

or vascular changes. The writers discuss their interesting case with reference to the recent experimental work of Aschner and of Camus and Roussy. In man, as in dogs, lesions of the ventral part of the third ventricle may be accompanied by profound disturbances of the circulation and of the regulating mechanism of the hydration of the tissues. In the production of these phenomena the pituitary has but an indirect rôle. As to the nature of these centers in the infundibulum or the tuber cinereum, only hypotheses can at present be offered. But the facts of the writers' case and of the experiments named speak in favor of the theory of modern anatomists that there is a series of visceral centers, arranged at intervals from bulb to infundibulum, whose action radiates over the whole of the vegetative nervous system. The writers mention that Aschner found that puncture of the floor of the third ventricle provoked an acute glycosuria in animals. They explain the absence of glycosuria in their own case partly by the fact that the nutritional state of the patient was very unfavorable for its appearance, and partly by the limitation of the neoplasm.

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Elsberg, Chas. A. MYXOSARCOMA OF TEMPORAL BONE. [Neurological Bulletin, Vol. I, 5, 1918.]

The patient had a somewhat extended history of various illnesses in all of which the left side of the body, and especially the cranial nerves of the left side, were affected. The first of these illnesses began when the patient was four years old, when an attack of small-pox followed by oritis, left behind a paralysis and atrophy of the left side of the tongue and diminished hearing in the left ear. At the age of thirty-three a post-partum attack—probably one of cerebral embolism—added a paresis of the left side of the face and a weakness of the left arm with paralysis of the left vocal cord. Some years later after removal of glands of the left side of the neck, a branch of the left facial nerve was found to be completely paralyzed (*ramus marginalis mandibulae*). Finally the patient developed symptoms which were clearly referable to the left lobe of the cerebellum and the left posterior fossa—ataxia, nystagmus, *adiadochokinesis*, hypesthesia over the distribution of the left trigeminus, complete paralysis of the left facial, complete nerve deafness in the left ear, and loss of the normal caloric reactions on that side. The case was diagnosed as tumor in the left cerebellopontine angle, and an operation performed. On exposure of the dura covering the lower part of the left hemisphere considerable yellow gelatinous material began to extrude from the left posterior fossa, and on depressing the dura, the left posterior fossa was found to be entirely filled by this material. Considerable of the gelatinous material was removed, and was found on examination to be of the nature of a myxosarcoma. The patient died ten days after the operation. Cranial autopsy showed the brain of normal size and shape. There was moderate distension of the third and lateral ventricles. Right cerebellar lobe was normal. The

left side of the pons and medulla and the left cerebellar lobe were deeply indented by a large tumor mass of gelatinous consistency which entirely filled the posterior fossa on the left side between the dura and the bone. At one spot the growth had perforated the dura and a second tumor mass lay against the pons and medulla inside of the dura. Removal of the brain the petrous portion of the left temporal bone was found almost entirely destroyed by the tumor, only a thin shell of bone remaining. The tumor had evidently originated in the petrous portion of the left temporal bone, had perforated the bone, and filled the posterior fossa on the left side. A moderate foraminal depression on both lobes of the cerebellum showed there had been a protrusion of the cerebellum into the foramen magnum, which explained the sudden medullary death of the patient.

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Sabrazès, J. TENTACULAR GLIOSARCOMA OF THE CORPUS CALLOSUM.

[Gaz. Hebd. des Sci. Méd. de Bordeaux, 1918, XXXIX, p. 25.]

A gliosarcoma of the corpus callosum which extended, by tentacle-like expansions, forward into both hemispheres. A woman, 52, was admitted on January 24, 1913, and died four days later. For four years she had had paroxysmal frontal headache, rather worse on right side. Her intelligence seems to have been always very mediocre. In 1909, uncertain and titubating gait, obstinate constipation, boulimia, exaggerated thirst; and gradually psychical symptoms developed in the shape of a disaccord between her words and her actions. There was apraxia. She could not take care of herself. Increasing amnesia, verbal confusion, and disorientation in space. She then lapsed into chronic mental confusion, could not converse, and gave erroneous and contradictory answers. Two years later (August, 1911), when very feeble in mind and body, she had a stroke which left her lower limbs paralyzed; the left, and then the right lower limb became contracted, the flexion of the fingers on the palm producing ulcerations. Sensibility to prick apparently blunted on both sides. She lay in right lateral decubitus, with thigh and leg flexed but mobile, and not contracted on this side. She never complained, and was indifferent to everything. A month before admission in 1913 she spoke no more, and neither ate nor drank spontaneously. She passed excreta in bed. She had large bedsores in numerous places, with fever, stiffness, and mental clouding. She could not be made to put out her tongue. Urine albuminous, with skatol reaction and slight excess of indican. Flaccid paralysis. Articular sensibility to limb-displacements was preserved, and was even increased on left. Lively reflexes, with Babinski positive on L., doubtful on R. She died from the infection of her multiple bedsores in a state of cardio-pulmonary collapse. Necropsy: a gliosarcoma of anterior region of corpus callosum extending into both hemispheres. In the left hemisphere the genu of the callosum is invaded by the tumor which at this level is of the size of a chestnut. It extends along the roof of the