

Dr. B. Onuf said that Dr. Castelli had made the statement that in a large percentage of cases of general paresis—70 or 80—the Wassermann reaction was positive, and also in about 60 per cent. of cases of senile dementia. Could we conclude from that that senile dementia was simply a late form of general paresis? That syphilis produced a rather rapid exhaustion of the nervous system, while in senile dementia identical changes occurred in a longer course of time? Did he mean to identify senile dementia with general paresis?

Dr. Boleslaw Lapowski, discussing the Wassermann reaction, said that on account of its technique and the material and control experiments that it involved, it would always remain a laboratory test. By terming it the "Wassermann reaction" we were inadvertently doing an injury to others who laid the basis of the reaction. Wassermann simply substituted dissolved substances of bacterial extracts of organs instead of emulsions of bacteria, but the basis was the fact discovered by Bordet and Genou, and to them at least some credit was due.

The test was of undoubted value in corroborating or establishing the diagnosis of latent syphilis, but even then it could not always be relied upon, and in dealing with primary or secondary syphilis it was not necessary.

The president, Dr. Sachs, said that while the Wassermann test could not be done at the bedside, its technique was not difficult and could be easily acquired. For the present, of course, this test, as were many others, would be restricted to the laboratory and had to be made by persons who were specially qualified along those lines. Thus far, the reaction had been practically limited to cases of suspected tabes or general paresis, but at the Mt. Sinai Hospital an effort was being made to employ it in other doubtful spinal or cerebral cases where syphilis was suspected.

PHILADELPHIA NEUROLOGICAL SOCIETY

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The President, DR. J. W. McCONNELL, in the Chair

TUMOR OF THE RIGHT INFERIOR PARIETAL LOBULE. OPERATION; PARTIAL REMOVAL; IMPROVEMENT

By F. X. Dercum, M.D.

T. G., age 39, single, laborer by occupation, was admitted to the Jefferson Hospital, May 12, 1908.

Family History.—Father died of an accident at 45 years of age. Mother died at 50 from tuberculosis. Two brothers and one sister died of tuberculosis.

Personal History.—Does not recall having had the usual diseases of childhood. Has always had good health with the exception of an occasional severe cold. Has used tobacco and liquor moderately. Had gonorrhea ten years ago; no syphilis.

Present Illness.—Three weeks before admission while working, he became suddenly very short of breath and dizzy and fell to the ground;

he was not unconscious, and immediately arose, but was so weak that he could not walk without assistance; he was short of breath for several minutes. He was obliged to go to bed, where he remained for several weeks because of general weakness. He also suffered from dull headache.

Condition upon Admission.—Complains of general weakness, of headache, of occasional attacks of dyspnea and of pain in the left side of the chest. He is fairly well developed and in a fair state of nutrition. There is some impairment of resonance over the right apex and anteriorly prolongation of expiration. There is also some prolongation of expiration over middle and lower lobes of right lung when many fine crepitant rales are heard.

Examination of the Nervous System, May 27, 1908.—Patient is quite weak. Has difficulty in standing upon either leg alone, but the left leg is distinctly weaker than the right. The grip in the left hand is somewhat weaker than in the right. The knee-jerks and tendo Achillis jerks are both slightly plus on both sides. There is no ankle clonus and no Babinski sign upon either side. Tendon reflexes of both arms are slightly plus. No inequality of tendon reflexes can be elicited. The left angle of mouth is slightly lower than the right and there is slight flattening of the left side of the face. The patient recognizes all objects promptly with the right hand; with the left hand he recognizes them with considerable difficulty and every now and then fails. In other words there is an incomplete astereognosis in the left hand. There is considerable mental hebetude and also dull headache.

The ophthalmoscopic examination made on the same day reveals marked choked discs. In the left eye there are two flame-like hemorrhages over the disc. There is present a neuro-retinitis. The veins are large and tortuous, the arteries are small and straight. The pupils are slightly irregular but react normally. The movements of the eyeballs present no anomalies save that they are tardy. There is also present a left lateral homonymous hemianopsia.

The diagnosis of tumor of the right inferior parietal lobule was made. The question of operation was considered and presented to the patient who, however, withheld his consent for the time.

Reexamined on June 2, 1908, it is found that the right knee-jerk is more pronounced than the left and that the weakness in the left hand is a little more marked. Astereognosis also is now slightly more evident in the left hand.

Reexamined June 7, the same symptoms are noted as before save that there is now a faint hypesthesia of the left side of the face, left side of the trunk and left upper extremity, especially the hand. Ankle clonus and Babinski are still absent. Headache is quite pronounced. Hebetude is marked; questions are answered very slowly.

Eyes reexamined June 8, reveal double optic neuritis, more marked in the left eye. No hemorrhages or patches of exudation are noted in this examination. The veins are dilated and tortuous, arteries are contracted. An examination of the fields reveals a clearly marked left lateral hemianopsia with no apparent contracture of the periphery.

On June 11, 1908, the patient was operated upon by Dr. J. Chalmers Da Costa. A large osteoplastic flap was made over the right parietal region. The bone over the area was sclerotic and worm-eaten and was evidently the seat of old tuberculous caries. Bone, membranes and brain were fused together over an area the size of half a dollar. The dura

showed yellow tuberculous masses over both outer and inner surfaces. On attempting palpation, the finger broke into a softened area in the center of the mass which extended downward into the brain substance for about an inch. A portion of the mass was removed. An attempt was made to close the dura using fine silk sutures, iodoform gauze packing was inserted and the osteoplastic flap replaced.

The portion of tissue removed consisted of a grayish-white nodule which upon microscopical examination proved to be tuberculous.

Eyes reexamined June 18, 1908. An ophthalmoscopic examination made by Dr. Hansell revealed double optic neuritis, more marked in the left eye. Nerve head was but slightly swollen. Left eye still shows marked swelling of discs with hemorrhage. There is also some contraction of the peripheral field. Left lateral hemianopsia is still present. Contraction of periphery.

The subsequent history of the case was uneventful. By June 20 the wound was healed while the patient was in good general condition. He was discharged from the hospital on June 10.

The patient was reexamined on July 28, 1908. States that he suffers very little from headache. Mentally he is much clearer and much more alert. Walks normally but does not stand quite as well upon the left leg as upon the right. Grip of the left hand is still weaker than that of the right, the right hand registering 42 and the left hand 32 on the dynamometer. The left knee-jerk is somewhat plus; right knee-jerk normal. Left tendo Achillis jerk is also plus as compared with the right. There is no Babinski. The astereognosis formerly present in the left hand has almost disappeared but not entirely so. The hypesthesia has disappeared save over the left hand where it is still faintly present. Fields are still hemianopsic, though there is some contraction at the periphery.

The patient was readmitted to the Jefferson Hospital on October 8, 1908, suffering from marked general weakness. The examination revealed little change from the condition last noted save that the optic neuritis had subsided in both eyes but atrophic changes had become very evident. Contracture of the remaining visual field had also become very pronounced. There had been some recurrence of headache. The above case is interesting mainly as regards the question of localization. It resembles in this respect the case reported by Drs. Mills and Frazier at the last meeting of the American Neurological Association. The fact that the patient has tuberculosis, of course, makes the outlook unpromising. However, the improvement of symptoms following the operation, namely, the relief of headache, the subsidence of the neuritis, the cessation of the progress as regards the hemi-paresis, the practical disappearance of the hypesthesia and the improvement in the stereognosis of the left hand, fully justified the surgical interference, although the future will probably prove that the relief has been only temporary.

Dr. D. J. McCarthy said it had always been a question in his mind as to whether the function of astereognosis was a complex function composed of various sensory impressions and was localized to one or to both sides of the brain. Dr. Dercum's case would indicate that there is a center for astereognosis on the right side of the brain as well as on the left. It might be well to remember that multiple foci of tuberculosis are much more frequent than single foci. This does not refer absolutely or particularly to one type of tuberculous lesion, by which statement he means that it is not infrequent to find with a local tubercu-

lous lesion a subacute or a chronic form of leptomeningitis or pachymeningitis and not infrequently associated lesion of the spinal cord.

NEURITIC FORM OF SYRINGOMYELIA

By Alfred Gordon, M.D.

A man of 29 whose occupation was carrying ice, five years ago fell. A few hours later he began to suffer pain in both arms. The pain continued two months. It was at first dull but continuous; soon sharp pain would come on. At times it was excruciating. At the end of two months it gradually subsided but dull aching remained. At that time the patient developed a gradual oncoming atrophy in the upper limbs. At present the atrophy is marked in the hands, arms, shoulders and scapular regions. The hands present the "main en griffe." Fibrillary contractions and reactions of degeneration are present. There is also some wasting in the lower extremities. The reflexes are all markedly increased. In the upper extremities there is a quite marked syringomyelic sensory dissociation; the same is observed in the scapular regions and upper part of the thorax. The arms are very tender. A slight grasping of the forearms and arms provokes pain. The old neuritis is evidently still present. The lower extremities are free from neuritic symptoms.

The case is analogous to the one reported by Guillain in 1901. He observed a patient whose history was reported first by Mme. Dejerine-Klumpke, and later by Dejerine; he found syringomyelic symptoms which gradually followed the ascending neuritis. Dr. Gordon's case is interesting from the etiological and diagnostic standpoints, the original trauma, subsequent neuritis and later syringomyelia. It is also interesting to note the existence of syringomyelia and neuritis at the present stage of the disease.

A CASE OF ADENO LIPOMATOSIS

WITH SOME REMARKS ON THE DIFFERENTIAL DIAGNOSIS OF THE AFFECTION
FROM ADIPOSIS DOLOROSA AND OTHER DISEASES

By Charles K. Mills, M.D.

The patient was a man 33 years of age, who was under examination and treatment in the wards for nervous diseases in the Hospital of the University of Pennsylvania. The patient has been a steady user of beer, and had a history of several attacks of articular rheumatism. About three and a half or four years before coming under observation he developed a small pendulous mass or swelling under the chin. This fatty swelling gradually enlarged and other masses of a similar description appeared in the mammary region, on the shoulders, the upper arm, the back, abdomen and thighs. The enlargements gradually extended and from at first having been more or less isolated, became somewhat diffused. The masses at the date of the exhibition of the patient were enormous, as indicated both by appearance and measurements. Examination of the patient's blood showed some anemia, not of pernicious type. The eyes were a little protuberant and a slight von Graefe's symptom was manifest,