

in other respects over the rest of the army medical officers, he could not undertake that their pay and rate of promotion should be identical. There never has been any difficulty in obtaining medical officers for the Guards." We are disposed to agree, to a considerable extent, with Mr. Childers, although we think he has over-estimated "the great advantages" supposed to be enjoyed by these officers. We believe that it was owing to pressure brought to bear by themselves on the War Office that they were exempted from the operation of late Warrants. If this be so, they must be content to bear the disadvantages arising from this in consideration of having retained what they deemed privileges. At the same time we think that, in the interests both of the medical officers and the men entrusted to their care, certain modifications in the department are necessary. The most important of these is the appointment of an officer for administrative duties. We pointed out lately the absence of all information in the Army Medical Department Report on the subject of the barrack accommodation and general sanitary arrangements of the Guards. We think that the Senior Surgeon-Major of the Brigade might advantageously be made a Brigade-surgeon, for the purpose of inspecting the barracks and hospitals, and advising the General Officer in command of the Home District on all questions relating to the health of the Guards, and that he should be required to report on such matters to the Director-General, for the information of the Secretary of State. Considering the very slow promotion in the brigade, it would be only just to extend to it the principle adopted in the line, of granting promotion to the rank of surgeon-major after a certain number of years' service. It may be very true, as Mr. Childers pointed out, that no difficulty has been felt in obtaining medical officers for the Guards, but it is a serious question whether it is advisable to continue a system which must naturally give rise to feelings of discontent and, as a probable consequence, to a want of zeal and efficiency in the discharge of important duties. We trust that the Secretary of State may see his way to introduce such changes as may remove any such unsatisfactory condition, and also secure to the Household Troops an efficient supervision in sanitary matters.

#### VOLUNTEER AMBULANCE DEPARTMENT.

The official inspection of Surgeon-Major Godwin's class of volunteers connected with the Arsenal took place at Woolwich on the 2nd inst., when the certificates of proficiency in stretcher drill and first dressings to the wounded were presented to the class by the President, Surgeon-General William Munro, C.B. The inspection, which began at eight o'clock, was witnessed by Colonel Farrell, the Commandant of the 26th Royal Arsenal Volunteers, and several officers who accompanied Surgeon-General Munro from London. The class went through the "stretcher drill" most steadily, and showed considerable skill and knowledge in applying bandages, splints, &c. Certificates were then delivered to over thirty members of the 26th Kent and Kent Artillery Volunteers by Surgeon-General Munro, who complimented the class on the particularly steady manner in which they had gone through their work, and their knowledge and skill in applying the various dressings. He urged them to continue to study and practise bandaging and first dressings, as from their work in the Arsenal they may have constant opportunities of putting their knowledge to a practical test.

#### GOOD SERVICE PENSIONS.

We have much pleasure in announcing that Her Majesty has, on the recommendation of H.R.H. the Field Marshal Commanding-in-Chief, bestowed six pensions of £100 a year, for "distinguished and meritorious service," on the following medical officers of the army:—Director-General Sir Wm. Muir, K.C.B.; Surgeon-General C. A. Gordon, C.B.; Surgeon-General Huntly G. Gordon, M.D.; Surgeon-General William Munro, C.B.; Surgeon-General H. H. Massy, C.B.; and Surgeon-General Thomas Crawford, M.D. The officers were selected from those on full pay on the 1st of April, from which date, the commencement of the financial year in the army, the pensions are drawn. We offer our sincere congratulations to the Army Medical Department on this substantial recognition of the good work done by members of their service in all parts of the world.

The officers of the Army Medical Department employed with the Cabul Field Force in Afghanistan have erected a

handsome and substantial monument over the graves of Deputy Surgeon-General J. H. Porter and Surgeon Alexander Keith, both of whom died in Cabul in December last, from pneumonia brought on by the exposure and privation they had gone through during the campaign.

Surgeon William Finlay, Army Medical Department, has been appointed Assistant-Surgeon to the Royal Military College, Sandhurst, vice Surgeon-Major John Anderson, who has accompanied the Marquis of Ripon to India as Surgeon on the Personal Staff of the Viceroy.

Brigade-Surgeon J. L. Jameson has been appointed to officiate as Deputy Surgeon-General of the Allahabad Division, vice Deputy Surgeon-General J. Gibbons, C.B., invalided to England.

ARMY MEDICAL DEPARTMENT.—Brigade-Surgeon Thomas Smith Hollingsworth is granted retired pay, with the honorary rank of Deputy Surgeon-General; dated June 9th, 1880. Surgeon Francis George Adye-Curran, M.B., from half-pay, to be Surgeon; dated May 5th, 1880. Surgeon Phineas Barrett Tuthill, M.D., from half-pay, to be Surgeon; dated May 12th, 1880.

VOLUNTEERS.—Surgeon Angus McMillan, M.D., resigns his commission in the 4th East Riding Corps, but is permitted to retain his rank and to continue to wear the uniform of the corps on his retirement; dated June 9th, 1880. Henry Eugène de Méric, gent., to be Surgeon in the 2nd Tower Hamlets Corps; dated June 9th, 1880. Acting Surgeon Edgar John Don Bavand resigns his commission in the 1st Cumberland Corps; dated June 9th, 1880. Acting Surgeon George Cran, M.D., to be Surgeon in the 1st Kincardineshire and Aberdeenshire (late 2nd Kincardineshire) Corps; dated June 9th, 1880.

ADMIRALTY.—The following appointments have been made:—Staff Surgeon H. J. Lauder and Surgeon A. W. W. Reid to the *Defence*; Surgeon G. J. Irvine to the *Hector*; Surgeon C. W. Magniac to the *Flora*.

## Correspondence.

"Audi alteram partem."

### ON THE DIAGNOSIS OF TUMOURS OF THE CEREBELLUM.

To the Editor of THE LANCET.

SIR,—I desire to make some comments on Dr. Althaus's letter<sup>1</sup> referring to a paper of mine with the above title.<sup>2</sup>

To clear the ground, I will first point out that certain things to which he gives prominence require only passing notice. Everybody knows that tumours of the cerebellum, or of the cerebrum, may exist without any symptoms, at any rate, without striking symptoms, or symptoms available for diagnosis. My experience is quite in accord with that of Nothnagel and other observers, who have pointed out that localising symptoms are more frequently present when the middle lobe of the cerebellum is the part involved by disease. It is, as far as I know, the accepted opinion that the stress of cerebellar disease falls on the legs before it affects the arms. It has been asserted, over and over again, that vomiting and optic neuritis are of no localising value, and it has long ago been pointed out that pain at the back of the head is not to be trusted in the diagnosis of tumour of the cerebellum. On these matters I, at any rate, cannot be at issue with Dr. Althaus.

The "first principle of diagnosis" is very true. There is no one who would not prefer as evidence for or against localisation a circumscribed small lesion to one which might involve several parts, or to one large enough to exercise pressure on other parts. We must make the best of the cases we meet with. The reader must not overlook the fact that in the cases Dr. Althaus is remarking on the diagnosis of cerebellar tumour *was made*. Apparently, according to

<sup>1</sup> THE LANCET, May 8th, 1880.

<sup>2</sup> Ibid., April 3rd, 10th, and 17th.

Dr. Althaus, it ought not to have been made on the evidence adduced.

Of course it is quite legitimate to infer that better reasons for the diagnosis might have been given, or that the necropsy showed that the diagnosis was a mere guess. On the latter supposition it would be remarkable that in three successive cases a correct guess should have been made on the same grounds.

In other parts of his letter Dr. Althaus confidently expresses certain opinions, which of course he has a right to do. I am glad he has. In the following I join issue with him, and after his own method I express confident opinions to the contrary. One of us, or very likely both of us, will have to take the scientific consequences.

The walk in ataxy and in cerebellar disease is, according to Dr. Althaus, "generally very similar." "Very similar" is a vague expression here, and so is the expression that in "some cases" it is impossible to draw a distinction. These are generalities which cautious men will leave as they are. I may, however, remark that observers are constantly making the distinction. Further, I can say that I never knew anyone find a cerebellar tumour in a case he had declared to be tabes dorsalis, and I never knew anyone find posterior sclerosis in a case he had called cerebellar tumour. The diagnosis of cerebellar disease is often made from the gait alone. For, as aforesaid, optic neuritis, headache, and vomiting are of no localising value. By them we infer, almost with certainty, that there is a tumour, and by a reel we infer that the tumour is cerebellar, or at least sub-tentorial.

Next as to vertigo of the kind Dr. Althaus describes. I have not myself found that vertigo is present to any marked degree in cerebellar tumour; never to a degree which I should trust in diagnosis. Vertigo is a symptom which it is most difficult to estimate properly. This, of course, is only opinion against opinion. The issue will be decided by cases.

I am particularly glad that Dr. Althaus has expressed his disbelief that the tonic convulsions can be due to disease of the cerebellum. I say this because his denial enables me again to draw attention to the matter. That they occur with disease of the cerebellum there is no doubt; that they might depend on squeezing of the subjacent medulla was suggested long ago, as also that they might depend on some change induced in the corpora quadrigemina.<sup>3</sup> So, then, there are two opinions. Time will decide this issue: Do the tonic convulsions occurring with cerebellar disease depend on discharge of the part wherein the tumour lies, or on the more or less severe pressure it exercises on another part, such as the medulla oblongata?

Of course, it goes almost without saying that we have to establish the absence of tonic convulsions in tumour of other parts. With tumour of one large division of the nervous system—the cerebrum proper—we may say that they are almost never seen. This is the more significant since another kind of convulsion is very common with tumour of that division. However, Dr. Hughlings Jackson has mentioned one case—the only one of the kind he had seen—in which with a large cerebral tumour there were tonic convulsions at the very close of the patient's life. Since it has been said that tumour of the cerebellum may exist without any symptoms, or any marked symptoms, it is really superfluous to say that there may be no tonic convulsions. It is well, however, to give prominence to this. In cerebral tumour there sometimes are, and sometimes are not, convulsions. But it is granted, too, that there may be reeling gait, and also a certain kind of rigidity in cases of tumour of the cerebellum where there are no tonic convulsions. So it is of tumour of the cerebrum: there may be hemiplegia without epileptic or epileptiform convulsions.

With reference to movements of the eyeballs, Ferrier's experiments prove that electrical excitation of the middle

lobe of the cerebellum produces movements of the eyeballs, in association with movements of the head, in a direction varying with the application of the electrodes. He shows, also, that the effects he thus produces are not due to conduction. I am aware that injury to the middle peduncle of the cerebellum produces particular deviations of the eyeballs. M. Nonat, many years ago, diagnosed correctly disease of this part from this symptom. I have witnessed as part of the tonic convulsions which occur with tumour of the cerebellum movements of the eyeballs; but as, according to Dr. Althaus, the tonic convulsions which occur with tumour of the cerebellum are not due to affection of the cerebellum, he may not regard this fact as of any importance.<sup>4</sup>

Enlargement of the head occurs in children; it scarcely can occur except in children. I would here mention in passing that in cases of tumour of the cerebellum in adults we often find at the necropsy dropsy of the lateral ventricles, which, no doubt, answers to the symptom—a slowly developing hebetude from the gradual deterioration of the compressed brain.

It is well known that large tumours, or other masses, in one cerebral hemisphere may cause enlargement of the head in children, and, since in little children the gait is tested with great difficulty, a slight hemiplegic defect might be confounded with the reel of cerebellar disease in a young or indocile child. But I have never known this mistake to be made. Enlargement of the head in a child past the age when ordinary hydrocephalic enlargement usually occurs, in association with optic neuritis indicating some intracranial growth, is some evidence of the disease involving the middle lobe of the cerebellum. As above said, it might occur from a large mass in one cerebral hemisphere, but even then the diagnosis is practically limited to one of these two regions, which is a step towards localisation. Sir William Gull was, I believe, one of the first to draw attention to enlargement of the head from tumour of the cerebellum.

Finally, as to the cases which formed the text for my remarks. That the post-mortem appearances were not given in greater detail is explained by my not wishing to burthen the pages of THE LANCET.<sup>5</sup> I thought I had stated what was essential, but since I find my omitting certain negative conditions appears to render the cases incomplete, I will now supply further details.

Cases 1 and 2 were carefully examined by myself. In Case 1 the whole of the cerebrum, the pons, medulla, and upper half-inch of the spinal cord appeared healthy. In Case 2 there was no disease of the pons, and small part of the spinal cord removed with the brain. The medulla oblongata showed the squeezing I described, but section of it showed no apparent disease. There was no tubercle in any parts than those I named. In Case 3 I was only present at the commencement of the necropsy. I saw the tumour and surrounding parts *in situ* and after their removal, but being unable to remain to complete it, the detailed examination was conducted with great care and patience by Mr. Frederick Treves. He reports: "The pons and medulla and, indeed, the entire encephalon, were examined in the most careful manner possible—indeed, I spent the whole afternoon over them. Every nerve was isolated and examined, and every part, both of the cortex and of the cerebral collections of grey matter. I was much interested in the case, having watched the symptoms during life, while the lad was on the surgical side. The pons and medulla and, indeed, every part except the cerebellum, were perfectly healthy in every respect so far as the naked eye could judge. The tumour from its position could not have influenced (by pressure) the functions of either the pons or the medulla, as it was well separated from these structures. We can hardly conceive a lesion more accurately isolated or more uncomplicated than was the lesion in this case." It is well known that nervous organs bear slow pressure remarkably well. "I might add that the notes I took of the case were made on the spot, and not from memory afterwards. The outline of the sketch was also made from the specimen before the parts were disturbed."

I remain, Sir, your obedient servant,  
Finsbury-square, E.C. STEPHEN MACKENZIE, M.D.

<sup>3</sup> Of quite recently published cases in which tonic convulsions were present with cerebellar tumour, I may refer to the following: Dr. Hughlings Jackson, THE LANCET, Jan. 24th, 1880, p. 122; Dr. G. Mackenzie Bacon, Brit. Med. Journ., Feb. 21st, 1880, p. 280; Dr. Drummond (Retraction of head), Dublin Journ. Med. Sci., April, 1880, p. 287; and Dr. Dreschfield, Journ. of Anatomy and Phys., vol. xiv., p. 237. Dr. Hughlings Jackson recorded a case in Brit. Med. Journ., Nov. 4th, 1871: he, indeed, holds the hypothesis that tonic convulsions are owing to cerebellar discharges.

<sup>4</sup> Dr. Drummond describes (op. cit.) in his case oscillation of the eyeballs with deviation of one eyeball.

<sup>5</sup> We are always anxious that the reports of cases in which pathological details have been ascertained should be as full as may be necessary for scientific purposes, though closely condensed.—Ed. L.