M.K.R. and the macro-M.K.R. were only once wrongly negative; (b) the Sachs-Witebsky was never wrongly positive, and was more sensitive than the original Sachs-Georgi, but not than the Wassermann; (c) the B.W. Sachs-Georgi was the most unsatisfactory and gave most 'doubtfuls,' whilst the macro-M.K.R. and Sachs-Witebsky gave least; (d) the M.K.R. reactions were superior to all others in sensitivity. A routine procedure is suggested, consisting of applying a micro-M.K.R. to all admissions, and testing the positives by means of a macro-M.K.R. By this means a correct diagnosis is likely to be arrived at in at least 99.7 per cent. of cases.

C. S. R.

SENSORIMOTOR NEUROLOGY.


In this communication an endeavour is made to differentiate a syndrome for growths implicating the apex of the temporal bone. These tumours, generally malignant, come from the nasopharynx or are metastases of distant carcinoma, or may spread from middle or posterior fossa. The clinical syndrome combines three sets of symptoms, viz., auricular, trigeminal, and that of the abducens. In the ear are 'otitic' symptoms produced by stasis; the trigeminal group comprises involvement of motion and sensation in the region of the fifth, Arnold's nerve, and sometimes the n. petrosus superficialis major. A comparison of the syndrome with others derived from lesions in the vicinity of other structures and foramina near the temporal apex follows.

S. A. K. W.


Between the years 1920-1930 an unsuspected or undiagnosed brain tumour was discovered 57 times in 2,054 autopsies on the head at the Hufeland hospital. For these cases, the diagnosis had been arteriosclerotic softening in 88, cerebral syphilis in 12, disseminated sclerosis in 4, and others in still smaller numbers. The causes for the mistakes in diagnosis were various, among which may be noted sudden onset of symptoms as with a stroke, the old age of some of the patients, a course identical with that of
encephalomalacia, absence of papilloedema (35 out of the total), fixed pupils (this is a curious point, which is fully discussed), absence or minimal quality of headache and vomiting, and so forth. The findings in the spinal fluid often misled also. The paper is well worth reading in its entirety.

S. A. K. W.


A critical review of the question of crossed aphasia in left-handed persons is given. The literature is confused on the question of lesions in the right hemisphere being productive of aphasia in left-handed people. In the author's own case of left hemiplegia with aphasia, large areas of softening were found which certainly involved the 'speech centre'; but although nothing was discovered macroscopically in the left hemisphere, when microscopic examination was undertaken an area of edema was found in the 'speech centres' of that hemisphere. This finding seems to make the question of crossed aphasia doubtful.

R. G. G.


The vexed question of serous meningitis, of circumscribed serofibrous meningitis and of adhesive arachnitis, is discussed in detail by Professor Brouwer on the basis of personally observed examples. He believes the spinal form of circumscribed arachnoiditis is commoner than is generally supposed. Its differential diagnosis from extramedullary tumour still remains curiously difficult. If the affection is preceded by some acute infective condition diagnosis is perhaps less troublesome. Spinal tumours may vary in their course, as does arachnoiditis; further, they may well be accompanied by arachnoid collections of fluid.

S. A. K. W.


A certain number of cases of headache and giddiness, often dismissed as 'neurasthenic,' have objective neurological signs. The syndrome here discussed includes (1) local symptoms referable to either frontal lobe or
cerebellum, (2) absence of signs of raised intracranial pressure, except lassitude and sickness, and even a lowered diastolic pressure in the central artery of the retina, (3) reduced protein content of the spinal fluid, (4) a characteristic vestibular finding in the form of unilateral hypertonus of ocular muscles with caloric stimulation, and (5) limited collection of air over the cortical surface shown by encephalography.

The author considers that this syndrome can be found after any severe infection with cerebral symptoms, in typhoid and typhus, influenza, and in particular as a vicinity syndrome in affections of ear or nasal sinuses. Pathologically, its origin is an arachnitis adhaesiva circumscripta. Relief is often obtained by injection of 60-80 c.cm. of air.

Fine encephalograms illustrate the paper.

S. A. K. W.


Dr. Luthy has written a very carefully compiled study of the disease, based on two personal cases, and remarkably complete in its analysis of more than one hundred found in the literature. The numerous problems of the affection are discussed judicially, and much valuable information is collected for the purposes of reference. The sections dealing with pigment-formation, with the relation of the liver changes to the disease, and with pathogenesis, are instructive, even if there are many lacunæ in knowledge still to be filled.

S. A. K. W.


'Kernicterus,' paralysis agitans, and Parkinsonism are not calculated to throw any light on the interrelation of liver and brain disorder. In respect of Wilson's disease and pseudosclerosis the author considers it is not absolutely certain that hepatic disturbance precedes the other; both possibilities have been recorded. The two may therefore not be causally connected, but merely occur in combination. In view of the familial incidence of these affections, the suggestion is made that hereditary factors account for each of the main symptom-groups. A long bibliography accompanies the article.

S. A. K. W.

A long article on a much-discussed problem does not contain any outstanding novelty. It deals adequately with the appropriate literature and incorporates concise description of two cases of senile chorea with autopsy. Dr. Meyjes is content to adopt a non-committal attitude, affirming that there is much evidence for a cortical component in chorea, but also for an extrapyramidal component; the two may work together. He considers it is not yet fully proved that the efferent path for choreic movement is the corticospinal.

S. A. K. W.


The authors describe a case which they put into the category of so-called electric chorea. It was that of a little boy of eight, who from the age of five suffered from brief and abrupt little choreiform movements, at first confined to the right arm. Analysis of the symptoms leads the authors to distinguish three types of movement: (1) choreiform movements, chiefly of face, mouth and tongue, but also of the extremities—all rather slow, irregular, and ‘creeping’ in character; (2) clonic twitches, seizing the whole body and endangering balance, producing displacements and usually accompanied by normal synergies; (3) myoclonic twitches, as abrupt as electric discharges, confined to one muscle or part of a muscle. Those of the second category were influenced by volition, those of the third were not.

J. S. P.


A comprehensive review of the subject of tear secretion and its derangement. The path for the purpose runs in the seventh nerve, and the secretory centre of pontine level can be influenced in a variety of ways, which are fully described. There are many references to the literature.

A. B.
When the sphenoidal sinus is infected the structures which may be implicated thereby include (1) the optic nerve, (2) the pterygoid canal with the Vidian nerve within, (3) the cavernous sinus and various ocular nerves, (4) the spheno-palatine ganglion. The syndrome of sphenoidal empyema comprises pain in and about the eye, extending down over the cheek to the upper teeth, and back into the temporal region. Operative treatment usually relieves the pain, but it may not—in which case Sluder’s neuralgia persists over the whole or some part of the region typically affected. It differs from tic douloureux in being more constant, less stab-like; it is not influenced by eating, or by hot or cold fluids, nor are there any ‘trigger points’ associated with it. It was termed by Sluder ‘lower half headache.’ According to him it is due to irritation of the spheno-palatine ganglion, which lies deeply in the spheno-maxillary fissure, and can be cured by alcoholic coagulation of the ganglion, through the nose, where it lies, rarely more than 4 mm. in depth, lateral to the large spheno-palatine foramen.

According to the writer, who gives a complete anatomical survey of the constitution of the ganglion, with its motor, sensory, and sympathetic roots, Sluder’s neuralgia can be cured by the same measures that are employed for the treatment of ordinary major trigeminal neuralgia. He argues with much ingenuity, relying on the facts of comparative anatomy, that in the Gasserian ganglion is a special nerve-cell group which has to do with the naso-ciliary system (a system fused with the nerve of the first branchial cleft and one to which the spheno-palatine filaments of the second division of the fifth may be surmised to belong), and that this group is mainly in the median part of the Gasserian, i.e., the part largely associated with the ophthalmic nerve or first division.

Sluder’s neuralgia appears to be an infective neuritis of the nerve-fibres supplying the mucous membrane of the nasal cavity and adjacent sinuses. These fibres seem to constitute a separate entity in the fifth nerve.

A. B.


Monoplegia masticatoria is a clinical rarity. The case described is that of a young man of 23 who, suffering from toothache, had a premolar extracted under gas. Three days later he developed a moderate fever, with pains in
the right side of the neck and slight difficulty in swallowing. A day or two later he had a feeling as if the right mandibular articulation had ‘sprung out.’ There were pains elsewhere in the body, with sore throat; the blood was negative for organisms, and a monocytosis of 11 per cent. was found. On examination the left masseter and left temporalis were seen to be completely paralysed, without any other cranial nerve involvement—in particular, none of the sensory fifth.

The case is regarded as one of neuritis affecting solely the motor fifth on the left side, comparable to those of sciatic neuritis in which the symptoms are purely motor. The literature is carefully recorded.

J. V.


The patient was a man of 46 whose symptoms commenced nine years prior to his coming under observation. Their outstanding features were precisely those of disseminated sclerosis, viz., spastic pyramidal symptoms and signs, incoordination, intention-tremor, nystagmus, involuntary laughing, dysarthria, and a general mental imperfection. Post-mortem, an entirely different picture from that of disseminated sclerosis was found. In the basal ganglia and internal capsule, in crura cerebri, red nuclei and substantia nigra were noted collections of plaques similar to the senile variety. A long pathological description of the case is furnished, with a critical examination of theories bearing on the formation of senile plaques. In many places the amyloidosis of the case stood in relation to blood-vessels. The plaques found in the brain, however, differed in their site from the senile variety, in their intimate structure, and also in their numbers.

J. S. P.


An interesting historical introduction is followed by a scheme of classification and detailed reports of two personal cases. In the first, an underlying minimal infection was surmised but not proved; in the second, after a trifling endogenous toxicosis, the syndrome of acute ataxia developed, leaving after it a series of vasomotor derangements, central and peripheral. Review of
the recorded cases does not permit any definite conclusion as to the worth or otherwise of Leyden's own conception, viz., that of a specific encephalomyelitis. Dr. van Bogert considers that an infection or toxaemia may do no more than activate a virus already harboured without danger by the person concerned.

J. S. P.


From time to time records of amyotrophic lateral sclerosis in which sensory changes have been found clinically appear in the literature. These are summarised by the author of this thesis, who adds five personal cases, some with pathological corroboration. He notes that these changes may be both subjective and objective; they are usually discrete, not systematised, and involve all forms, both superficial and deep, in an irregular fashion. They can properly be correlated with pathological alterations in posterior columns and roots.

S. A. K. W.


The author describes the details of nine cases which he has collected. They corroborate in general fashion the conclusions which he had reached previously (see this JOURNAL, vol. ix, p. 170). Binasal hemianopia is far more common in men than in women, and is usually seen in the prime of life. Other symptoms of any kind are often extraordinarily meagre, and there is no simple mark whereby it can be easily recognized; it has to be sought for. Its causes vary, and include ventricular tumour, syphilis of the base, and arteriosclerosis.

S. A. K. W.

PROGNOSIS AND TREATMENT.


The author finds that sulphur in olive oil, when injected into the muscles of the outer part of the thigh, produces a high fever, lasting from thirty-six to sixty hours, with variable elevation in the pulse rate, a vasomotor and a diaphoretic response less marked than in fever from typhoid vaccine,