

the interior of the left lateral ventricle for over thirty years. To avoid injury of the brain, Dr. Keen had a curved piece of tin fastened to the inside of a skull cap worn by the patient. The case is probably unique as regards the length of life after operation, and the wide open ventricle. It was Dr. Keen's first brain tumor operation, and one of the first on record. It interested Dr. Keen especially in the surgery of the lateral ventricle, and caused him to recommend, for suitable cases, the operation of tapping and draining the ventricles and to describe a technic which is now almost commonplace in its general use.

Knapp, P. TEMPORAL LOBES AND PSEUDO CEREBELLAR ATAXIA. [Deut. med. Woch., June 27, 1918.]

Knapp shows that lesions of the temporal lobes may cause an ataxic syndrome absolutely simulating cerebellar ataxia. This ataxia is an important symptom of lesions of the temporal lobe, after which should be mentioned sensorial aphasia (left temporal lobe), partial paralysis of the third pair and contralateral hemiparesis due to compression of the cerebral pedunculus. These four symptoms serve to differentiate pseudocerebellar temporal ataxia from true cerebellar ataxia, as there is nothing characteristic in the gait which would lead to a correct diagnosis. At autopsy, as Loewenstein has shown, there is no macroscopic nor microscopic lesion of the cerebellum. Pseudocerebellar ataxia from lesion of the temporal lobes is, consequently, not due to a distant action on or by extension to the cerebellum, corpora quadrigemina or the labyrinth, and should be considered as a focal phenomenon. It can only be explained by admitting that the temporal lobe contains a cortical mechanism for equilibrium.

Strachauer, A. C. BRAIN TUMOR. [J. A. M. A., Sept. 14, 1918.]

The author reports a case of brain tumor which he thinks illustrates a new principle to be followed in the surgical treatment of these growths. Craniotomy for brain tumor frequently fails to disclose the neoplasm. The evidence of increased pressure may be present, but inspection, palpation and exploration by incision or aspirating needle fail to reveal the cause. Definite localizing information, however, may develop after decompression, and the brain tumor may then be taken out by reoperating. The cases with focal symptoms before operation, and those without, which do not develop localizing data are considered hopeless and the patient dies. The necropsy shows the tumor. In the case he reports a deep-seated tumor had developed, and by the assistance of the cystic degeneration that occurred after the first operation, which may have been favorably influenced by the decompression, had to a degree come to the surface, revealing itself, and was removed by a second operation, the patient recovering his power to walk and the control of his sphincters. The causes of death in neurologic surgery are discussed and the advantages of decompression stated. Cessation of respiration is rather a

common occurrence and may be the cause of death. Another factor that is responsible for mortalities, and the most frequent one, is shock. Direct shock is subject to the laws of concentration, and dosage and rapid operation is equivalent to a concentrated dose of shock and is to be avoided. Indirect shock is synonymous with hemorrhage, which should be within the control of the operator. The special point of the paper is that operation for brain tumor failing to reveal the cause is not necessarily hopeless, and that deep, inaccessible tumors may develop in time and become accessible, and reoperation may turn defeat into victory.

Jones, W. A. CEREBRAL EDEMA FROM PRESSURE. [J. A. M. A., Oct. 19, 1918.]

Jones takes up the subject of localized cerebral edema from various causes, especially from pressure conditions, and also to call out similar cases, recorded or observed by members of the Section on Nervous and Mental Diseases. General cerebral edema is a frequent accompaniment of many of the bodily disorders commonly associated with stupor, convulsions, and fundal lesions. When these combinations of symptoms occur it is reasonably fair to assume that the mobility of the cerebro-spinal fluid has been altered, possibly due to circulatory disorders within the cranium. Jones reviews the theories of edema of the brain, quoting more specially from C. G. Mills and Preston and Rawling who have called attention to the possibility of localized cerebral edemas. Jones also reports two personal observations which bear on the subject. His conclusions are that there are undoubtedly many cases occurring of unsuspected, local or general cerebral edema. Patients with a history of localized injury, however remote, may have a localized cerebral edema from pressure or from simple concussion of the brain with or without infection. Occasionally focal symptoms may be wholly due to a localized edema and Jones thinks cases of epilepsy may justify exploration for such conditions. There are many cases of hard thick skull obstructing free circulation in the pia-arachnoid and in the cortical veins and lymph spaces which may be temporarily or permanently relieved by a decompression operation.

Redlich, E. WAR EPILEPSIES. [Wien. med. Woch., May 4, 11, 1918.]

E. Redlich studies the possible parts played in epilepsy by such factors as syphilis, intestinal worms, burying by bursting shell, etc. The writer has met with other cases in which the epilepsy became manifest during service at the front, although he was unable to fix upon any etiological factor. Many of such instances may be related, Redlich maintains, to disturbances of the vasomotors. In his second paper Redlich discusses the emotional factors more fully, stating among other things: These peculiar emotional reactions enter into the class of individual variation and is not of necessity in relation to an hereditary taint or evident antecedents. It is this "reactivity" that is to be invoked in order