the nose. Acromegaly was beginning and the sella turcica was large. The right disc was atrophied, this eye being blind; the left had vision of 0.06 after correction, 0.15 before. The röntgen rays were applied in crossfire from seven fields, for fifteen minutes each, from the brow, temples and anterior fontanel. By the second sitting vision was materially improved. Fourteen exposures were made in the course of four months, and vision constantly improved in the left eye and the right was able to recognize objects. A year later the acromegaly had almost completely subsided, but menstruation had not returned. The author thought that pituitary feeding might be added to advantage.

Pouliot, L. OBSTETRIC PITUITARY TREATMENT. [*Médecine*, April, 1920.]

Since pituitary extract has so strong a contractile power on unstriated muscular tissue, any mechanical cause impeding delivery is a contraindication to its use. To give more than 0.10 gm. of the fresh gland is dangerous. Intramuscular or subcutaneous injection are the proper methods of use. The dose should not be repeated unless the action of the first is exhausted, allowing a two hour interval.

II. SENSORI-MOTOR NEUROLOGY

2. MID-BRAIN.

V. Monakow, C. ADDITION TO V. ECONOMO'S TREATISE ON ENCEPHALITIS LETHARGICA. [*Schweizer Archiv. f. Neurol. u. Psychiat.*, 1920, Vol. 6, No. 2, p. 293.]

V. Monakow fully recognizes a certain independence of the disease which v. Economo, doubtless, was the first to describe and adds some remarks of histopathological nature. From his examinations of cases belonging to this group he places the point of origin of the pathological changes in the veins of the brain stem which are situated near the base. These changes are certainly most pronounced in the floor of the third ventricle, in the central gray matter of the aqu. sylvii, in the form. reticularis of the brain stem (region of the nuclei of the eye muscles), and he considers these veins as the starting point of the disease processes. On serial sections at a certain distance from the small disseminated extravasations of blood, infiltrated vessels, glia proliferations, accumulations of white blood cells, products of decay, etc., described by Economo, it was easy to discern in some of the medium sized veins white stratified thrombi, which were continued in smaller branches. The vessels thickly infiltrated with lymph cells, etc. (accumulations of swarms of lymphocytes in the adventitial sheaths) are usually the central continuation of these thrombosed veins. The congestion, in the author's opinion, is a secondary phenomenon specially conditioned by the white thrombi. The same is true of the capillary extravasation. In the brain tissue immediately surrounding the thrombosed veins there are zones of reaction

with accumulation of ameboid glia cells, products of decay and the like. From an histopathological point of view the main difference between the encephalitis lethargica and encephalitis of influenza, which makes its appearance more in the form of lesions, is set forth. V. Monakow had observed many cases in the epidemic of 1889 and still possesses microscopic preparations of some of them and states that in the influenza encephalitis the white inflammatory thrombi which stand in connection with the pathological changes of the blood colonize in the large arteries, especially in the cerebrum, and condition extensive necrotic lesions. In encephalitis lethargica, on the other hand, the thrombi are likely to be found in the veins (of the brain stem), causing phenomena of congestion together with changes in the ependyma and in the choroid plexus. As the affection extends to the capillaries and parenchyma a varied histological picture is presented (often without coming to actual necrosis of the tissue). In this form of encephalitis the cause of the processes is probably an excess of CO₂ and in the other encephalitic type to deficiency of blood containing oxygen. [J.]

Demole, V. MYOCLONIC LETHARGIC ENCEPHALITIS PREDOMINANTLY UNILATERAL. DELIRIUM TREMENS AT ONSET. [Rev. Méd. de la Suisse romande, 1920, June, p. 354.]

A carter, 50, mentally feeble and alcoholic, had malaise, vertigo, and shocklike contractions in limbs, followed by increasing fatigue and delirium. On admission he gave the picture of a delirium tremens: agitation, titubation, disorientation in time and space, but with retention of autopsychic orientation, tremors, visual hallucinations, pyrexia and sweating. His delirium was "professional," turned on horses, etc. In five days all this quickly ceased. Then he had tremors of tongue and of hands, especially the left, somnolence and lively reflexes; also involuntary pronation and supination movements of left arm, and rythmical contractions of abdominal muscles and diaphragm at rate of 20 to 26 a minute. The abdominal myoclonus began always on the left half of the abdominal wall. The somnolence increased but the myoclonus became less frequent and slower (10 a minute) a month after the onset. A slight touch on the skin of the left half of the abdomen gave immediately a contraction of the left abdominal muscles, followed directly by contraction of the right. This sensory zone (Th. 10-11-12) is slightly hyposthetic. The umbilical cutaneous reflex is abolished. The spinal fluid showed lymphocytosis, hyperalbuminosis, the presence of globulins, and a positive Noguchi reaction. Recovery about seven weeks after the onset. [Leonard J. Kidd, London, England.]