

Society Reports.

NEW YORK NEUROLOGICAL SOCIETY.

May 2, 1899.

The President, Dr. Frederick Peterson, in the chair.

A CASE OF CHARCOT-MARIE-TOOTH AMYOTROPHY.

Dr. Frederick Peterson presented, on behalf of Dr. W. H. Caswell, a young girl who, when seven years of age, had an attack of measles. About two years later she became lame in one foot, and a few years later the other foot became similarly affected. Six or eight years after this atrophy began to develop, first in one hand, and then in the other. For a time the case was treated, as most of these cases are, as poliomyelitis. The history was characteristic, the speaker said, of a Charcot-Marie-Tooth amyotrophy. The picture presented was that of an old multiple neuritis. There was great wasting of the muscles of the extremities, including the smaller muscles of the hands. The peculiarity of this form of muscular atrophy was that it affected the legs below the knees, and the arms below the elbows, so that the limbs tapered off in such a singular manner that the diagnosis could be made from this aspect alone. The muscles of the roots of the thighs and of the trunk, on the other hand, were perfectly preserved. While there was no ataxia of the limbs, weakness made it impossible for her to stand still and she kept up a continual tramping, reminding one of the tramping of a horse in his stall. Reaction of degeneration in the muscles had been noticed for at least two years past. The knee-jerks were absent. The speaker said that the affection seemed to be a form of chronic progressive motor neuritis. It was a very rare disorder.

A CASE OF MULTIPLE TUMORS OF THE BRAIN, WITH AUTOPSY.

Dr. E. D. Fisher reported this case. The patient was a colored man, forty years of age, with a history of syphilis and alcoholism. He had been able to continue his occupation of cook up to about two weeks before coming under observation. When first seen he was weak on the right side, and when walking staggered toward that side. Examination had shown partial paralysis and partial anesthesia of the right side of the body. It was difficult to say at the time which side of

the face was paralyzed. Dr. Fisher thought he had been able to detect an incomplete ptosis of the right eye, which was partially overcome by drawing up the muscles of the forehead. This would partly explain the appearance of a partial paralysis on the left side of the face. Considerable exaggeration of the reflexes existed on both sides, and marked optic neuritis was detected. Under iodide of potassium the patient had improved decidedly, but soon afterward he had become almost completely unconscious. After a time he had recovered from the unconsciousness and had been able to go about the ward again. Soon afterward he had developed pneumonia, from which he died.

With such rather vague symptoms a positive opinion as to the location of the growth had been difficult. While in the hospital the patient had had two apparently typical epileptic seizures. The probable diagnosis had been a growth in the left side of the brain, in the region of the crura, or in the upper portion of the pons. At the autopsy a tumor, which was about half an inch in diameter, had been found in the left side of the brain, involving the lenticular nucleus on that side. This would have been sufficient to explain the partial hemiplegia. A similar growth was found on the opposite side of the brain, involving especially the optic thalamus. Microscopic examination by Dr. E. K. Dunham had shown the growths to be gummata. The post-mortem examination had also revealed multiple lesions in the liver and spleen. The spinal cord was not involved.

Dr. G. M. Hammond asked what were the symptoms attributable to the lesion in the thalamus.

Dr. Fisher replied that there had been no symptoms pointing to such a lesion, and it was this that had led to the erroneous diagnosis.

Dr. Fraenkel said that last year he had reported to this society a tumor of the optic thalamus, and had taken occasion to point out certain symptoms that he thought should be carefully looked for. It was generally stated that thalamic tumors usually did not give noticeable symptoms. It was not uncommon in the clinical examination to neglect to examine the facial musculature as carefully as other parts of the body. One reflex of the facial was the psychical or mental reflex. The behavior of the patient when laughing or crying was often significant in cases of lesions of the thalamus. These patients were able to make the grimaces expressive of laughter when told to do so, but the side of the face opposite to the lesion in the thalamus would not participate in the act of either laughing or crying. The patient in the case just reported probably had paralysis on both sides of the face—on one side a mental paralysis. Nothnagel had first pointed out this mental or psychical reflex. The behavior of the vegetative functions should be carefully watched in these cases, for there might be a transient paralysis of these functions.

Dr. Fisher said that the patient was a perfect mimic, and was laughing most of the time, and there could be no question that both sides of his face laughed, although there was always this difference be-

tween the two sides. Several physicians besides himself had watched this case, but had not agreed as to which side of the face was paralyzed. During life the case had suggested multiple tumors, but the location of the secondary tumor had not been exactly determined before death.

Dr. Noyes presented a man who had been injured last November by his right arm being caught in some belting. When he was seen in January there had been partial paralysis and anesthesia of the forearm. On February 1 the anesthesia was confined to the ulnar and posterior interosseous. Quite recently recovery had been fairly complete. A skiagraph was exhibited showing that callus had formed between the bones of the forearm. Pronation and supination were in abeyance. An operation would be necessary to restore the motion of the forearm, and the question arose as to whether such an operation would greatly interfere with the innervation of the arm.

Dr. Fisher said that the man had improved so much that he would suggest that the operation be postponed to allow of further improvement.

Dr. Noyes said that at first he had supposed the condition of the nerves was the result of pressure from the callus, but the rapid improvement had led him to think that it was possible that the injury to the nerves had resulted rather from wearing the plaster-of-Paris dressing than from the original injury. He was afraid that operation might lead to further involvement of the posterior interosseous.

Dr. Peterson said that from the history he would say that the case was probably one of paralysis from the pressure of the bandage or splint. With ordinary care the surgeon should be able to operate without inflicting further injury upon the nerves.

SENSORY DISTURBANCES IN EPILEPSY AND HYSTERIA.

Dr. E. D. Fisher read this paper, which was based on two cases, one of epilepsy and the other of hysteria, in which he had noted a peculiar distribution of the anesthesia. Richter had collected, he said, 71 cases of hysteria which had been examined especially as to the sensory disturbances. Dr. Fisher's patients had both been entirely unaware of their anesthesia until the examination.

The first case was that of a woman of seventeen years, who had had her first epileptic seizure at the time of the establishment of the menses. The seizures had recurred with each menstrual period, and without any aura. There was absolute anesthesia of certain parts of the face, trunk and upper extremity. Between the seizures the patient had been in full possession of her faculties. While there was a tendency for the anesthetic area to decrease, certain features had remained permanent. There was absolute loss of sensation over the central portion of the forehead from the glabella to the root of the hair. All portions of the scalp and face possessed normal sen-

sation. In the first two weeks there was some anesthesia over the shoulders and chest. The extensor side of the forearm and the dorsal surface of the hand exhibited a similar condition. There were no other symptoms indicative of disease.

The second case was that of a woman of twenty-four years, large and well nourished. She came to the hospital complaining of great pain on the left side, directly under the scapula. This pain was not increased by motion. Further examination showed plaques over the chest and shoulders which were absolutely anesthetic to all forms of irritation, and varied from time to time. The extensor side of the forearm and the dorsal side of the arm remained at all times absolutely anesthetic. The patient had remained under observation for several weeks, and died of pneumonia involving the side primarily affected.

The speaker said that these cases resembled in some respects examples of syringomyelia, and he was inclined to think that there was some spinal disturbance. One interesting feature was the similarity of the distribution of the anesthesia in cases of such different character, and coming under observation at the same time.

Dr. G. M. Hammond said that it had never seemed to him that the anesthesia was a symptom that properly belonged to epilepsy. The fact that the patient did not know of the existence of the anesthesia was not of much importance, for this ignorance was frequently observed in true hysteria. In many cases of epilepsy, particularly where the lesion was cortical and situated in the sensory areas, it was probable that there would be disorders of sensibility; nevertheless, he did not think such disorders should be considered pathognomonic of the epileptic state. Where such sensory disorders were observed he would rather believe that there was a hysterical element combined with the epilepsy. He would like to know if tests had been made regarding constriction of the color field and visual field, and a search made for the stigmata of hysteria.

Dr. Fisher replied that such an examination had been made in only one of the cases.

Dr. Fraenkel said that these cases only served to emphasize the importance of making careful examinations of the sensory disturbances. Such disturbances he knew personally varied greatly from time to time. He had made it a rule to have a chart made of the sensory conditions of every patient entering the Montefiore Home, and in studying these he had been astonished to find sensory disturbances in connection with tuberculosis and all sorts of diseases in which there was no disorder of the nervous system. Frequently they could be traced to slight injuries of the nerve filaments. The most interesting feature, however, was the variability of these disturbances. He recalled one case of syringomyelia that had been in the Montefiore Home for a number of years, in which he had discovered by accident a marked change in the sensory symptoms from morning to afternoon. He had not yet met with any cases of epilepsy presenting marked areas of anesthesia.

Dr. S. E. Jelliffe asked whether Dr. Fisher's patient had been taking large doses of the bromides, for in such patients there were

certain forms of anesthesia. The anesthesia of the pharynx was well known, and there were other anesthetics in other parts of the body observed in persons taking bromides.

Dr. Bailey said that he had been especially interested in the absence of all knowledge of the anesthesia on the part of the patient. It was important to draw the line between the functional and organic anesthetics, and it could often be done by this very question of the knowledge or ignorance of the patient of the existence of such anesthesia. He had never seen anesthesia extending down on the arms and hands, and resulting from organic disease, that the patient was not aware of. In typical hysterical cases the patients were not generally cognizant of its existence.

Dr. Peterson said that one should be very careful in studying the areas of anesthesia, especially in functional cases. He had observed marked variations in cases of syringomyelia, particularly in the boundaries of these areas. All were familiar with the transitory anesthetics occurring in epilepsy. Such instances, he thought, could be classified with the exhaustion pareses. In regard to the theory offered by Dr. Fisher as to the irregular areas of anesthesia distributed over the whole body in hysteria and epilepsy, he would say that he would look upon them as of a hysterical nature, and not of spinal origin. It was known that a hysterical element was present in epilepsy, as it was present also in tuberculosis and certain other diseases which influenced the nervous system quite profoundly.

Dr. Fisher, in closing, said that the two cases reported had been a surprise to him. They had presented exactly the same symptoms, and so far as he knew, these areas had remained unchanged. There was nothing remarkable about the anesthesia itself, or its variability. Anesthetics changing from time to time he certainly would not refer to the spinal cord, but when they were permanent it would seem that they must have an organic lesion as a basis. He was not speaking of these two cases alone, but of a number of similar ones reported by others. He had seen a case of syringomyelia in which there had been an area of anesthesia on the hand, and the patient had been entirely ignorant of its existence until his hand had been injured. One of the patients had never taken bromide, and the other had taken it in very moderate doses, if at all. He had never seen even the largest dose of bromide produce an anesthesia in which there would be no response under severe irritation. He felt sure that a great many more cases of this kind would be found, now that attention had been directed to the subject.

Dr. Bailey remarked that the case of syringomyelia referred to was hardly a fair one to cite as a proof of the existence of complete anesthesia without the knowledge of the patient.