PULMONARY COMPLICATIONS OF APoplexy.

By Philip Coombs Knapp, M.D.

Pulmonary complications add to the gravity of the prognosis in all cases of apoplexy, and are much more frequent in the fatal cases than in those which recover. Two chief types of pneumonia, the hypostatic and the inhalation forms. Neither seems to have any relation to the side of the body paralyzed, both lungs usually being affected. Prophylaxis of some importance. Danger of change of position much exaggerated.

Dr. Knapp said he had left out in his presentation of this matter the emphasis upon the mechanical production, supposing it to be obvious to the Association. Some of Dr. Mills's recommendations in regard to the conduct of the case, etc., were made by one of our honorary members many years ago in an article by Dr. Edes in Pepper's System. Dr. Knapp perhaps had studied Dr. Mills's book rather too hastily, but he did not think he had emphasized in his book as much as he does now the importance of frequent changes in position. Dr. Knapp thought Dr. Mills is in error when he recommends turning patients upon the paralyzed side, because the paralyzed side certainly has a little less action in very many cases than the sound side, and it increases the blood upon the paralyzed side by the respiratory muscles acting against the weight of the patient and there would naturally be less free respiration. As to the necessity of extreme care in turning, which Dr. Mills has spoken of, Dr. Knapp could not see the importance of it. Furthermore, another point which Dr. Mills has not touched upon, the importance in early stages of getting the patient in a better position to offset the action of gravity than can be gotten by the ordinary head rests, because with such head rests the body slides down toward the bottom of the bed and the patient is kept in a cramped position. Therefore, Dr. Knapp spoke of the advantage of getting them out of bed and in a sitting posture because in that way they can breathe better. He felt certain that in all stuporous cases—fracture of skull, alcoholic wet brain, apoplexy—there is an improvement in the cerebral condition by getting them actually out of bed and into a chair, and he had never seen harm come of it.

CONTRIBUTION TO THE GROUP OF HEREDITARY DISEASES:
PROGRESSIVE GLOSSOPHARYNGEAL PARALYSIS WITH PTOSIS

By E. W. Taylor, M.D.

Report of a family in which, after the age of fifty, a slowly developing paralysis of the muscles of deglutition takes place, with coincident ocular ptosis, but without other involvement of cranial nerves. Death from starvation. So far as possible to ascertain, the disease first appeared in the mother of the patient described. In the patient's generation, two brothers, a sister, together with the patient, have been victims of the affection. Three have died, and the patient is now suffering from marked ptosis and considerable difficulty in deglutition. Another sister is still living.

Dr. Camp said he understood that, in this case, there was no atrophy and it appeared to him that the symptoms somewhat resemble those seen in the asthenic type of bulbar palsy.
Dr. Taylor said Dr. Spiller asked whether Dr. Taylor had been able to examine other members of the family. This he had not been able to do so far as this generation is concerned, since with the exception of one sister in Canada, whom he hoped later in some way to be able to learn more about, they are all dead. This sister is reported to be still well; but owing to her reticence, it is difficult to get absolute facts. Dr. Taylor was interested in what Dr. Spiller had to say regarding the question of ptosis. This in itself is not particularly remarkable, but in combination with the glossopharyngeal paralysis constitutes a grouping which is apparently unique. None of the other cranial nerves in the case which he had carefully examined are in any way involved. The knee-jerks are perfectly normal, as are the other reflexes of the lower extremities. There is, therefore, no evidence whatever of involvement of the pyramidal tracts. There had been no other diseases of a motor sort in the family so far as ascertained. With regard to Dr. Camp's suggestion, that possibly the condition is one of myasthenia gravis, it may be said that this is altogether improbable because of the unique and constant localization of the paralysis in many members of the family, because the affection is steadily progressive, and because in no other regard does it in any way resemble myasthenia. Furthermore, the fact that it occurs only after the fiftieth year is strongly against the hypothesis of a myasthenia, as is also its manifestly hereditary or family character. Even were it to be included in this group, it would be none the less remarkable on that account. The condition is presumably a degenerative one, doubtless involving the nuclei of certain cranial nerves, analogous perhaps to progressive bulbar palsy, but differing in the nerve involvement, which so far as Dr. Taylor was aware has not hitherto been described.

THE PATHOLOGY OF TABETIC OCULAR PALSY

By William G. Spiller, M.D.

Difference of opinion exists as to the nuclear or nerve origin of tabetic ocular palsies, and a distinction is made in the pathology of the ocular palsies of tabes and brain syphilis. The author has studied with microscopical serial sections a case of complete ophthalmoplegia in tabes. The subject brings into consideration the relation of parasypphilis to syphilis.

Dr. Fry asked whether in these third nerve palsy cases there is not more pain in the "syphilitic" ones than in those we have been in the habit of calling "post-syphilitic" from a clinical standpoint.

Dr. Fisher asked Dr. Spiller, as in many cases of tabes we have these early ocular palsies which just as in syphilis disappear and often never return, whether that fact does not indicate that the lesion affects the nerve roots rather than the nuclei.

Dr. Spiller thought that the so-called parasypophilic affections of the brain are of more chronic type and therefore less likely to be with pain but many of the "syphilitic" ocular palsies are painless.

He believed a complete recovery would be more probable from a nerve lesion, but of course recovery is possible from nuclear lesions if they are not too severe, as is seen in poliomyelitis.