

the gyrus hippocampi are strikingly spared. So also is the calcarine region; but the medullary substance and the cuneus and the lateral occipital convolutions are small, and microgyria is present here and there. There is no important secondary degeneration of the pyramidal tract. But there is diminution in size of the right pons, tegmentum, and bulb. No cortical cerebellar changes. From his survey of his findings, and from a review of the comparative anatomy of the cerebrum, Brouwer points out that in his case the phylogenetically younger parts of the brain had offered less resistance to the morbid process than the phylogenetically older parts had done. [Leonard J. Kidd, London, England.]

Howe, H. S. ANEURISM IN THE POSTERIOR CRANIAL FOSSA. [Neurological Bulletin, September, 1919, Vol. II, No. 9, p. 323.]

The case recorded is that of a nurse, aged fifty-three, who had no illness until the onset of her present trouble in June, 1915. As she was preparing for bed she felt a slight momentary tremor in the right side of her tongue. A day later a similar spasm occurred, also two days later and four days later. The next day, three occurred. Seven days after the onset she noticed that she was unable to move her tongue as formerly and that it protruded to the right. Swallowing was difficult. She had attacks of coughing and choking and occasionally food regurgitated through the nose. About a week after the onset she began to lose her voice for periods of about four or five hours during which she could not speak above a whisper. This condition continued for nearly a year when she lost her voice entirely and has never been able to speak louder than a whisper since. Two months after onset she noticed a noise in the right ear which seemed like a "distant pumping machine." This was constantly present and gradually became louder until it sounded like "escaping steam." Later it became still louder and was likened to "terrific rhythmic pounding." Two months after onset of tinnitus she became absolutely deaf in the right ear. In August, 1915, she was under observation at the Neurological Institute with a tentative diagnosis of syphilitic meningitis, but as lumbar puncture and Wassermann were entirely negative she was discharged without a definite diagnosis. In November she consulted Dr. Cushing in Boston who advised hysterectomy for removal of a fibroid but gave no diagnosis as to the cause of her cranial nerve palsies. He expressed the opinion, however, that the condition was stationary and would not progress. All symptoms remained stationary until June, 1918, when the entire right side of the face suddenly became paralyzed. In May, 1919, she suddenly developed a stiffness in the right side and back of her neck, and an area of exquisite burning pain at the base of the skull to the right of the midline. From this time until the time of writing there had been almost constant tonic-spasm of the muscles of the right side and back of the neck, which was so severe that she was unable to turn her head to the right. These spasms were accompanied by agonizing pain. Previous to the onset of

this pain she had noticed an atrophy of some of the muscles in the right side of the neck; and subsequent to its onset she had attacks of vomiting nearly every day when the pain was most extreme. During the two weeks before the time of writing the pain had been much less severe and there had been practically no vomiting attacks.

The neurological findings were entirely confined to the cranial nerves. There was complete paralysis of the right side of the face, absolute deafness in the right ear, absence of secretion of tears in the right eye and diminished secretion of saliva in the right portion of the mouth. There was probably involvement of the right vagus, causing difficulty in phonation and in swallowing. The right spinal accessory was affected as was shown by atrophy of the right sternomastoid and superior fibers of the right trapezius. There was complete paralysis of the right hypoglossus nerve, the tongue protruding markedly to the right with atrophy of this half of the tongue. Auscultation over the right mastoid process disclosed a loud blowing murmur which was synchronous with the heart beat. It was loudest at this point but transmitted down the neck along the line of the carotid vessels for a distance of about two inches. Compression of the carotid artery against the carotid tubercle caused the murmur to disappear.

The diagnosis of intracranial aneurism seemed reasonably certain on consideration of the clinical history and neurological findings. The history was that of irritation and later paralysis of the right twelfth, eighth and eleventh nerves, with paralysis of the seventh and involvement of the tenth on the same side. These lesions could conceivably have been produced by a new growth, a basilar meningitis or an aneurism of the vertebral arteries. It did not seem probable that a new growth of four years duration in this locality could produce this group of findings without also causing compression of the medulla or cerebellum and signs of increased intracranial pressure. Basilar meningitis was not likely in view of the negative serological findings. The murmur, while not pathognomonic, was considered evidence in favor of an aneurism; and taken in conjunction with the other findings it seemed probable that there was an aneurism of the right vertebral artery originating at the junction of this vessel with its largest branch, the posterior inferior cerebellar. [Author's abstract.]

Klessens, J. J. H. M. ABSCESS IN LEFT HEMISPHERE, IN A RIGHT OTITIS MEDIA. [Nederland. Tijdschr. v. Geneeskunde, 1920, LXIV, p. 1269.]

Patient had migrainous vomiting attacks for many years, but was never seriously ill. Recently right otorrhœa and otalgia. Then, paresis of right facial nerve, with gradually increasing mental dullness; no pyrexia; pulse rather slow. Right tympanic membrane red, and retinal veins slightly dilated. Motor and partial sensory aphasia. Somnolence. Possibly slight weakness of right arm. Right Babinski sign. Slight