

loses feeling in the left foot and is unable to locate its position. Before entering the hospital while walking in the street, and without any preceding vertigo or headache or ill feeling of any kind, he suddenly fell unconscious as if shot. On examination in bed there is no evidence of either palsy or ataxia, but as soon as he gets upon his feet a certain motor difficulty is apparent. He has great trouble in standing, much increased by closing the eyes. The left knee and hips are alternately flexed and extended, and the trunk sways backward, forward, and laterally, but always to the left side. After a minute or two, if the eyes are shut, the movements of the left leg become quite wide in extent and he falls. In walking, which he can only do with the eyes open, he has great difficulty in putting the left foot where he wishes, the trouble being purely ataxic and not at all paralytic. He cannot follow a straight line, but always deviates toward the left. On the other hand he cannot turn around toward the left. So soon as he completely lifts the right foot from the ground and attempts to rotate the left upon the floor, the left leg begins to jerk, the body to sway, and he falls with some violence. He turns fairly well to the right. Under all conditions the ataxia of station is greater than that of motion. He can stand upon the right foot alone as well as, or even better, than upon both, and can stand upon the left only long enough to take a step with the right. There is no ataxia in the right leg, the disturbance of equilibrium occurring when he stands upon it being caused by the irregular movements in the left leg. All movements of the arms are executed well. In short, he stands and walks like a man drunk in one leg. He has, one may say, *astasia abasia* of one leg. There is anesthesia to touch, pressure, pain and temperature over the entire left side from crown to toe, and stopping precisely at the middle line. Taste sense is absent on the left half of the tongue and there is a partial deafness in the left ear. The visual field is contracted to a small area, corresponding to the *macula lutea*. Vision is  $\frac{2}{8}$  for the right eye,  $\frac{1}{8}$  in the left. On the third day after admission the hemianesthesia disappeared, but the contraction of the visual field of the left eye, the unilateral loss of taste and partial deafness and the motor trouble continued. The last symptom rapidly improved and on leaving the hospital ten days later he was able to stand quite well, though still unable to turn shortly to the left.

SHIVELY.

## HYSTERIC NATURE OF COCCYGODYNIA.

Bremer (Med. Record, Aug. 1, 1896) enters a vigorous protest against the use of the knife in these cases. He considers the affection to be nearly always hysterical and cites two illustrative cases. Of one of these he says:

"On presenting herself to me for examination and consultation, this patient has the appearance of a healthy, well-preserved matron, whose looks do not betray the slightest trace of the *Iliad* of woes which she relates in a graphic manner. Knowing by experience with other cases that *coccygodynia* is almost always one of the symptoms of hysteria, sometimes apparently monosymptomatic, all the other manifestations of the disease being overshadowed or rendered dormant or insignificant by the overtowering dominance of one—the excruciating pain, I make the preliminary diagnosis of hysteria.

"Of course, I look for hysterical stigmata, but there are none; above all, there is an absence of *anæsthesia* of any kind anywhere, nor is there the slightest indication of a history pointing to hysterical attacks. This woman has been exceptionally healthy all her life. But on close examination I find that travelling and change of scenery lessen the pain, that at times she is slightly aphasic, that there is a tendency to a pulling back of the head, and that often she has "a lump in the throat." I add to this that she is of a gay temperament, and

that in spite of the overwhelming pain she has at all times, but which is particularly aggravating in the sitting posture, she does not present the aspect of a sufferer after having sat in my office for a number of hours, and I come to the conclusion that in the present case the coccygodynia is of an hysterical nature."

He says further:

"The text-books on medicine, and those on neurology in particular, describe the affection spoken of as being neuralgic or rheumatic in character. Probably there exists such cases, although among the dozen that during the last twenty-five years have come under my observation not a single one was of such nature. They were all symptomatic of hysteria, some of them apparently, but not in reality, monosymptomatic. For it is a striking fact that most women thus afflicted positively declare that there is nothing else the matter with them, though closer inquiry brings out the fact that a number of minor complaints exist or have existed, which, however, are ignored or have been forgotten. Hysteria is noted for the tendency to oblivion of ills that have passed.

"In all cases of coccygodynia that I have seen, a history could be elicited, if not of hysteria proper or some allied neurosis in the ascendants, at all events of the existence of the hysterical temperament. In all of them an immediate or provoking cause, a provoking agent (*agent provocateur* of Charcot-Guignon) could be demonstrated. A trauma, severe and prolonged emotional and intellectual strain, infectious diseases, convalescence, parturition and lactation, chronic intoxication (alcoholism, saturnism, etc.) can generally be shown to have existed before at the time of the cropping out of the trouble. The case briefly reported above is one of traumatic (monosymptomatic) hysteria. The several therapeutic procedures (insignificant in the healthy) acted like so many distinct shocks and provoking agents. The administration of the anæsthetic (in some predisposed individuals this alone suffices to bring about hysteria, transient or lasting) in conjunction with the wound, and later on the irritation set up by the introduction of the electrode into the rectum, sufficed to aggravate a condition which, if left to itself, would probably have remained within the bounds of toleration."

Regarding the evidence of hysteria the following statement may be of interest:

"What Charcot and his school have not mentioned in their classic delineations of the syndromes of hysteria are the spastic tendency of the retractors of the head and a trace more or less noticeable of aphasia. I consider them as stigmata of a subtle character, the anæsthesias being of a coarser kind. They are very common in hysterical females and sometimes the only obvious ones in a chaos of indistinct and undefinable malaise."

We think that the experience of all surgeons and neurologists would scarcely be in entire accord with that of the author, as presented in the following paragraph:

"I do not mean to say that never and under no circumstances has the removal of the coccyx been successful in curing pain. Perhaps there are cases in which the operation has been beneficial. Personally I do not know of any. Even in cases of success the question is legitimate: Would not other and simpler means have been equally effective? Generally speaking, the results of coccygodynia are as hopeless as neurectomy in facial neuralgia."

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ON SENILE EPILEPSY AND GRIESINGER'S SYMPTOM DUE TO BASILAR THROMBOSIS. By Prof. Naunyn. *Journal de Neurologie et d'Hypnologie*, Nos. 1 and 2.

Griesinger has pointed out that compression of the carotid arter-