

65. CONTRIBUTION A L'ÉTUDE DES RAPPORTS DE L'IMPALUDISME ET DE L'ÉPILEPSIE (Malarial Infection and Epilepsy). Marandon de Montyel (*Revue de Médecine*, Dec., 1899).

While not in opposition to the recent theory that the infectious diseases exercising a beneficial action upon epilepsy, the latter may be cured or modified by inoculation with the germs of various maladies, the author believes that infection is a two-edged sword, and that its influence is not always beneficial, but sometimes, indeed, injurious. Malaria has by some authorities been held to be a sovereign remedy, so that they had advised the construction of epileptic hospitals in malarial regions, or the sending of epileptics to malarial districts with the view of substituting the latter disease for the former, and then curing it by the administration of quinine. The author reports fourteen cases in which malaria distinctly aggravated the epilepsy, or caused a return of attacks which had long been absent, or even induced attacks for the first time in some neuropathic patients. Therefore, he thinks that causation should be exercised in the treatment of epilepsy by other infections, although it is very possible that in some cases the influence exercised might be a beneficial one.

CLARK.

66. MINOR EPILEPSY. Gowers (*British Med. Journal*, Jan. 6, 1900).

Tonic spasm is merely a superposition of clonic spasm, and may be considered singly as a subintractant clonic spasm. The slighter forms of idiopathic epilepsy consist of a clonic spasm only, being a slight general rigidity in contradistinction to the clonic spasm of organic epilepsy, and this may be called "medium epilepsy" as standing between the usual classes of grand and petit mal. In minor idiopathic epilepsy loss of consciousness precedes the convulsions; in focal epilepsy the order is reversed and pallor follows minor seizures; then, too, the brain is not anemic in minor epilepsy. In three cases studied with the ophthalmoscope the retinal vessels showed no change. Involuntary micturition may accompany minor attacks and is of great diagnostic value, and if it occur once in the patient it becomes constant; it is much more common in females and may accompany the exclusive tonic attack. True minor epilepsy may occur without loss of consciousness. All possible subjective sensations are met with in minor epilepsy; automatism is always prominent after minor attacks, and from a medico-legal standpoint deserves much attention; hysterical convulsions, too, often follow minor attacks. In differentiating minor epilepsy from cardiac syncope, we must remember that pallor precedes in the latter case; attacks come on slowly and pass off gradually without mental confusion.

Bromides are of much less value in minor epilepsy, and may arrest the major attacks while the minor continue as before. When bromides fail, we may get results from zinc salts, the oxide being the best salt, and is given in from 3 to 10 gr. doses, nausea being readily caused, however. Borax is of inferior utility in minor attacks. The following drugs are of some value in this class of cases: Nitro-glycerine, hydrobromate of hyoscyne, belladonna, Indian hemp and strychnine.

CLARK.

67. CEREBRAL RHEUMATISM. Francis P. Morgan (*Phila. Med. Journal*, Jan. 13, 1900, p. 116).

Acute articular rheumatism is sometimes complicated by a set of cerebral symptoms so severe and marked as to give their characteristic

stamp to the course of the disease. The term cerebral rheumatism is applied to such cases. In almost any acute disease high temperature may give rise to marked cerebral symptoms—restlessness, sleeplessness, delirium, headache, stupor or convulsions. Some cases of acute articular rheumatism are accompanied by very high temperature and marked cerebral disturbances, such as we should expect from our knowledge of the effect of high fever upon the brain. Therefore, the term cerebral rheumatism usually brings to the mind the thought of hyperpyrexia and its attendant cerebral disturbance.

Morgan cites a number of writers, who seem to think that cerebral rheumatism is due to the effects of a high fever on the brain, and also two who think that there must be some other cause for the cerebral disturbance. He believes (1), that cerebral rheumatism and hyperpyrexia are two distinct and separate complications of acute articular rheumatism; (2), that the symptoms of cerebral rheumatism are not dependent upon high fever, although it may be present; (3), that hyperpyrexia may present symptoms very similar to those of cerebral rheumatism; (4), that true cerebral rheumatism is due to a toxic agent in the blood, which acts on the brain and its membranes, producing the characteristic symptoms. Predisposition plays an important rôle in the production of cerebral rheumatism. The writer cites a case in support of the opinion that true cerebral rheumatism is not primarily due to the effects of hyperpyrexia, and that it may occur without high fever, in which the temperature only once went above 102° F. after the cerebral complications appeared. As to the nature of the toxic agent causing cerebral rheumatism, the investigations and conclusions of numerous writers here cited tend to show that the disease is an infectious process caused by the pressure and growth in the body of the ordinary *pus cocci*. If this theory be proved correct, all the symptoms of the disease will be easily explained as due to the toxic effects of products elaborated by the pathogenic bacteria. According to Pepper, cerebral rheumatism occurs in about three to four per cent. of all cases of rheumatic fever. In the majority of cases of cerebral rheumatism no pathologic changes are found in the brain or its membranes after death. Occasionally changes are found. When this is the case there is always a strong suspicion that a meningitis complicated the articular rheumatism, and not a true cerebral rheumatism. The symptoms of the disease usually begin with mild nocturnal delirium, headache, disturbance of vision, and subsultus tendinum. Sometimes there is profuse perspiration and vertigo. As the disease progresses the most prominent symptoms are cerebral excitement, great restlessness, deepening at times into convulsions, and coma. Coma is rare, except in the last stage of fatal cases. Usually there is nearly constant wakefulness. The delirium is generally a quiet, talkative kind, with hallucinations, but sometimes is noisy and violent. The hallucinations are usually of space and time and general surroundings. Distrust and ideas of persecution may be present. There may be disturbances of the special senses, with the characteristic symptoms. The motor portion of the brain is affected, and there is restlessness, tremors, choreic jactitation, and even convulsions. The diagnosis is usually easy, as the above symptoms are characteristic. Care must be taken not to mistake the symptoms due to large doses of the salicylates for those of cerebral rheumatism, as they very closely resemble each other. Two cases are reported showing the symptom-picture due to large doses of salicylates. In cerebral rheumatism the prognosis is bad. In 107 cases reported there were 57 deaths and 50 recoveries. The treatment is wholly symptomatic. The condition does not appear to be affected at all by the salicylates.

BONAR.