THREE CASES OF INTENTION TREMOR AND JERKING
SPEECH PROBABLY CAUSED BY ALCOHOLISM

By William G. Spiller, M.D.

Dr. Spiller said he presented these cases because he had known similar cases to be regarded as examples of multiple sclerosis. The tremor was distinctly of an intention variety and the speech was like that observed in multiple sclerosis. Other symptoms of this disease were not present. All three men had used alcohol excessively. These symptoms are not sufficient to warrant a diagnosis of multiple sclerosis. Dr. Spiller had studied two cases with the symptoms mentioned which had been regarded by many as undoubted examples of multiple sclerosis; one was found to be a case of cerebrospinal syphilis, the other one of cerebrospinal arteriosclerosis.

Dr. J. Hendrie Lloyd thought the patients had a very wide intention tremor of a type not unusual in chronic alcoholism. He spoke of an instance of extraordinary alcoholic tremor which had occurred at Blockley. There were two brothers affected with the tremor. One of them, he thought, was on the pay roll, the other a patient in his ward. These men have been chronic inebriates for years. They obtain their discharge from the hospital, go out, keep drunk for several weeks, and are then readmitted. They have a similar tremor, which almost exactly resembles that of paralysis agitans, associated with the characteristic attitude and gait. They are comparatively young men, hardly having reached middle life.

Dr. T. H. Weisenburg said that he had a most excellent moving picture of a patient with alcoholic tremor, one of Dr. Pott's patients. In that particular case Dr. Weisenburg took the picture because of the remarkable resemblance of the tremor to paralysis agitans.

Dr. Cadwalader said that Dr. Spiller mentioned that one of his patients presented some paleness of the temporal side of the optic discs in addition to marked intention tremor. Paleness of the temporal side of the discs is common in multiple sclerosis but is not necessarily characteristic of that condition. Whenever the internal carotid vessels are very sclerotic they may press upon the optic nerves which lie near by and in that way cause paleness of the discs. In Dr. Spiller's patient this may have occurred.

Dr. Spiller said the cases of alcoholic tremor resembling that of paralysis agitans referred to by Dr. Lloyd had been in his (Dr. Spiller's) service and had been used by him in lectures. They were the cases referred to by several speakers.

A PATIENT WITH MARKED ATAXIA OF THE ARMS
AND HANDS

By J. Hendrie Lloyd, M.D.

Dr. Lloyd showed this patient. He was an Italian, aged 30 years, a blacksmith, who had always enjoyed good health and denied venereal infection. In 1910, after working out in cold winter weather, he began to have numbness in both hands, which gradually spread to the arms, then to the feet. Then he began to notice unsteadiness in his walking as though he were drunk, also ataxia in his hands. There were no brain symptoms, and he had control of the bladder and bowel.

There was marked ataxia of the arms and hands. On attempting to unbutton his coat the patient moved his arms and hands in an incoordinate way, and used his eyes to assist the motion of his hands. If his eyes were closed the ataxia was much increased. The disorder was not an intention tremor; the man could carry a glassful of water to his lips without spilling a drop. There was no paralysis of his arms or hands; no fibrillation or atrophy; and the tendon reflexes of the biceps and triceps were increased. The patient's lower limbs were not much affected: he swayed perceptibly and staggered slightly when he shut his eyes. The knee jerks were exaggerated, and there was a Babinski reflex. The eye-grounds showed no changes.

The patient complained of a sense of pain or burning beneath his sternum and between his shoulder blades. This seemed something like a girdle sense. The usual tests showed sensation to touch, heat and cold normal over the whole body, except that on the palmar surfaces of the fingers there was anesthesia, and the patient had well-marked astereognosis. Thus he could not distinguish a key or knife held in either hand, and he could not tell the position of his fingers with the eyes closed. There was slight lateral nystagmus, but no speech defects. The cerebrospinal fluid gave negative results when examined by the Wassermann, Nonne, and Noguchi tests.

Dr. Lloyd discussed the differential diagnosis, especially with reference to cervical tabes, multiple sclerosis, syringomyelia, and peripheral neuritis. He concluded that the case did not correspond to any one of these affections, but that it was probably a rather rare form of myelitis of indeterminate causation and pathology.

Dr. C. S. Potts said that he had seen the man for a few minutes recently and he was inclined to the diagnosis of multiple sclerosis. He did not believe it was tabes because, aside from ataxia, there is not another symptom of tabes. On one side he seemed to have a doubtful Babinski. He had marked nystagmus.

Dr. Lloyd said he thought that he had omitted to say that the man's eye-grounds were carefully studied and found entirely healthy. There was no involvement of the optic nerves. Oppenheim states that he had seen what he calls a cervical and medullary form of multiple sclerosis, with ataxia of the arms. This man had no hemianesthesia, such as Oppenheim claims to have seen in his case. He had simple ataxia of the arms. It suggested, but was not identical with, cerebellar ataxia. At first Dr. Lloyd rather objected to the diagnosis of multiple sclerosis, still, he could see that there was some ground to support that diagnosis. The condition came on after severe exposure in winter weather. If the patient had been a drinking man, or exposed to lead, Dr. Lloyd said he would have thought of the possibility of a pseudo-ataxia due to peripheral neuritis, but the integrity of the deep reflexes and of the muscular nutrition was altogether against such a diagnosis. The preservation of the deep reflexes was also against the diagnosis of cervical tabes, in which the columns of Burdach in the cervical cord are involved, but the columns of Goll in the same region are exempt.

Dr. S. D. W. Ludlum reported a case of injury of the internal popliteal nerve, associated with double crutch palsy.

Dr. Lloyd said that he had seen this patient in the Philadelphia Hospital. It was an unusual case. The man had had a popliteal aneurism and had been operated on at another hospital; and the impairment of the internal popliteal nerve was found on admission to Blockley. He had

distinct anesthesia in the small area supplied by the short saphenous nerve. There was also diminished contractility, atrophy and paralysis of the calf muscles. He was also a cripple with double crutch palsy, having been put on crutches when he left the hospital where the operation had been performed. Both musculo-spiral nerves were paralyzed. Dr. Lloyd suggested that surgeons might be a little more careful to caution patients when they put them on crutches and turn them adrift. This was the second case of double crutch palsy, following surgical operation on the leg, that he had seen within a year. It is bad enough for a patient to be crippled in his leg from some grave surgical condition, without the additional misfortune of being needlessly paralyzed in both arms.

BILATERAL FACIAL PARALYSIS OF THE THIRD AND SIXTH NERVES WITH OPTIC ATROPHY

Dr. H. Maxwell Langdon read this paper.

Dr. William G. Spiller said that he should be inclined to regard the case as probably one of tabes, the positive Wassermann, lost patellar reflex on one side, diminished on the other, slight ataxia, micturition, polyuria, ocular palsies he should be very much inclined to regard that as syphilitic. At the present time Dr. Spiller said he was studying a case of tabes where the ocular muscles were greatly paralyzed. It was very interesting to observe the condition of the ocular motor nucleus. He had not studied the sixth nucleus or the fourth. There were very few cells in the oculo-motor nucleus in this case of tabes. The ocular motors are very small, all three, the fourth and the sixth on each side and in the nucleus of the oculo-motor cell there may be few nerve cells and comparatively few nerve fibers coming from the second nuclei.

Dr. Spiller called attention to the fact that when the patient was sitting he was quiet. There were no athetoid movements, such as would be present in Huntingdon's chorea or tic. This is characteristic of this disorder. It is only when he puts his muscle into use that he is thrown into these movements of distortion. We look to the lenticular nucleus for all these peculiar movements of a choreiform or athetoid type.

Dr. Spiller said that Dr. Leopold had asked whether there was any family history of the condition present of tremor. Yes. The oldest one of the three said that his brother did have a history of tremor. They all had a history of excessive alcohol. They have all been using alcohol for a great many years. As for tremor being like paralysis agitans, Dr. Spiller had in his service two brothers with alcoholic tremor that resembled very much cases of paralysis agitans.

PHILADELPHIA NEUROLOGICAL SOCIETY

APRIL 25, 1913

The President, DR. GEORGE E. PRICE, in the chair

Dr. Sam Leopold reported a case of brain tumor.

Dr. W. B. Cadwalader and Dr. E. P. Corson-White read a paper on the relation of syphilis to progressive muscular dystrophy.

Dr. Charles W. Burr exhibited a brain from a woman with acromegaly shown before the Philadelphia Neurological Society some months ago.