A CASE FOR DIAGNOSIS

By Julius Grinker, M.D.

Patient, a school-boy, 14 years old, entered Dr. Grinker's service at Cook County Hospital on December 7, 1915. The onset of his illness dates about one year ago. The beginning was gradual, with a feeling of weakness in the neck muscles patient experiencing difficulty in maintaining neck and head erect. When this condition had gradually improved, he began to stagger in walking and generally felt uncertain on his feet. About the same time his speech became less distinct—syllables were slurred and there was present what might aptly be called "explosive" speech. A symptom attracting his own family was his rapid growth during the last year—about twelve inches. There have been no other disturbances—neither headache nor vomiting. Special senses normal. The optic nerve presented neither edema nor atrophy; perhaps the outer nerve head on left side was slightly paler than the one on the right side, but not sufficiently so to call it pathological. The family and personal history is unimportant. Intelligence is of the average type and memory not impaired, though the mother thinks that patient is not as bright as formerly. There is no similar trouble in the entire family; in fact, it is free from all forms of nervous disease. Examination reveals normal viscera, negative urine, blood and spinal fluid (both tested for Wassermann). Radiographic examination of skull in two positions demonstrated an exceedingly small sella turcica with well-defined anterior and posterior clinoid processes.

Nervous Findings.—Deep reflexes are generally exaggerated, but no pathological reflexes are present, nor is spasticity a symptom. Motion and sensation normal everywhere. Extremities are markedly elongated, but the soft parts show no excessive development. Face is normal. There are nystagmoid jerkings in extreme lateral positions of the eyes, though no spontaneous nystagmus has been observed. Tremor is present in tongue and in fingers, but not of the intention variety of multiple sclerosis; the tremor partakes more of ataxia than of motor disturbance. The gait is markedly ataxic and of the cerebellar variety. Speech is of the scanning type, monotonous and without accentuation of syllables, occasionally slurring. Abdominal reflexes are both well marked. The thyroid is somewhat enlarged.

In observing this patient one is struck by the symptoms of what one might call the cerebellar syndrome, yet the rapid growth must lead one to think of hypophysis disease. However, the absence of enlargement of that organ as shown by the radiogram must turn our attention to other possibilities.

Dr. Grinker, in replying to Dr. Bassoe, said that the patient had had headaches once or twice, but this was not a prominent symptom. There were no atrophies or dystrophies. He has had transient vertigo on one or two occasions. The abdominal reflexes are present. Mentality normal. Patient attends school. Has had no fainting spells; no epileptiform convulsions, but vomited once.

Dr. Meyer Solomon said that it seemed to him that Dr. Grinker had not mentioned a possibility that is perhaps most likely, namely, multiple sclerosis. It is true that there are slight suggestions here and there of ductless gland disorder, but nothing specific or definite to get hold of. Possibly observation over a prolonged period may bring out the fact whether or not there is really a ductless gland disorder.

One point with reference to cerebral roentgenology: The present standpoint of the foremost men in that line of work is that the single exposure is valueless; that in order to get an idea, especially of the pituitary fossa, there should be several exposures in different positions, and that the best way is the stereoscopic view.

Dr. Peter Bassoe asked about the sugar tolerance, to which Dr. Grinker replied that these tests had not yet been made.

Dr. Sigmund Krumholz thought that the case presented by Dr. Grinker required more detailed analysis and longer observation to definitely determine upon the diagnosis. The unusually marked growth of the patient in the last few months would make one suspect some disturbance of the hypophysis. If the X-ray picture would show a separation of the epiphyses in the extremities of the patient, it would strengthen the latter suspicion. Physically, the patient is partially infantile. It would be interesting to know whether he also shows signs of psychic infantilism. On the other hand, the neurological symptoms, namely, the nystagmus, ataxic gait, with tumbling toward the right, are suspicious of some pathological process in the area of the vestibular tract and cerebellum. As a whole, the case, as presented, is suspicious of a hypophyseal affection and lesions in the area of the cerebellum and vestibular tract.

Dr. Grinker (closing the discussion) expressed the view that the most probable diagnosis of the case is multiple sclerosis. While he thought that there must be a liberal representation of patches in the cerebellar territory, it is not unlikely that some sclerotic patches will also be found in the glands of internal secretion, thus stimulating excessive growth in the long bones. This view he believes not incompatible with the appearance of the roentgenogram showing a small sella, as it is not impossible for a patch of sclerosis to irritate the glandular tissue without causing hypertrophy of the same. However, this is pure hypothesis, and he ventures to put it forth, because no one has attempted any other explanation of this interesting case.

FACIAL HEMIATROPHY

By James C. Gill, M.D.

Miss J., 18 years of age, born in Chicago.

Family History.—Father 48 years of age, born in Norway, steamfitter by occupation. Mother 45 years of age, born in Norway also. Both parents are healthy; no history of any nervous disorder on either side of the family. Grandparents, uncles and aunts, so far as can be determined, showed no hereditary trouble. Miss J. has five sisters and one brother all in good health.

Past History.—The mother states that birth was normal. Infancy and early childhood passed without any serious ailment. Physical and mental development normal. Present trouble was first noticed at six years of age. The first manifestation was a slight discoloration of the skin in the region of the infraorbital foramen on the left side. The mother says this followed an injury to the left cheek caused by running against the corner of a sewing machine. From this starting point there has been a gradual but progressive involvement of the skin, subcutaneous tissue and bony structures about the left side of the face and extending to the frontal region of the skull.

It is interesting to note apparently that the disturbance is confined to the distribution of the sensory branches of the trifacial nerve. At no time has the patient experienced any considerable pain, only occasionally slight neuralgic disturbances of no special consequence. Electrical tests show an absence of R. D. An examination of the mouth reveals a congenital absence of the first and second lower bicusps on the left side. Examination of the eyes shows slight inequality of the pupil, the left being smaller than the right; eye grounds normal. The patient states that over the involved area there is a condition of anidrosis that has been noticeable for a number of years.