PHILADELPHIA NEUROLOGICAL SOCIETY

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The President, DR. T. H. WEISENBURG, in the Chair

A CASE OF TABES WITH UNILATERAL FOOT DROP

By S. D. Ingham, M.D.

The patient, a man of forty-two years, gives a history of a primary syphilitic lesion several years ago, and the typical symptoms of tabes have developed during the past two years. During the past year there have developed symptoms of soreness and weakness in the right leg, and for nine months he has had complete foot drop on that side. The left leg is not affected. Measurement of the calf shows that the circumference of the right leg is about three quarters of an inch smaller than the left. Excepting the ocular muscles, peripheral paralyses in tabes are not very common. Of the cases reported, some have been attributed to neuritis, others to involvement of the anterior horns of the spinal cord. From the pain and soreness present, and from the absence of fibrillary twitching, this case may be considered one of peripheral nerve involvement rather than of the anterior horn.

DISSOCIATION OF SENSATION IN THE FACE OF THE TYPE
INVERSE TO THAT IN SYRINGOMYELIA: THE RECOGNITION OF CONTACT IN THE EYEBALL THROUGH THE FIBERS OF PAIN

By William G. Spiller, M.D.

The case reported was one in which temperature and pain sensations were lost on the entire right side of the body, including the face and limbs, while tactile sensation was preserved in these parts, and passive movements were recognized in the right hand. Tactile sensation, and in a large measure pressure sensation, were lost in the left side of the face in the region innervated by the trigeminal nerve; while pain and temperature sensations were entirely normal in these parts, except that heat was not felt so well over the left forehead. Contact with the right eyeball was scarcely recognized, if at all, whereas contact was promptly recognized in the left eyeball. The symptoms mentioned with other symptoms made a diagnosis of a lesion of the left tegmentum of the pons probable, and this lesion was supposed to be multiple sclerosis. Contact with the eyeball was recognized on the side in which pain sensation was preserved, even though tactile sensation was lost; it was very imperfectly recognized, if at all, on the side in which tactile sensation was preserved but pain sensation was lost.

Dr. F. X. Dercum said it would be difficult to devise an explanation more in accordance with our knowledge of anatomical structure than that formulated by Dr. Spiller. Dr. Spiller spoke of the explosive utterance, and this is in keeping with the view that we have here to deal with a sclerotic process, possibly a multiple sclerosis.

Dr. Charles K. Mills said that when he saw this patient in 1907 all the symptoms had not developed. He was examined by him several times