all this involves as much, if not more, study as is demanded of those who present themselves for a Fellowship of the Royal Colleges of Surgeons or a Mastership of Surgery at a university, or an M.D. in obstetric medicine, in State medicine or in pathology, or an M.S. in dental surgery.

All these degrees in special branches may be acquired at the London University, and I sincerely hope that on similar lines a graduate may ere long be able to take a higher degree in our speciality. Surely the practitioner who so qualified himself for work in laryngo-otology should have the opportunity of being tested by examination and of obtaining his higher degree in this department. He would be better equipped for making the utmost use of his riper clinical experience than by devoting himself instead to acquiring an exact knowledge of the anatomy of the whole body and the whole range of advanced medicine or general surgery, at the expense of systematic liberal study of his speciality and all that pertains to it. To test such study by examination too late in life would be a misfortune.

Nowadays one might suppose Plato's maxim read "Life without examinations is not worth living"! for already the tendency in this country is to continue medical examinations unduly, and thus to trench too far on the precious years of early adult life, when a man's best original ideas are germinating and should be cherished and allowed spontaneous growth, instead of being trammelled and choked out of life by scientific pedagogy.

We gather fruits in autumn, but life's spring is the sowing time. It is worse than useless to spend too long a time in tilling and preparing the ground, and still worse to disturb the roots by examination when we should be looking for the blossoms of research. There is more truth in the world-renowned Oslerism than is generally suspected, and, particularly in the field of science, it is an open question whether after the age of 40 one's mind ever breaks new ground in the sense of being original.

An Address

ON

SOME POINTS IN THE DIAGNOSIS AND LOCALIZATION OF INTRACRANIAL TUMOURS.*

BY

J. S. RISIEN RUSSELL, M.D. EDIN., F.R.C.P. LOND.,

PHYSICIAN, UNIVERSITY COLLEGE HOSPITAL; PROFESSOR OF
CLINICAL MEDICINE, UNIVERSITY COLLEGE, LONDON.

DR. RISIEN RUSSELL said the problem as to whether tumour or functional affection of the nervous system was to be held responsible for certain cephalic and other symptoms that might occur had first to be dealt with. It would have been possible for him to quote cases in which hysteria and tumour had been confounded, and in which patients had been trephined for the organic condition when hysteria accounted for the clinical picture, but as his time was limited he preferred to deal with the cases in which difficulties arose in the diagnosis between neurasthenia and tumour, for this problem was becoming more and more common owing to the rapid increase of neurasthenia in the community. He could have quoted many cases in which the question that he had been asked to decide was whether tumour existed when, in reality, neurasthenia was alone responsible for the symptoms, but he thought it more instructive to refer to two in which neurasthenia was supposed to account for symptoms which were due to tumour. In one of those cases the patient died without revealing any of the positive signs by which tumour could have been recognized, while in the other the absence of organic signs allowed the patient to be sent for a voyage from which he returned with unmistakable indications of tumour which proved rapidly fatal.

After dealing with the physical signs on which reliance must be placed for the diagnosis of tumour, he referred to

a case in which the symptoms ultimately proved to be due to neurasthenia, but in which he had to reserve his diagnosis for some time, owing to the fact that the optic discs were rather high coloured and one plantar reflex, though not by any means extensor in type, was not as definitely flexor as the other. There were certain physical signs that could not possibly exist in the absence of organic disease, but, nevertheless, he from time to time met medical men who allowed their knowledge of the patient's hysterical tendencies or a neurotic family history to outweigh this evidence in a way that was wholly unjustified. What he had said about neurasthenia would prepare his audience for what was to follow in regard to general paralysis of the insane, for it was no uncommon thing for this grave disease to be met with when the symptoms had appeared to be adequately accounted for by neurasthenia. To those who expected grandiose delusions and other characteristic signs of madness this would seem absurd, but he must remind them that general paralysis revealed itself in the earlier stages in many different ways, and that the diagnosis had constantly to be made in the absence of grandiose delusions or any other obvious signs of madness.

He had met with more cases in which tumour was suspected where general paralysis accounted for the symptoms, but he was also familiar with the other class of case in which tumour accounted for what was supposed to be due to general paralysis. In calling attention to the physical signs that should be relied on in differential diagnosis, he referred to the value of lumbar puncture and the Wassermann test, and directed attention to a paper by Dr. Grainger Stewart in *Brain*, in which he had brought out the points that favour the diagnosis of a frontal tumour of the brain, a variety that was especially liable to be confounded with general paralysis.

He next discussed cases in which vascular disease occasioned a clinical picture which caused tumour to be suspected, and pointed out that although under ordinary circumstances vascular lesions of the brain resulted in the sudden or rapid appearance of symptoms, exceptions occurred in which the progress of symptoms was so slow as to justify the suspicion of tumour. Two classes of cases were met with in this connexion, one in which there were general symptoms of intracranial disease without paralysis, and the other in which hemiplegia of slow onset formed part of the clinical picture. Two cases were quoted in which there had been great uncertainty in his mind as to the correct diagnosis. In one he suspected tumour where the subsequent course of the case justified the view that vascular disease accounted for the symptoms; in the other, after much hesitation as to the correct diagnosis, the patient was trephined, a procedure that proved to be fully justified by the increase of intracranial pressure revealed at the operation, and by the subsequent course of the case. In considering the evidence on which differential diagnosis must rest, emphasis was, of course, laid on the state of the vascular system and kidneys, but, unfortunately, the vascular system was not above suspicion in some cases of tumour, and moreover, vascular lesions might complicate tumours in a manner that might readily lead to errors in diagnosis.

It was impossible to discuss these vascular cases in relation to tumour without being reminded of the confusion that might arise between them and aural vertigo, and between the latter affection and intracranial tumour. The cerebellum was naturally the supposed seat of the tumour that was suspected in the instances that he had experienced, so that attention was called to the indications that would favour the graver diagnosis of cerebellar tumour. Dr. Risien Russell took the opportunity of referring to a difficult case in which tumour of the cerebellum had been diagnosed; in this diagnosis he had not been able to concur. Nevertheless, aural vertigo could not account for all that was present. In a younger subject this class of case might well pass for an anomalous case of disseminated sclerosis, but in a person at the patient's more advanced age it was more likely to be due to vascular disease and its consequences.

Time did not allow him to deal with migraine in the way that he had hoped would be possible, but he could not pass over this subject without referring to the special liability there might be of confounding the variety known as *migraine ophthalmoplégique* with intracranial tumour,

* The annual address at the Department of Pathology of the Oxford Medical Society, November 11th, 1902.

owing to the oculo-motor paralysis which accompanied the headache. The recovery from the paralysis which was to be expected in the earlier attacks had been responsible for an error in diagnosis on his part in a case in which a patient died of intracranial tumour who was supposed to be suffering from this variety of migraine, owing to the remarkable improvement without antisyphilitic treatment which took place in the ocular paralysis accompanying the headache. There was no optic neuritis or any other organic sign except the ocular paralysis on which the diagnosis of tumour could be based.

To those familiar with the ordinary classical picture of disseminated sclerosis it must seem a little far-fetched that this affection, so largely spinal, should be capable of being mistaken for tumour of the brain. Nevertheless, such confusion did occur, and he could recall many instances in which errors had been made, and even some in which patients had been sent into hospital in the hope of operation for cerebellar tumour when, in reality, disseminated sclerosis existed. Two typical cases of this kind were quoted, in one of which the extraordinary unilaterality of the signs and the absence of sensory defect and sphincter disturbance fully justified the suspicions of tumour at first entertained and subsequently abandoned by the medical man under whose care the patient had been. A third case was quoted in illustration of the opposite state of things, in which disseminated sclerosis was suspected where tumour obtained. Emphasis was laid on the presence of optic neuritis and the absence of indications of involvement of the pyramidal tracts as in favour of cerebellar tumour, in addition to what had already been said in regard to sensory defect and affection of the sphincters.

Time only allowed of brief reference to a few points in regard to difficulties that might arise in localization; but he referred his audience to an important paper by Dr. James Collier on this subject. A wrong conclusion might be arrived at owing to the case coming under observation late, when possibly sufficient weight was not given to the significance of the earlier manifestations. How readily mistakes could occur was illustrated by a case in which all the indications save one pointed to the cerebellum as the probable seat of the tumour, but the presence of hemianopia resulted in trephining over the correct position, namely, the occipital lobe. Concomitant vascular lesions might, however, complicate matters, and lead to errors in localization. It was impossible to overrate the value of every physical sign that could be determined in these cases, so that he was glad to have the opportunity of calling attention to a point brought forward by Dr. Farquhar Buzzard at a discussion in the Ophthalmological Section of the recent meeting of the British Medical Association in London. He had found that loss of the pupil reflex to light justified the conclusion that the tumour was deep-seated, and was notably met with in those which involved the third ventricle. Attention to such details was most important, in view of the possibility of relief by operation, for while decompression might give considerable relief in deep-seated tumours, the attempt to remove such growths could lead to no good result. How important it was to give strict attention to what might possibly be regarded as insignificant details was illustrated by a case in which defect of upward movement of the eyes and a few other manifestations so well set out by Dr. Gordon Holmes as part of the symptom-complex that was produced by mesencephalic tumours, enabled him to arrive at a correct diagnosis, but in which, in opposition to his view, the patient was operated on for supposed tumour of the cerebellum, with fatal result.

THE value of the estate left by the late Dr. Sydney Ringer, Emeritus Professor of Medicine at University College, has been sworn at £54,287.

THE autumn dinner of the Southern Branch of the Durham University Medical Graduates' Association was held on December 2nd, at the Criterion Restaurant, when many members and guests were present. The Vice-President of the Association, Dr. J. Inglis Parsons, occupied the chair. The toast of the University and Association, proposed by Sir W. H. Allchin, was acknowledged by Dr. Wm. Rawes, and that of the visitors by Mr. Charters Symonds. Dr. W. Davis made a delightful speech in proposing the vice-president's health. Excellent music was provided by Mr. John W. Trimley.

A Lecture

ON

THE TREATMENT OF GASTRIC AND DUODENAL ULCER.

DELIVERED AT THE MEDICAL GRADUATES' COLLEGE, OCTOBER 10TH, 1910.

BY

E. C. HORT, F.R.C.P. EDIN.,
LONDON.

TREATMENT of ulceration of the stomach and duodenum is, except in a prophylactic sense, of course in no way concerned with treatment of such results of ulceration as perforation, stenosis, visceral deformity, abscess, etc. The treatment of these is strictly surgical, a standing witness to unconfessed failure to cure the ulcerative lesion which gives rise to them. Happily, not all of such tokens of failure are often seen, though ulceration itself of duodenum or stomach, whether acute or chronic, is a much commoner event than is frequently supposed. Ulcer of the stomach demands practically the same treatment as does that of the duodenum. We have therefore only to consider the treatment of acute and chronic ulceration itself, and of its two most frequent accompaniments, haemorrhage and pain, when not due to adhesions or other results of ulceration.

Until comparatively recent years the treatment of gastric and duodenal ulcer, both acute and chronic, has been entirely medical. Medical treatment, until towards the end of last century, may be summed up in the word "rest and starvation," both for acute ulcers and for chronic. All gradations in rest and starvation were observed, according to the needs of the individual case, from absolute rest for many weeks or months with the merest pittance of food administered by the bowel, to less restricted movement and the administration by the mouth of nutriment mainly of a liquid nature. As improvement set in, as it often did, a gradual return to active life and more satisfying diet was allowed, and the seal of professional approval was set on an almost universal practice. To a large extent the same method of treatment, and the same satisfaction with the results obtained, prevail to-day. Gradually, however, especially on the Continent, it began to be seen that confidence in the time-honoured method of treatment by rest and starvation for all cases alike was seriously misplaced. Not only did many cases fail to respond to the treatment, but others considered as cured were found, either during life or on autopsy, not to have been cured; or, again, cases in which temporary cure was apparently an actual fact repeatedly relapsed. In consequence it came to be realized, though by no means generally, that starvation was not essential to the production of cure, and that the small nutrient enemata, measured in ounces, previously given could be safely replaced by nutrient rectal injections measured in pints. The food-absorptive power of the large bowel was, however, much over-estimated, and the results were not materially improved. Tentatively then experiment was made of increasing the amount of food by the mouth, and it was found, chiefly by Lenhartz, that food could safely be given in larger quantities, and of higher nutritive value, than had previously been held wise or safe. The Lenhartz treatment was widely tried, and, though the results *quâ* cure are not strikingly superior to those of the older method, the treatment had a great educational value in demonstrating how dangerous and unnecessary the starvation inseparable from rectal feeding is. He also unquestionably proved that feeding by the mouth in all but the most urgent cases is not necessarily fraught with risk. In spite, however, of his teaching, and to some extent because of it, even those who grasped the importance of avoiding starvation in the treatment of these cases continued and still continue, when administering food by the mouth, to adhere to the custom of giving it mainly in liquid form. This they do quite regardless of the unscientific nature of such a proceeding, a statement which I shall presently justify. About the time that the