

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 bicuspid 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.

An interesting part of Miss J.'s history is a nervous disturbance beginning at nine years of age, when she had a convulsive seizure, epileptiform in character. These epileptiform seizures have persisted at irregular intervals since, assuming the nocturnal type, never having occurred during the day. But she describes a sensation occurring rather frequently during the day, manifested by slight vertigo or confusion, bearing the stamp, it seems, of the petit mal type of epilepsy. Headaches of the migrainous form have persisted at infrequent intervals for several years. The functions of the organs of the body, aside from those mentioned above, are performed, so far as can be determined, in a normal way.

Dr. Gill suggested that such condition might be due to a perverted function of the trifacial and associated sympathetic nerves, complicated frequently by epileptiform seizures. Questions not satisfactorily answered: Why this disorder occurs more frequently in early life? Why it occurs more frequently in females? Why is it so frequently accompanied by epileptiform seizures?

Dr. Meyer Solomon thought the case extremely interesting, and it seemed to him that, although there was a history of injury immediately antedating the development of the hemiatrophy, injury was probably nothing more than an inciting factor; that the predispositional factor was previously present. It seemed to him that a nutritional disorder of some sort, the presence of migraine, plus the epileptiform spells, shows that there is something more than merely the hemiatrophy in this case. These are all probable manifestations of some underlying state.

He thought thyroid extract was being tried by some in facial hemiatrophy, with some reported improvement in the condition. In Dr. Gill's case, however, on account of the long history of the condition, it had probably become ingrained into the system, as it were, and thyroid or other ductless gland products might be of no value, but he wished to suggest the treatment and that it might be worth trying.

Dr. Peter Bassoe thought the largest statistics gathered on hemiatrophy were those of Stier, who has been paying so much attention to right and left-handedness. He pointed out that most cases are on the left side, and that in left-handed persons it usually occurs on the right side, *i. e.*, it affects the "inferior" side.

On looking at the patient, it would appear to him that at a distance one would at once think of some circulatory disturbance—a nevoid condition, and with the history of convulsions we recall the cases of nevus or angioma of one side of the scalp and face, extending into the meninges and causing convulsions. Here we apparently have the opposite condition, namely, a decrease in vascularity. After all, there may be something of that sort about it—something nevoid, and it may be that the convulsions are focal. Are there any changes in the reflexes?

Dr. Gill replied in the negative.

Dr. S. Krumholz said some observers have reported cases of epilepsy with left-handedness, which present minute cortical changes. In the cases of epilepsy associated with left-handedness, Redlich, on careful examination, frequently observed a slight paresis, on the opposite side of the body, especially immediately after the seizure. This corroborates the assumption that epilepsy with left-handedness has an anatomical basis. As Dr. Gill's hemiatrophy case has epilepsy and is left-handed, it occurred to him that this affection might possibly be due to a pathological process in the cortex or sub-cortical region.

Dr. Gill (closing the discussion) had hoped that someone would enlighten him regarding the question, especially as to why it occurred in the young, and more frequently in the female.

Dr. Meyer Solomon said that if it is due to a ductless gland disorder, we know that the ductless gland system is more unstable before twenty years of age, and also that it is more unstable in women than men. That might be a possible answer.

Dr. Gill said that was interesting, in lieu of any other explanation, and he accepted it for what it was worth. The case interested him. Might it not be possible that the same causative factor underlying any case of epilepsy, of nocturnal or diurnal type, was responsible for this condition, regardless of the presence of the facial hemiatrophy? Possibly there is a vasomotor disturbance underlying the trouble. These things had suggested themselves to his mind.

JANUARY 20, 1916

The Vice-President, DR. LEWIS J. POLLOCK, in the Chair

Dr. Lewis J. Pollock read a paper on The Cause of the Allorhythmic Type of Tremor in Paralysis Agitans.

Dr. H. J. Smith understood Dr. Pollock to say that some of the men who had studied these tremors previously did not find this same variation in rhythm, and he wondered if these men had studied them in the same thorough way as Dr. Pollock, or whether they had guessed at the results without taking simultaneous tracings with recording apparatus.

Dr. Harold N. Moyer asked if the condition described bore any relation to the heart's action or does voluntary respiratory inhibition affect the tremor.

Dr. Pollock (closing the discussion), in answer to Dr. Smith, stated that investigations have been made relative to the probable relation between respiration, circulation and these tremors by Maude, Marie and Wertheim-Salmonson. Marie made a tracing in which he showed the carotid pulse along with the tremor. The tremor was not a regular allorhythmic tremor. Wertheim-Salmonson showed a tracing that he admits is not a very clear one, with which opinion we are forced to agree. It is not even an ordinarily good tracing. The tracing of the circulatory movements is very poor, and the nodes of the tremor irregular.

Perhaps to further reply to Dr. Smith's query, he would reply to Dr. Moyer: There is one notable feature about the allorhythmic type of tremor in paralysis agitans, namely, you cannot get it unless the patient is in a state of complete distractibility; that is, he should have no conscious knowledge that you are particularly interested in getting any definite result, because as soon as he becomes interested in his own tremor, then the character of the tremor immediately changes, and you no longer get these nodes. When he commanded the man to stop respiration, it is true, he did get cessation of the allorhythmic type of tremor, but it continued long after breathing recommenced. Other factors, such as excitement, etc., brought on an atypical tremor.

The reason respiration has not been recognized as being essential to the causation of these nodes is that they have not been studied extensively enough. For many have been content with the works of preceding authors, and such work has been based on perhaps one tracing, and that obtained under imperfect conditions.

WASSERMANN REACTION IN FEEBLEMINDEDNESS

By H. C. Stevens, M.D.

Dr. Stevens said that attempts have been made to show that inheritance in accordance with Mendel's law is the chief cause of feeble-mindedness. The