

some of which had invaded the cord, and also with a large psammoma on the occipital cortex. This case appeared to be closely allied to one described by Verocay in 1910. There seemed to be no doubt that all these tumours of the acoustic nerve were of one type, and should be classed along with neurofibromata occurring in other situations, which they resemble histologically, and along with which they occur sometimes. A general agreement on this point would avoid the misleading use of names such as 'myxofibroma' and 'fibro-glioma' for tumours of the acoustic nerve, which, in the writer's opinion, are derived from the cells of the nucleated sheath of Schwann.

AUTHOR'S ABSTRACT.

VEGETATIVE NEUROLOGY AND ENDOCRINOLOGY.

- [16] **The pilomotor reflex** (Le réflexe pilomoteur).—ANDRÉ THOMAS.
La Médecine, 1920, i, 283.

PILOMOTOR reflexes are easily elicited, but they vary widely in different individuals, and even in the same healthy person under different conditions. Researches on wounded men confirm the results of Langley's experiments. The centres for the head and neck are in the first three dorsal segments; for the upper limb in the 4th to 7th dorsal segments; for the lower limbs in the 9th dorsal to 2nd lumbar. Alterations in lesions of the cord and nerves are described. The reflexes are modified in all lesions of the sympathetic, and vary with the nature of the lesion. In spite of their extreme variability, the ease with which they can be examined makes them very useful in cases where investigation of the state of different parts of the sympathetic nervous system is called for.

W. J. ADIE.

- [17] **On angioneurotic (acute circumscribed) œdema** [Ueber das angio-neurotische (acut umschriebene) Œdem].—G. BOLTEN.
Monats. f. Psychiat. u. Neurol., 1919, xlv, 201.

THE name Quincke's disease, used in Germany, is incorrect and unjust, for the condition is not a disease but a syndrome, and the first exact description was given by Graves. Ten new cases are described by Bolten. The main symptom has fairly constant characteristics, but the accompanying phenomena are very varied. Urticaria, intermittent hydrops of the joints, acrocyanosis, erythromelalgia, acroparæsthesiæ, idiosyncrasies to drugs and food, even gout and migraine, must be considered as related to, or analogous with, angioneurotic œdema. The underlying cause in all the above-mentioned conditions is the same—sympathetic hypotonia. Treatment, according to the author, though protracted, is simple and rational; increase the tone of the sympathetic by thyroid or other glandular extracts, and the results will be very satisfactory.

W. J. ADIE.

- [18] **Lipodystrophia progressiva** (La lipodystrophie progressive).—L. BOISSONAS. *Revue neurol.*, 1919, xxvi, 721.

THIS condition is characterized by a progressive disappearance of the subcutaneous fat in the face and upper part of the body, followed at a later

stage by a pronounced increase of fat below the iliac crests. Barraquer published the first case in 1906, and Simons gave it its name. All the published cases, twenty-two in number, occurred in the female sex, except two described in the paper. The age of onset varies from 5 to 42, and the etiology and pathology are unknown. No post-mortem examination has yet been recorded. The wasting of the face first attracts notice. The fat of the mammary gland escapes. The bones and viscera are normal, there is no pain, there are no signs of disease in the nervous system, and the general health remains good. The increase of fat below the waist commences usually in the gluteal region, and travels down the legs to stop short at the ankles. The carbohydrate tolerance is normal, and the reactions to pilocarpine and adrenalin present no unusual features.

Six cases of disappearance of fat without hypertrophy in the lower limbs are described ('atrophic graisseuse progressive'), all in the male sex.

A hypothetical discussion as regards pathogenesis completes the paper. The condition cannot be satisfactorily explained by disturbances in the functions of the endocrine glands, which are associated only with *generalized* adiposis. The hypertrophy would appear to be compensatory in character, such as is seen in the nuchal region of the hibernating hedgehog. It is pointed out that in woman there are seven principal regions where fat is normally deposited, viz., neck, mammary region, abdomen, loins, pubic region, buttocks, and thighs. In lipodystrophia the connective-tissue cells in the first five regions have lost the property of storing fat, while in the last two the fixation of fat is exaggerated.

Mention is made of the fact that the hind leg of an animal in which the sciatic nerve has been cut contains two to seven times more fat than the sound limb. A case of Turney's is also quoted in which the upper part of the body was excessively fat and the lower part thin, and attention is directed to instances of hemi-obesity, and to hereditary trophœdema of the legs (accumulation of water as opposed to fat). The author concludes that the only possible explanation lies in some disturbance of innervation of the tissues, and suggests as a possible site for the lesion the region of the hypothalamus and third ventricle.

An excellent bibliography is appended.

J. L. BIRLEY.

- [19] **Oculosympathetic syndrome of Claude Bernard-Horner as the result of shell concussion. Phenomenon of ocular adduction provoked by every peripheral stimulus (Syndrome oculo-sympathique de Claude Bernard-Horner par commotion d'obus. Phénomène de l'adduction oculaire provoquée par toute excitation périphérique).—LÉRI and THIERS. *Revue neurol.*, 1919, xxvi, 808.**

THE subject of this paper was first blown up by a shell in July, 1916, as a result of which both tympanic membranes were ruptured: thereafter he suffered from headache, vertigo, and blowing noises in the left ear. In December, 1917, he was blown up a second time, and on rising suffered from

violent vertigo and unsteadiness of gait. On examination shortly afterwards he complained of a constant tendency to deviate to the left, which also appeared in his gait. Romberg's test resulted in a 'statuesque' fall backwards whatever the direction of the face. Aural inspection revealed a small perforation of the left drum, with a considerable degree of deafness, air conduction being better than bone, and Weber lateralized to the left. There was therefore evidence of damage to the middle and internal ear on this side. On the left also he showed the signs of paralysis of the sympathetic supply to the eye—myosis, narrowing of the palpebral aperture, and enophthalmos. Ophthalmic examination was negative, but nystagmoid jerks were apparent on conjugate deviation upwards and to the right. No abnormalities were detected in the reflexes, sensations, or cerebellar functions. The Wassermann test was negative.

No evidence could be found to show that the oculosympathetic palsy had existed before the concussion, and in support of the possibility of this being the cause the authors quote another case recorded of isolated oculosympathetic paralysis following similar trauma. They admit that the pathology of their case is difficult of explanation, suggesting alternatively a lesion of the sympathetic fibres connected with the vestibular and oculomotor nerves, or a minute hæmorrhage in the dorsolateral region of the medulla.

In the performance of the caloric tests they found that the introduction into the left auditory meatus of a wisp of cotton-wool soaked in cold water resulted in complete adduction of the left eye, contraction of the muscles innervated by the lower branch of the right facial, and retro-pulsion, with complaint of vertigo and diplopia. Further exploration demonstrated that the phenomenon of ocular adduction could be provoked equally well by stimulus of any kind applied to any part of the body, e.g., plunging the right hand into a bowl of hot or cold water, pinching the skin, etc. On withdrawing the stimulus or maintaining it for more than twelve seconds, they observed the eye return to the normal position.

They then examined twenty-three other patients, all with nervous lesions, as controls. One case only, a man with an old-standing nerve deafness, the result of a fractured base, showed the phenomenon of ocular adduction on the same side as the deafness. Among the negative controls were two with the Babinski-Nageotte syndrome, both having oculosympathetic palsy on the affected side. The inference is that in the original case the phenomenon of adduction is to be associated, not with the sympathetic, but with the labyrinthine lesion.

The authors refer to a number of cases recorded, having some resemblance to their own, in which bilateral adduction of the eyes has been produced by vestibular stimulation, but point out that the essential novelty of the phenomenon they have described is its comprehensive reflexogenous area. They suggest that it may be evidence of an underlying disturbance of balance between the ocular muscles which is intensified and brought into view by reflex stimulation.

C. P. SYMONDS.

- [20] **Hereditary and familial exophthalmic goitre** (Goitre exophthalmique héréditaire et familial).—J. LERMOYEZ. *Revue neurol.*, 1919, xxvi, 20.

IN a family of sixteen members, seven in three generations showed the complete picture of Graves' disease. Four of them, seen by the author, are described. As a rule similar heredity is transmitted through the females, but these patients were cousins through their fathers.

W. J. ADIE.

SENSORIMOTOR NEUROLOGY.

- [21] **A pathologico-anatomical classification of motor disturbances of corpus-striatum origin** (Erster Versuch einer pathologisch-anatomischen Einteilung striärer Motilitätstörungen nebst Bemerkungen über seine allgemeine wissenschaftliche Bedeutung).—CECILE and OSKAR VOGT. *Jour. f. Psychol. u. Neurol.*, 1918, xxiv, 1.

THE writers explain the absence, in certain striate lesions, of the symptoms of one or other variety of involuntary movements, by severe concomitant involvement of the corticospinal paths, a view which has already been put forward by others and has much to commend it. Negatively, they do not know of any case of the syndrome of the corpus striatum being present in spite of pyramidal disease, but in the reviewer's opinion this statement should not be taken too absolutely. The Vogts distinguish four types of pathological change in the corpus striatum.

1. *État marbré* (status marmoratus)—a 'marbled' condition of outfall of nerve-cells in irregular fashion and their replacement by nests of the finest myelinated fibrils (*not* glial overgrowth). It may be regarded as a dysplasia, a developmental defect, which the Vogts are inclined to associate with asphyxia neonatorum. They have examined six cases of *état marbré*, which all began in earliest infancy and were associated in each instance with the striate syndrome of choreo-athetoid movements, or tremors, associated movements, variable tonic muscular spasms, involuntary laughing and crying, etc., without genuine muscular paralysis. Some improvement in the cases was noted up to the fifth year of life. They were bilaterally spastic, but not in any sense paralyzed, and are comparable to some cases of Little's disease. The authors, in short, limit the latter conception strictly to spasticity without paralysis, and couple with it the condition of 'athétose double', which they consider a "more severe form of Little's rigidity": the two they separate rigorously from infantile cerebral hemiplegia or double hemiplegia.

2. *État fibreux* (status fibrosus)—a shrunken condition of the corpus striatum, as a result of which those myelinated fibres that remain seem unusually closely set, so that the ganglion gives a spurious appearance of being richer in fibres than ordinarily. With this the writers associate a slow progressive bilateral chorea without psychological impairment: they agree with other observers who have demonstrated the connection between disease of the corpus striatum and the involuntary movements of Huntington's chorea.