

the interior of the mass. Brouardel quotes a case of sudden death with similar post-mortem findings. C. D. CAMP (Philadelphia).

THE RELATION BETWEEN A CUTANEOUS NAEVUS AND A SEGMENTAL NERVE AREA. G. Lenthal Cheate (The British Medical Journal, Aug. 18, 1906).

The author regards as unique in the literature a naevus occupying the complete area of distribution of the third cervical nerve. The article is illustrated by photographs, but further data of the case is not given.

C. D. CAMP (Philadelphia).

THE BACILLUS PARALYTICANS. F. W. Langdon (Cincinnati Soc. for Medical Research, October, 1906).

The bacillus paralyticans recently announced by Dr. Ford Robertson, of Edinburgh, has been the subject of some research work in the clinical laboratory of the Cincinnati Sanitarium, and pure cultures of the bacillus and also photomicrographs were shown. It belongs to the diphtheroid group, but unlike the Klebs-Loeffler bacillus is non-pathogenic to guinea pigs, although fatal to rats in two or three months. It occurs in rods, singly and with a tendency to groups of threes, and also in a thread form. It has been found in the bronchial, alimentary and genito-urinary mucous membranes, in the cerebrospinal fluid, in the brain, in the walls of the cerebral blood vessels, in the blood, the urine and other secretions and tissues. Robertson believes that it gains access to the system mainly through the respiratory tract and the alimentary canal. Syphilis, alcoholism, etc., are merely contributory factors in breaking down the defenses of the body against bacterial invasion. The invasion of the blood, lymph and tissues by the organism gives rise to the production of toxins, which are responsible for the various trophic, degenerative, convulsive and paralytic phenomena. The polymorphonuclear leucocytes exert a marked lysogenic action upon this bacillus, and to this action is attributed the recession of the bacterial invasion and the remissions so characteristic of paresis. Like the Klebs-Loeffler bacillus, this organism appears remarkable for its polymorphism. It occasionally shows barred as well as solid color forms when stained with methyl blue and carbol fuchsin.

LANGDON.

CEREBRAL DECOMPRESSION. W. G. Spiller and C. G. Frazier (Journal A. M. A., Sept. 1, 8, 15 and 22).

From a rather extensive review of the literature, these authors concluded that palliative operations in cases of cerebral tumor are justifiable. Headache is the principal symptom calling for relief; Spiller is somewhat skeptical as regards any beneficial effect on Jacksonian convulsions. The possibility that operation may obscure focal symptoms is considered and he advises that palliative operations be performed before general symptoms become intense, and especially before optic neuritis threatening blindness has developed. The general unanimity as regards the effects on choked discs of opening the skull makes the necessity of early operation very evident. Palliative operations are not a substitute for radical measures. The tumor should be removed when possible and when sufficient skill is at command. There should be no attempt to remove a glioma, and Spiller thinks that partial removal is generally inadvisable. Sometimes complete relief may follow simple opening of the

skull and dura, but only one case of actual disappearance of a tumor seems to be on record: that of Horsley. Spiller sums up his views as follows: (1) "Palliative operations should be performed early in every case in which symptoms of brain tumor are pronounced and before optic neuritis has advanced. (2) Partial removal of a tumor, especially of a glioma, is a questionable procedure. (3) Palliative operation does not cause atrophy of a brain tumor, and probably does not arrest its growth; on the other hand, it probably does not hasten its growth. (4) Palliative operation is not to take the place of a radical operation when the latter can be performed without great risk to the patient. (5) In some cases the symptoms of brain tumor disappear almost entirely for a long time or permanently after a palliative operation. This result is obtained either by relief of intracranial pressure or by removal of some lesion (meningitis serosa, etc.), other than brain tumor, and yet causing symptoms of tumor." The surgical aspects of the subject are discussed by Dr. C. H. Frazier at some length. The question whether a palliative or a radical operation is to be chosen is dependent on whether the tumor is operable or not, and there are two classes of cases, he says, in which a decompressive operation may be required. One is when there is reason to believe that the tumor can not be entirely removed and the other when it can not be localized and yet the symptoms call for relief. This happens more frequently with cerebellar tumors, and in certain cases he has removed from one-quarter to one-third of the cerebellar hemisphere.

CASE OF OBSCURE INTRACRANIAL TUMOR, WITH EXTENSION TO FOURTH VENTRICLE. G. H. Grant Davie (The British Medical Journal, Aug. 11, 1906).

The first symptom noted was a severe occipital neuralgia which was always most severe at about 5 A. M., and prevented further sleep. There was also a choking sensation when lying down. Gait and station were normal, but the patient had a sensation when walking or "running forward on her toes all the time." The pain later increased in severity and extended forward to the left ear and angle of the jaw. A kneeling position with her forehead to the floor gave her the most relief. An eye examination six weeks before her death showed 6-12 vision, but was otherwise negative. At necropsy, a layer of soft gelatinous tissue was found covering to a depth of one-quarter inch the whole of the anterior half of the under surface of the left cerebellar hemisphere and extending as a delicate covering over the hinder half of the floor of the fourth ventricle. The growth was distinct from the adjacent brain and was histologically a round cell sarcoma with almost complete absence of intercellular stroma. The ventricles were enlarged and filled with a clear fluid.

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