to the speech centers, so that he had a complete motor aphasia. The hemorrhage occurred in a glioma which was traced to the anterior horn, where there were evidences of two old hemorrhages. It appeared that not until the third hemorrhage when the motor areas had become involved were there any symptoms. In examining the history of the case, the only evidence of something wrong was that two or three months previously this secretary, who had always been prompt in collecting the dues for his organization and giving the members credit, had forgotten the names of those who paid him and made mistakes in his books. He had never complained of headache and had no other symptoms of brain tumor. The specimen was interesting because it showed three kinds of hemorrhages of different age; the first was probably two years old, the next one year old, and the last one was quite recent.

Dr. Patrick wished to know whether Dr. Hall had carefully examined for sensory disturbances on the abdomen, as cases with gastric crises usually showed something there when they failed to show anything elsewhere.

Dr. Hall said he had examined carefully and had found no sensory disturbances.

A CASE OF DERCUM'S DISEASE

By Julius Grinker, M.D.

The patient, a man of about fifty years of age, came to the hospital for nervousness and incipient delirium tremens.

He was weak and nervous, complained of failing vision and was short of breath, especially on exercise. He entered the hospital for the first time in 1909 for a pronounced mitral lesion. Even at that time he related that shortly after he had developed heart trouble he had noticed several small lumps on his body which were very painful and tender on pressure and occasionally caused spontaneous pain. In 1906 appeared the first nodule on his left arm. Later a second one developed on the opposite side, but not in symmetrical order. Then nodules appeared on the trunk, abdomen and thighs. These were small tumors under the skin which had the peculiar feel of fatty tumors. No evidence of their existence was seen on the skin itself. In many cases there has been noticed a peculiar whitish spot over the skin

before a nodule develops. In general the patient had the feeling of soreness, rather a paresthesia than pain, unless the nodule was being pressed.

He admitted having had a chancre twenty-two years ago and had been a heavy drinker for many years, principally whiskey. Was married but no offspring. There was double optic neuritis, the pupils were sluggish to light and both Achilles jerks were lost, though the knee jerks were still present. Wassermann reaction strongly positive. There were lues, alcoholism and *adiposa dolorosa* in the same patient. This may be important when considering the etiology of *adiposa dolorosa*.

Dercum in 1888 and 1892 first described this disease. It consists of the formation of fat nodules in various parts of the body either in circumscribed or diffuse distribution. There is a variety of the disease in which the discrete nodules become almost generalized. This variety resembles general obesity more than anything else, but the characteristic point is that the nodules are painful to the touch. In many of these cases there is even a relative degree of objective anesthesia. In other cases there is hyperesthesia. Dr. Grinker's patient had hyperesthesia over a great part of the skin of his back. The pain is variously described by different patients as burning, paroxysmal, spontaneous, or may only be elicited on pressure. The lumps never occur on the hands, face or feet, but are found on the trunk, thighs and abdomen, as well as over the arm. A not rare symptom is some degree of mental weakness. Many patients have suicidal tendencies and others mere dementia. Dr. Grinker's patient was not mentally weak but rather emotional which might in this instance be due to alcoholism.

As to the pathology we are still ignorant. The thyroid and hypophysis have been found enlarged in many cases. There was no thyroid enlargement in Dr. Grinker's case and the radiogram showed a normal hypophysis. There was a suspicion, however, of calcified pineal gland, according to the radiograph.

Dercum believes this disease belongs to those caused by glandular disorders, but pathological findings have thus far been indefinite. Increased connective tissue and fat have been found among the contents of the nodules.

In the treatment thyroid tablets have been recommended but thus far no cures have been recorded. For the syphilis the patient was given antisyphilitic treatment.

HYSTERICAL HEMIPLEGIA WITH HEMIANESTHESIA

By Julius Grinker, M.D.

The patient is married and has two living children. Two years ago she was operated on for a perineal tear. She left the hospital well, but later developed gonorrhea and then gonorrheal arthritis, for which complaint she returned eleven months ago. Her right knee was placed in a cast and she recovered. After the cast had been removed she fell in the ward one day and the next day her left side was paralyzed. This paralysis has remained about the same. The left arm and leg were involved but not the face. The gait is typical; a dragging gait, and it does not correspond to any known organic gait, neither to the spastic, the steppage or the ataxic stamping gait; it is the typical hysteric gait described long ago by Charcot. Diagnosis can almost be made from a glance at this gait. Of course, there is no Babinski sign, nor spasticity, nor other evidence of pyramidal tract lesion.

An interesting feature is the combination of hemiplegia with hemianesthesia and hemialgesia beginning exactly in the middle line. This is true hemianalgesia.

In addition there is a contracted field of vision, so-called tubular vision.