and impotence, headaches, languor and weakness may appear in varying degrees in different cases at different periods. The classic signs and symptoms of hypopituitarism are subnormal temperature, dry skin, adiposity, low blood pressure, slow pulse, constipation, amenorrhea, drowsiness and inactivity. Lack of attention, impairment of memory, actual dullness, and mild psychoses to actual convulsive seizures with epileptic attacks may occur. The cause may be glandular deficiency of one or both lobes, a pituitary tumor with damage of the gland, or a neighborhood tumor or hydrocephalus with pituitary pressure. The symptoms of intracranial tumor may be more prominent than those of pituitary deficiency. Infantilism, dysgenitalism and obesity, symptoms of intracranial tumor, warrant pituitary study.

Lereboullet et Hutinel. PITUITARISM. [Bul. méd., August 2, 1919.]

These observers showed two adults at a meeting of the Société Médicale des Hopitaux, with the adiposo-genital syndrome of pituitary origin. The first was a male thirty-three years old, whose illness commenced at the age of twenty-seven with spasmodic headaches and polyuria; at twenty-nine there was genital impotence; at thirty ocular disturbances occurred, and progressed as the polyuria increased, and obesity developed. He had also a typical bilateral hemianopsia associated with enlargement of and partial sinking of the sella. The adiposity, the impotence with atrophy of the testicles, the changes in the hair system, and the anemia with slight mononuclear leucocytosis, made the complete syndrome. There was no syphilis, but congenital syphilis could not certainly be excluded. Negative Wassermann. The existence of a pituitary tumor was very probable. The second patient was a woman of forty-five who also sought advice for almost complete blindness of the right eye and incipient hemianopsia of the left. The menses had ceased at the age of twenty, just as fairly pronounced adiposity appeared, accompanied by marked anemia. Then changes in the hair supervened, with manifest mental retardation. Bone changes, especially enlargement of the lower part of the face, acromegalic in nature, were noted. Radiographic examination revealed a profound modification of the sella.

Rössle. DYSTROPHIA ADIPOSO-GENITALIS PRODUCED BY MARKED HYPOPLASIA AND ATROPHY OF THE HYPOPHYSIS. [Naturwiss.-med. Gesellsch., Jena, July 20, 1916.]

A man of twenty-seven, bad heredity, was feeble-minded and sickly as a child. He was incapable of following a profession and died of general infection following an operation for *coxa vara* on the right side. Hypophyseal obesity was discovered as a side issue. Length of body 1.62, weight 50 kg., typical, but not very high degree of adiposity. There was hypoplasia of the thyroid (11 gr.), of the thymus (3 gr.), of

the suprarenal capsules (5 gr. altogether) and especially of the hypophysis. The latter was concealed in a very small and rather shallow sella turcica, showed no connection with the infundibulum and on microscopic preparation no posterior lobes could be revived. After fixation in formol the hypophysis weighed 180 mg. (average normal weight 700 mgr. for same age and sex). A microscopic series revealed a single posterior lobe and an anterior lobe subdivided by a multi-chambered cyst with psammoma granules, no trace of the hypophysis stalk. Testicles (those of a 3-year-old boy) and other genital apparatus very much underdeveloped; the seminal vesicle also showed almost complete aplasia.

Bate, R. A. POSTERIOR PITUITARY SECRETION IN THE TREATMENT OF MITRAL REGURGITATION. [Kentucky Med. J1., Nov., 1919.]

Regurgitation of the blood, from the left ventricle into the left auricle, during systole, takes place in any condition which prevents perfect closure of the mitral valve. Postmortem examinations have demonstrated the fact that the majority of regurgitant murmurs are permitted by myocardial changes. It is a universally accepted fact that myocardial hypertrophy compensates for the valvular deficiency. So long as compensatory hypertrophy obtains no systemic symptoms of mitral insufficiency are observed; hence, the treatment of mitral regurgitation has been based upon the establishment and maintenance of myocardial hypertone.

It has been shown that the blood regurgitating into the left auricle, while the right ventricle is pumping blood into the lungs, causes congestion of the pulmonary capillaries and dilatation of the right auricle. This is due to increased pressure in the right auricle where lowered pressure is normal during systole; hence, cardiac dyspnea, which is one of the first symptoms of mitral regurgitation, is the result of the pulmonary engorgement.

Hirschfelder, following von Basch, reasons that "the pulmonary stasis does not persist when the action of the left ventricle is sufficiently vigorous"; hence, he says "in the milder cases shortness of breath may be absent." Loomis, with much greater precision, states "so long as the hypertrophied right ventricle is able to fully overcome the abnormal pressure of the blood in the lungs, from mitral regurgitation, the patient is comfortable."

By and by cardiac hypertrophy is followed by myocardial degeneration and dilatation. General venous congestion now may be observed. As the lungs first indicated the primary vascular changes, so the blood enmeshed liver now indicates the secondary changes, which involve all the abdominal viscera. The renal, gastric and other symptoms result from visceral engorgement, just as dyspnea results from the pulmonary dilation and degeneration.