Dr. John Punton read a paper with the title: Hereditary Spastic Paraplegia. Report of Seven Cases in Two Families. (See this *Journal*, 1909, p. 588.)

OCCUPATION NEURITIS OF THE THENAR BRANCH OF THE MEDIAN NERVE

(A well defined type of neural atrophy of the hand)

By J. Ramsay Hunt, M.D., of New York.

A well defined clinical type of atrophy of the hand may result from compression of the thenar branch of the median nerve as it emerges from beneath the annular ligament of the wrist. This thenar branch is purely *motor* and innervates the abductor pollicis, opponens pollicis and the outer head of the flexor brevis pollicis. It is characterised clinically by a sharply defined thenar atrophy, limited to the distribution of the median nerve. The thenar eminence presents a scooped-out depression, lying between the outer boarder of the first metacarpal bone and the inner head of the flexor brevis pollicis muscle.

There are present also, the reactions of degeneration in the affected muscles; and *objective sensory disturbances in the distribution of the median nerve are absent*. This type of atrophy interferes very little with the general usefulness of the hand, as the other muscle groups are unaffected. The hand-writing may suffer considerably.

In connection with the *neural* atrophy of the hand muscles without sensory disturbances of median nerve origin (thenar type); Dr. Hunt calls attention to another well defined group of occupation atrophies of the hand described by him (*JOURN. NERV. AND MENT. DIS.*, 1908), which are dependent upon a compression neuritis of the deep palmar branch of the ulnar nerve as it passed between the tendinous origins of the abductor minimi digiti and the flexor brevis minimi digiti (hypothelar type).

In this type, all the intrinsic muscles of the hand are paralyzed, with the exception of those supplied by the median nerve. In the thenar type, objective sensory disturbances are also absent, the deep palmar branch of the ulnar being *motor*. The importance of these two types of compression (motor) neuritis, is very much increased from the resemblance which they bear to certain forms of the Aran-Duchenne type of spinal atrophy. This resemblance is enhanced by the well known fact that progressive muscular atrophy, beginning in the small muscles of the hand is not infrequent in connection with occupations necessitating an over activity of these muscles.

Dr. Hunt is convinced that cases belonging to one or other of these two types of occupation atrophy without sensory disturbances are not infrequently regarded as an early stage of spinal atrophy. Hence, their clinical and diagnostic importance.

HORIZONTAL OSCILLATION OF THE EYEBALL IN BELL'S PALSY

By L. Pierce Clark, M.D.; and H. H. Tyson, M.D.

Schlesinger's report. Bell's phenomenon. Differentiations of the horizontal oscillation signs from Stransky's associated nystagmus sign

and the reflex nystagmus of Bernheim and Baer. Horizontal oscillations of eyeball in the blind and in certain forms of catatonic stupor and excitement. Report of three cases of horizontal oscillation of the eyeball in Bell's palsy. Explanation of the sign—a central overflow impulse.

HOW SHOULD THE PAROCCIPITAL FISSURE BE REPRESENTED IN FISSURAL DIAGRAMS?

By Burt G. Wilder, M.D.

Commonly this and the parietal fissure are interpreted and represented as, respectively, the occipital and horizontal components of the intraparietal fissural complex. In apes and monkeys, young and adult, they are always continuous; the fetal conditions are unknown. In the human fetus they always commence independently and remain separate in about forty per cent. of hemispheres, but unite sooner or later in the other sixty. In many, perhaps most, of the cases of superficial continuity the original isthmus may be recognized as a more or less deeply submerged vadium or shallow, and it is a fair question whether cases in which the fissure at this point is less than one-half the greatest depth at either side should not be regarded as cases of separation rather than continuity. Superficial continuity is two or three times as common as separation on the left side, but on the right separation is more common, about fifty-five per cent. In the light of existing knowledge, the writer concludes that fissural diagrams should include the dorso-caudal aspect of this region, with continuity of the two fissures on the left and separation on the right; when only one lateral aspect is shown the fissures should still be separate but there should be a statement as to the conditions in the lower primates and in the human fetus and average adult.

THE HERPES ZOSTER OTICUS. A CONSIDERATION OF THE ZOSTER ZONES FOR THE GENICULATE GANGLION OF THE FACIAL AND THE JUGULAR GANGLION OF THE VAGUS

By J. Ramsay Hunt, M.D.

General anatomical considerations. Analysis of cases of herpes auricularis. Report of personal cases. An attempt to differentiate the zoster zones of the ear.

DREAMS AND THEIR INTERPRETATION AS DIAGNOSTIC AND THERAPEUTIC AIDS IN PSYCHOPATHOLOGY

By B. Onuf, M.D.

The merit of Freud's work in the interpretation of dreams. Analogies between dreams and hysterical states. Help of dreams in psycho-analysis. Dreams by suggestion, hypnotic and post-hypnotic. How to ascertain their completion by suggested landmarks. Diagnostic and therapeutic value of suggested dreams.