electric phenomena to arise from the cerebellum. (2) These must be considered as action currents which can be derived from the cerebellar nuclei (dentate and roof nuclei), but not from the cortex cerebelli. (3) Action currents can be made to arise chiefly from the homolateral cerebellar nuclei, but in a weaker degree also from those opposite to the stimulated labyrinth. (4) The electric stimulation of the labyrinth provokes manifestations of the same kind but it is less suitable than mechanical stimulation. (5) Changes in the situation of the head in regard to space causes action currents of remarkable intensity to arise from the cerebellar nuclei.

These results are in accordance with our knowledge regarding the excitability of the deep gray matter of the cerebellum and the inexcitability of the cortex cerebelli. They harmonize also with Edinger's supposition that the cortex should be considered as a sensory organ, and the nuclei as motor centers. [Da Fano.]

Sztanojevits, L. TERATOMA OF CEREBELLUM. [Neurol. Centralbl., December 1, 1918, No. 23, Vol. 37.]

This was a teratoma the size of a man's fist, which existed for a long time without any objective symptoms, and, in nerve pathology, tumors which exist for a long time without noticeable symptoms are rare. The patient was a Roumanian, thirty-two years of age, a war prisoner. He had been in the habit of drinking constantly, but in moderation. There was no evidence of lues. When examined by the author only slight symptoms of nervous disturbances were discovered, fine tremors of the distended hand and tongue, sluggish reaction of the pupils to light and in accommodation. Death occurred suddenly with phenomena of suffocation. The section revealed hydrocephalus internus in the fissura intersphærica and, at the place of decussation of the falx cerebri and cerebelli, a tumor as large as a man's fist and of jelly-like consistency. The cerebellum hemisphere was so closely connected with the tumor that it could not be distinguished from the same macroscopically, and was so overgrown with the neoplasm that the right half of the cerebellum was one half smaller than the left. In the medulla oblongata there was a mass also connected with the tumor about as large as the stone of a small plum and of the consistency of marmalade. On the border of the dough-like cyst, which in places gave the amyloid reaction, could be discerned, microscopically, traces of bone, fat, gland substance, and hair. Obviously this was a typical case of epignathus, in the structure of which all three germinal layers participated. The case is the more interesting because, contrary to the experience in the majority of cases of this sort, the pathological changes produced, during the life of the patient, no disturbances of coördination or other clinical symptoms indicating a disease of the cerebellum, but, nevertheless, causing death by pressure on the medulla oblongata, when the capsule of the tumor burst. It is

further of interest for pathologists that the tumor was localized at the point which is known to be the point of predilection in the animal world for dermoid tumors.

Bikeles, G. A TONIC PATELLAR TENDON REFLEX IN CHOREA MINOR.
[*Neurologisches Centralblatt*, January 16, 1918, No. 2, Vol. 37.]

The author describes a case and remarks that it is interesting in relation to the manner in which the tonic patellar reflexes in chorea minor are produced, because here the phenomenon occurred not with heightened, but with pronounced diminished knee reflex and could be produced by passive, *i.e.*, involuntary, movements of the lower extremities.

Gordon, A. CEREBELLAR LESION. [Phila. Neurol. Society, Feb., 1920.]

J. O., male, 13 years of age, has been complaining of severe headache for the last two years. During the last six months he has had many attacks of vomiting without any indication of a genuine gastrointestinal disorder. Soon he commenced to complain of vertigo which is still present but which is not continuous. Upon examination the following symptoms are observed:

When the eyes are in primary position and the patient looks in front of him nothing special is observed. When he turns his eyes sharply to the left, nystagmic movements appear; the latter are absent when the eyes are turned to the right. An occasional and very slight nystagmus is present when the eyes turn upwards. Both nerve heads are hazy at the margins. There is some fundus atrophy and the retinal veins are decidedly tortuous. The left temporal field of vision is somewhat diminished. Further examination reveals a diminution of pain sense over the entire right side of the face. The hearing is impaired on the right side.

Reflexes, station, gait—are all normal. In testing the upper extremities, pastpointing to the right is observed repeatedly in the right hand, but not in the left hand. A Bárány test performed by Dr. L. Fisher reveals the following nystagmus data: Upon turning test to the right the duration is 38 seconds, to the left 35 seconds. With the caloric test a right douche produces a nystagmus of 50 seconds, a left douche of 70 seconds. In view of the right pastpointing of the localization of the nystagmus of the finding with Bárány test, also of the eye grounds, of the headache and vomiting, the presumption is in favor of a cerebellar lesion situated on the right side. As to the nature of the lesion it is well to bear in mind that the patient has a purulent bilateral sinusitis; the ethmoids on both sides are badly diseased and there is a profuse discharge of pus from both nares. The question arises as to the possibility of a purulent focus in the right cerebellar region. On the other hand intracranial syphilis cannot be entirely eliminated in view of the fact that only the blood was examined for a Wassermann, with negative results. [Author's abstract.]