Alarrido Quañabaria; second secretary, Ernesto Senna, and treasurer, Marechal Jardin.

Brazil with its many charity hospitals, orphan and infant asylums, maternities, homes for the aged, and lepers, and insane asylums, most of them built and maintained by donations of its charitably-disposed citizens, and its excellent Board of Public Health, and the League Against Tuberculosis, may well feel proud of its humane labors and take consolation in the maxim: "Charity draws a blessing on the charitable."—*Le Sage*.

TABLE 1.

Yellow fever	.....	none
Bubonic plague	.....	none
Smallpox	.....	1
Whooping cough	.....	1
La grippe	.....	7
Typhoid fever	.....	3
Dysentery	.....	2
Leprosy	.....	1
Erysipelas	.....	2
Acute malaria	.....	1
Chronic malaria	.....	1
Pulmonary tuberculosis	.....	46
Other forms of tuberculosis	.....	3
Purulent infection, septicemia except puerperal	.....	2
Syphilis	.....	5
Cancer and other malignant tumors	.....	2
Other tumors	.....	1
Other general diseases	.....	1
Diseases of nervous system	.....	22
Diseases of circulatory organs	.....	31
Diseases of respiratory organs	.....	37
Diseases of digestive organs	.....	32
Diseases of urinary organs	.....	11
Diseases of skin and cellular tissue	.....	2
Congenital diseases and defects	.....	8
Senile debility	.....	3
Violent deaths, except suicides	.....	7
Suicides	.....	2

TABLE 2.

Year.	Number of cases.	Deaths.
1903	249	133
1904	15	2
1905	16	3
1906	17	6

TABLE 3.

Yellow fever	.....	6
Pest	.....	1
Smallpox	.....	3
Whooping cough	.....	5
Diphtheria and croup	.....	1
La Grippe	.....	34
Dysentery	.....	2
Beriberi	.....	3
Typhoid fever	.....	3
Leprosy	.....	3
Malaria	.....	21
Tuberculosis	.....	220
Other transmissible diseases	.....	20

TABLE 4.

Brazilians	.....	1,680
Portuguese	.....	481
Italians	.....	34
Spaniards	.....	63
Germans	.....	6
English	.....	7
French	.....	11
Other Europeans	.....	8
Anglo-Americans	.....	1
Spanish-Americans	.....	13
Turco-Arabs	.....	1
Other Asiatics	.....	3
Africans	.....	14
Nationality not known	.....	30

RIO DE JANEIRO, July 31.

(To be continued.)

Clinical Notes

REPORT OF A CASE OF INTRACRANIAL TUMOR RESULTING FROM TRAUMATISM.*

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Symptoms indicating the presence of a brain tumor are often ascribed to a remote blow or fall on the head. Their etiologic relationship is usually obscure. The development of an intracranial growth as the direct

result of traumatism is a rare occurrence. Hence, the report of this unusual case:

Patient.—A man, 25 years of age, was admitted to the neurologic service of the Lebanon Hospital Jan. 4, 1906, with the following history:

History.—Two years ago he received a fist-blow over the right temple, which did not seem to affect him very much, and was not followed by any immediate symptoms. During the following six months he complained of severe pain extending over the right side of the face, frontal and temporal regions. Paroxysmal attacks of headache accompanied by vomiting, and lasting several hours, occurred every morning on awaking. This continued for seven months and he was more or less somnolent, often falling asleep while at work or at his meals. During the next three months he obtained some relief from drugs. His eyesight then began to fail, and he lost the sense of smell. Two months ago, the headache became more intense and continuous, and he was totally blind. No history of alcoholism or syphilis.

Examination.—He was a well-nourished man, weighing 160 pounds. The heart, lungs and abdominal viscera presented no evidence of disease. Pupils equally dilated and rigid; slight horizontal nystagmus in attempts at fixation to either side;

Fig. 1.—Intracranial tumor resulting from traumatism; showing tumor (T) in its relation to the brain.

motility of eyeballs was otherwise normal; vision equaled perception of light; bilateral papillitis of 5 D. without retinal hemorrhages. Slight left facial paresis, affecting the lower branches; no objective sensory disturbance in the distribution of the right trigeminus; tongue normal; sense of smell absent on both sides; watch heard at twelve inches on the right and six inches on the left side; taste not tested; tenderness on percussion over the right parietal region, but no perceptible difference in the percussion note as compared with the opposite side; muscular power and resistance well-preserved in both upper and lower extremities; stereognostic sense intact; no objective sensory disturbance; gait normal; no static ataxia; knee-jerks and Achilles reflex equal and normal; no clonus; plantar reflex exaggerated on both sides, but of normal type; cremaster and abdominal reflex feeble on both sides. Urine contained a trace of albumin. Blood pressure 125 mm. (R. R.)

Subsequent History.—During his brief stay in the hospital he frequently complained of paroxysmal pain in the distribution of the upper branches of the right trigeminus, and over the entire right side of the head, often screaming during the attacks. The rectal temperature ranged from 97 F. to 99 F., pulse from 72 to 112, respiration from 20 to 28. The withdrawal of 20 c.c. of cerebrospinal fluid by lumbar puncture at once intensified the headache; the fluid was normal. The diagnosis was made of intracranial tumor involving the right

* Read in the Section on Nervous and Mental Diseases of the American Medical Association, at the Fifty-eighth Annual Session, held at Atlantic City, June, 1907.

hemisphere, probably located in the temporal lobe, and an exploratory operation was under consideration. A few days later, and two weeks after admission to the hospital, he suddenly became comatose and died within two hours from respiratory failure, the heart beating strongly for several minutes after respiration ceased.

Autopsy.—The autopsy was limited to the cranial contents. There were no external marks of violence. On opening the skull and removing the brain, there was found a spicule of bone projecting from the inner table of the skull through the dura, about two inches above and two inches posterior to the

Fig. 2.—Intracranial tumor resulting from traumatism; showing site of tumor pressure (S) and the tumor (T).

right external auditory meatus. A firm, hard nodular tumor 8 by 10 centimeters ($3\frac{1}{4}$ by 4 inches) originated at this point, being adherent to the dura and spicule of bone, lying in the middle cerebral fossa and partly in the posterior fossa, compressing the right temporo-sphenoidal lobe, but non-adherent to the brain. The posterior portion of the middle fossa was considerably eroded. The tumor was an endothelioma.

Although the blow on the head was not considered of much consequence at the time it was inflicted, yet it is

Fig. 3.—Diagram showing relation of tumor to skull and dura.

quite evident that the spicule of bone irritating the dura was the immediate cause of the neoplasm. The time elapsing between the initial injury and death was two years.

The site for operation was to have been in the location preferably selected for decompression when the position of the growth is uncertain, i. e., over the right temporal region. Had the operation been undertaken as intended, the tumor would have been at once exposed and easily removed.

AN INSTRUMENT FOR TESTING THE LIGHT-REFLEX OF THE PUPIL.*

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Those of us who have to make many examinations of neurologic patients have been confronted frequently with the great difficulty of obtaining satisfactory tests of the pupil light reflex. This is especially true when, for purposes of cerebral localization, it is desired to ascertain whether or not Wernicke's symptom (the hemianopic pupil inaction sign) is present. For ordinary purposes alternately covering and uncovering the eye with the hand permitting its exposure to the light of a candle, lamp or window is all that is necessary, but in those cases of very sluggish or very contracted pupils, such as are frequently observed in cerebral or spinal disease, it is essential to concentrate the light in order to ascertain whether the reflex is present or absent.

In order to make the test for Wernicke's hemianopic pupillary inaction symptom light can not be employed in the ordinary manner, as it is impossible to send its rays through the pupil on to the blind half of the retina only; a portion of such rays will fall on the seeing half of the retina and thus obviate the test. As the rectangular ophthalmoscopic mirror, such as that found on the Loring model, reflects the light with a more or less sharp edge, it is ordinarily employed in making the test; but the difficulty in permitting the edge of so large an area of light as the mirror reflects to fall on one-half of the retina only has been apparent to all who have ever attempted the procedure, and, indeed, in many instances a positive statement as to whether the symptom was present or absent could not be made.

A few years ago von Fragstein and Kemptner devised an apparatus for making the tests which so condensed the rays of an electric light that a small point could be obtained. The instrument is a good one but is rather expensive. As many ophthalmic surgeons and neurologists possess either a Dezing electric ophthalmoscope, retinoscope or Würdemann transilluminator, and as the handle of these instruments containing the electric light bulb is the same in each, the difference being only in the tips, I have had Mr. Dezing make for me a tip especially devised for testing the pupillary reaction to light. It consists of an ordinary cone of hard rubber similar to that employed for the transilluminator, in the center of which, however, is placed a long focus convex lens instead of a tube of glass. In addition, there are stops for cutting out some of the aberrant rays and to assist in the concentration of the light. By changing the distance of the tip from the pupil I can produce either a very small point or a line of light. For ordinary pupil-testing the point is better, but in testing for Wernicke's symptoms the line is preferable. The latter test can be best made by allowing the light to enter the pupil from the side opposite to that on which the instrument is held, as in this way all the rays can be concentrated on either a very small point or a line of light. For ordinary sired. When used with an ordinary battery or street current the circuit can be closed or broken by a slight movement of the switch controlling the current.

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