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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

for station, gait, etc. His impression was that some of the symptoms which had been described by Dr. Spiller were not then present. He had no doubt that the focal diagnosis he had given is correct. He was not sure, however, that the case was not one of tumor, especially a glioma. It is well known that in gliomatous growths invading nervous tissues fountioning may take place through the lesion. Dr. Spiller's account of this patient is an instructive analysis of a most interesting case.

Dr. Williams said the only difficulty he saw was in regard to deafness. Why should not the number of fibers which had passed to the right side present the degree of deafness in the right side which is present in the left? Would it not appear that the lesion has extended downward also, particularly as it has affected the fibers and nuclei of the sixth and seventh nerves?

A CASE OF CEREBRAL HEMORRHAGE SIMULATING CEREBRO-SPINAL MENINGITIS

By J. Hendrie Lloyd, M.D.

The case had interested Dr. Lloyd very much, both from a clinical and a pathological standpoint. The patient was a lady sixty years of age who had been for a good many years a private patient of his. Last May, after a day or two of very strenuous house-cleaning, she was taken ill in the middle of the night and Dr. Lloyd was sent for. He found her in bed complaining of very severe headache, and she had a little fever. She had made her own diagnosis that she had taken cold. There was nothing to indicate a serious brain trouble, and Dr. Lloyd was disposed to take her at her word. Although at the end of thirty-six hours she had improved, she did not get well. She continued in bed with very severe pain at the nape of the neck. In two or three days she had distinct retraction of the head. The course of fever was irregular and the whole appearance of the case became rather puzzling. At the end of the fourth day the patient was a little delirious. Dr. Lloyd had begun to suspect some meningeal trouble, and had her transferred to the Methodist Hospital at about the fifth day. By that time she was still more delirious and the appearance of the case was still more distinctly one of meningeal irritation. There was marked retraction of the head and persistent severe pain at the back of the neck. By the time she was taken into the Methodist Hospital the appearance was so much like a meningeal trouble that several physicians who saw her believed the condition was cerebro-spinal meningitis. There began to be some rigidity of the legs and curious delirious phases. She would lie in a semiconscious condition for a day or two and then arouse and seem better. There was nothing to indicate typhoid fever infection. In the second week Dr. Lloyd had lumbar puncture made by Dr. Hammond, which brought out a very bright blood-stained cerebro-spinal fluid. The blood was thoroughly mixed with the cerebro-spinal fluid as is seen when it is of meningeal origin. Examination of the fluid was entirely negative so far as bacterial infection was concerned. The disease continued with the meningeal symptoms persisting, and at the end of a few days another lumbar puncture was made. The Board of Health was notified in the meantime that a case of rather obscure meningeal symptoms was in the hospital. The physician from the Health Board went to the hospital and pronounced it a case