

The lesion in this case was located in the upper cervical region. The radiographs demonstrated no fracture nor dislocation.

A CASE OF SPINAL HEMATOMYELIA OF THE PARAPLEGIC TYPE

By Frederick Tilney, M.D., and C. L. Nichols, M.D.

The patient was a Russian tailor, 34 years old, who came to the Vanderbilt Clinic on September 16, 1914, complaining of inability to walk properly, with pain in the back when seated, swelling and coldness of the feet and lack of control of the bladder. The family as well as his previous history was negative.

Nine months ago, in an attempt to escape from a burning building, the patient either fell or jumped from a fire escape, a distance of two stories. He was picked up in an unconscious state and removed to the Gouverneur Hospital. He remained unconscious for two hours—perhaps longer—and on recovering his senses he was unable to move either lower extremity and had retention of urine. He remained in the hospital for six weeks, with slight improvement. He was then taken to the Beth Israel Hospital, where he remained three months and where some operation was done. Following this his condition improved and he regained some power to move the legs. He was now able to walk, with some difficulty.

Examination at the present time showed normal cranial nerves and normal reflexes, with the exception of those at the patella and ankle, which were exaggerated. The station was unsteady and the gait spastic. Motor power in both extremities was defective, with some atrophy of the muscles. There was a fine tremor of the hands and tongue. There was an area of anesthesia over the left gluteal region.

Dr. Frederick Tilney, who had seen the first two cases of Dr. Nichols in their early stages, said that in both instances he had concluded that the condition was due to hemorrhage into the cord. In the second case, that showing the Brown-Séquard syndrome, the question of an operation was considered by Dr. Arthur C. Brush who advised against it. The improvement in this case was so marked during the first three months after the injury that further delay was advised, and the patient was now able to walk, whereas when he was brought into the hospital he was completely paralyzed. In the first case, the patient with hemiplegia following a diving injury, the radiograph showed a fracture of the sixth cervical vertebra, but this was of such a character that the symptoms seemed to be due to hematomyelia rather than to a cerebral injury or a crushing of the cord. In this case an expectant plan of treatment was also followed and the patient had improved steadily.

One of the reasons why these cases were shown here tonight, Dr. Tilney said, was to get an expression of opinion from the members as to whether early operative interference was advisable in dealing with injuries of this character.

Dr. William M. Leszynsky said that in cases of traumatic lesions of the cord, of which he had seen a large number in hospital practice, the question of operation usually came up for discussion, and in answering it he had been largely guided by the clinical manifestations. If either by

palpation or the x-ray it could be shown that we were dealing with a fracture dislocation producing crushing of the cord, as evidenced by complete motor and sensory paralysis and abolition of reflexes below the lesion, an operation was inadvisable. When blood is found in the cerebrospinal fluid, the hemorrhage is usually subdural. When the cerebrospinal fluid is clear, as in *hematomyelia*, operation is not indicated.

In many of these cases, Dr. Leszynsky said, the early residual symptoms often became permanent, their severity depending upon the amount of damage done to the cord. It was impossible to give a positive prognosis as to the ultimate outcome.

Dr. Benjamin Rosenbluth said that the first case presented by Dr. Nichols he had seen at the Beth Israel Hospital, the man had been previously treated at the Gouverneur Hospital and was brought in with a complete flaccid paralysis of the lower extremities, anesthesia, loss of reflexes and localized pain over the spine. He was put in plaster but this proved so painful that it had to be taken off. Several radiographs were taken with no definite findings. A localized injury involving the body of the vertebra and transverse processes and possibly the cauda equina was suspected, and when the spinal canal was opened over the region of the cauda the nerves were found to be pushed about in all directions and there was a large collection of cerebrospinal fluid. This pressure was relieved and the man made a good recovery so far as motility was concerned, but he still had an area of anesthesia over the thighs. Dr. Rosenbluth said that was the fourth case of injury of the cauda equina that had come under his observation, and the result of the operation was the most encouraging he had seen. The symptoms were not hemiplegic, and his result showed a larger sensory disturbance than reported.

Dr. J. F. Terriberry, in reply to Dr. Tilney, said that in cases where one could be fairly certain that there was a hemorrhage within the cord, little could be expected from operative interference. This could perhaps be determined by the x-rays together with the clinical history. In the cases shown by Drs. Tilney and Nichols the history clearly indicated a hemorrhage into the cord itself, and under those conditions no benefit could be derived from an operation. The spinal cord is a very sensitive organ, as we all know, and any injury to it might be aggravated by operative interference. These cases, as a rule, did much better under proper general care, with subsequent reeducation of the lost muscular function if the residual symptoms demanded it. The fact should be borne in mind that this loss of function was sometimes attributable to a stiffening of the joints of the hands and fingers, which often did much to retard the reparative process, and it was only with care and perseverance that one could get the most out of these cases.

A CASE FOR DIAGNOSIS

By A. Skversky, M.D., and Smith Ely Jelliffe, M.D.

The patient was a child, seven and a half years old, of normal birth; who sat, talked and walked at the proper ages, and appeared to develop normally. She had measles at the age of three years, with an uneventful recovery. Six months later she was said to have had a high fever one night, but no residuals followed. Five weeks after this, without any