perature, the subsultus tendinum, the curled-up posture as he lay in bed like a ball of wool, the ensuing paralysis, irregular breathing, deepening coma, and then the end. These were all but a common variety of symptoms of this disease. I quote the case mainly to show how all these symptoms may be ushered in by initial attacks of an aphasic nature. I regret that in this case a necropsy was absolutely denied me and that I had to rest content with the history above set forth. We may, however, form a fair estimate of the lesion in this case and in doing so, a summary of the other two cases I have referred to may prove of interest.

CASE II (Schutz).—Aphasia as an Initial Symptom of Tuberculous Meningitis.—F. W. Elsner² gives the following summary of this case, which was apparently believed to be the only example of the kind recorded up till that date.

In the *Prager med. Woch.*, No. 31, 1881, Schutz relates the case of a man who, without any other disorder than an enlarged elbow joint, suddenly got disturbance of his speech without other phenomena of paralysis. He could understand and write down words, but could sometimes not articulate words even if spoken out for him. The aphasia increased and other symptoms appeared—headache, paralysis of facial nerve and atrophy, alternating with great disturbance and excitement. On the twelfth day stiffness and pain in the nape of the neck appeared; the right eye was turned to the right and its pupil was dilated. There were facial hyperaesthesia, rales in both lungs, slight cyanosis and incontinence, coma, stertorous breathing, retention of urine, and finally death. The temperature was elevated at night to 38.6° C. (101.5° F.). It was at first thought that there was embolism of the artery of the Sylvian fissure; but as there was no cardiac lesion the idea was abandoned, and tuberculous meningitis from tuberculous bone disease, with tubercles in the brain substance near the centres of speech (third left frontal convolution), was thought possible. The brain, however, was found free at the necropsy, while there was an aggregation of tubercles and copious exudation on the pia mater of the left operculum as well as in the Sylvian fissure, less on the right side. The aphasia must therefore have been connected with the primary appearance of tubercles in the pia mater of the left hemisphere, and the histological changes which such an affection must cause in the brain substance in its neighbourhood. All the other rare cases which have had aphasia in tuberculous meningitis had the affection better marked on the left side; no other case gives it as an initial symptom, it usually appearing late. The necropsy further showed acute general tuberculosis, right lobular pneumonia, and caries of the right ulna, which was regarded as having been the starting point of the malady.

CASE III (Déjerine).—Aphasia in a Case of Limited "Tuberculous Meningitis."—This case is quoted by Bastian³ as an illustration of aphasia resulting from damage to the commissural fibres in the vicinity of the island of Reil. It will be noted that there were several transitory attacks of loss of speech, and that the symptoms were due to a developing tuberculous meningitis.

A compositor, aged 20, suffering from phthisis, was admitted to the Hôtel Dieu on May 6th, 1884. On July 16th, at 8 a.m., the Sister when speaking to him noticed that he had a great difficulty in pronouncing words. Twelve hours afterwards the difficulty had disappeared. The next morning Déjerine says, at the hour of his visit, a certain amount of motor aphasia was noticed in the patient; he pronounced with difficulty certain words and certain letters, "d," for instance, could not be pronounced. There was also a certain degree of paraphasia, but no sensory aphasia; the patient easily understood what was said to him, and what he read. He wrote spontaneously and from dictation without mistakes. His face was slightly paralysed on the right side. Speech again became normal during the day, but in the evening the aphasia was found to have returned. The next morning (18th) it was yet more pronounced, though still only of motor type, and without agraphia. The right arm as well as the right side of the face was now weak. By the following day this was still more marked, as was also the aphasia. On July 20th the patient had an attack of epileptiform convulsions; many other attacks followed at short intervals during the day, and he died comatose at 2 a.m. on the following morning. The necropsy was made with great care. The lesion was found to be a limited tuberculous meningitis, involving the island of Reil and parts of the ascending frontal and parietal convolutions, while the convolution of Broca was intact throughout its whole extent. The whole of the island of Reil was covered by a fibrino-purulent exudation, containing innumerable granulations attached to the vessels which penetrated into the brain substance, so that the subjacent white fibres must also have been affected.

It will be noted that in all the above cases of aphasia occurring as the initial symptom of tuberculous meningitis, the cerebral trouble was secondary to a tuberculosis pre-existing elsewhere. In the case of Schutz it was secondary to tuberculous chronic bone disease; in my own case and that of Déjerine to phthisis pulmonalis. In the two latter the initial aphasia attacks were also of a transitory character, and in both cases a rapidly fatal termination ensued within a week. In the cases of Schutz and Déjerine there was motor aphasia without agraphia, and the damage was apparently due to the tuberculous deposit affecting the commissural fibres in the island of Reil. In my own case loss of writing was coincident with loss of speech, and I think we may assume that a tuberculous exudation affected the motor speech centre in Broca's area. Further the lesion was of such a nature as seriously to

impair the functional vigour of the nerve cells, but not actually to destroy their integrity. It will be remembered that the transitory attacks of aphasia came on in the course of an ordinary conversation, as if the functional activity of the speech centre had become suddenly exhausted. In other words, there was an induction of rapid cerebral fatigue. This might conceivably have been produced either by direct pressure of the tuberculous exudation on the nerve elements themselves, or by an interference with the nutrient arterial supply short of actual occlusion. In any case, the patient became completely aphasic after indulging in a few minutes' conversation, and the aphasia thus produced passed off in its turn after an interval of repose. The condition, indeed, reminded me forcibly at the time of a case described by my friend Dr. Hinshelwood⁴ under the name of "dyslexia," in which his patient suddenly became "word-blind" after correctly reading a few lines of print. In his case the visual word centre or its efferent fibres became similarly exhausted and a temporary word-blindness resulted. Adopting a similar nomenclature, my case might fitly be termed one of "dysphasia" rather than "aphasia." The symptoms found in dysphasia are exactly comparable with those present in the well recognized group of cases termed dyslexia, and might further be compared with the condition described by Gowers⁵ under the term "paroxysmal lameness," in which the patient becomes intermittently lame in the course of a walk—a condition believed to depend on some arterial degeneration affecting certain portions of the cord or brain.

As a deduction from the above cases, I would insist that the occurrence of an aphasia, even of a transitory character, in a person already suffering from any form of tuberculous disease, should be looked upon with the gravest suspicion, and regarded as the probable precursor of further meningeal trouble.

REFERENCES.

¹ Bristowe, *Theory and Practice of Medicine*, 5th ed., p. 985. ² Elsner, F. W., in *London Medical Record*, August 15th, 1882. ³ Bastian, C., *Aphasia and Other Speech Defects*, p. 241. ⁴ Hinshelwood, J., "Dyslexia, a Peculiar Form of Word-Blindness," *Lancet*, November 21st, 1896. ⁵ Gowers, *Diseases of the Nervous System*, vol. 1, p. 297.

A NOTE ON SOME CASES MISTAKEN FOR SMALL-POX DURING THE RECENT EPIDEMIC.

By CHARLES FRASER, M.B., CH.B.,
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DURING the last twelve months about 1,400 cases of small-pox were treated at this hospital. About 60 persons were sent to us as suffering from small-pox who on examination were found to be the subjects of some other disease. Chicken-pox alone accounted for one-half of these. In the case of not a few of the patients suffering from this disease it was observed that the eruption on the arms and legs, when it was present to any extent in these situations, was characterized by a certain hardness of the individual elements which was almost indistinguishable from the so-called "shot-tiness" of the variolous papule, and conveyed the impression of a lesion situated pretty deep in the skin. This phenomenon may in a measure have been responsible for the failure to identify the disease. In varicella one quite frequently meets with the phenomenon in question.

Four cases were found to be suffering from acne. The case of a female patient, aged 15, was one of these. She happened at the time to be in the third week of an attack of scarlet fever, and was desquamating freely. On her arrival at hospital, she complained of pain in her limbs, which appeared to be of a rheumatic nature. She had had none of the prodromal symptoms of small-pox, and had been successfully revaccinated six months previously. The eruption was plentiful, but discrete and pustular, and most pronounced on the neck and shoulders, and between the scapulae some of the pustules giving to the finger-tip an impression of firmness.

Other instances of mistaken diagnosis were one case of impetigo in a vaccinated child, aged 4; scabies—one case, that of an ill-nourished child, aged 6, with four good vaccination marks, and one case of urticaria in a well-vaccinated child, aged 7.

The following are the notes of a case of iodism:

D. A., female, aged 21, had been successfully revaccinated four months previously. She complained of severe headache, giddiness, and nausea. The eruption consisted mainly of pustules, discrete and very numerous on the face, neck, and between the shoulders. On the left forearm there was a wound discharging pus. The history of the case showed that she had recently been an in-patient in a general hospital where she had been treated, at first medicinally and later surgically, for a swelling of the forearm. She took her discharge six days before coming here, and on leaving brought away with her a medicine of which she had continued to partake up to the day of her removal to this hospital. On referring to the hospital in question, our suspicion received confirmation.

During the course of the epidemic two cases of lobar pneumonia were diagnosed as small-pox and sent here. The deceptive feature in both these cases may have been the plentiful crop of herpes labialis.

Other varieties include two cases of children with an eruption which was considered to be of vaccinal origin, one case of ptomaine poisoning,¹ and one case of German measles in a well-vaccinated child, aged 7.

The following are the notes of the only case of scarlet fever sent to us as small-pox:

A. B., female, aged 16, complained of headache, chills, sickness, and pains in the limbs. The neck and chest were free from eruption, and desquamation was not perceptible. There was, however, a very striking erythematous, slightly punctiform rash, roughly triangular in outline, confined to the abdomino-crural region; on the legs the faintest blush was visible. The degree of faucal injection was slight, and there was no enlargement of cervical and submaxillary glands; the papillae of the tongue were just a trifle prominent. The patient had four large distinct vaccination marks.

This case had been judged to be one of small-pox in the pre-eruptive stage, with a well-marked initial rash of the scarlatiniform type.

Two patients were found to be suffering from measles—one an infant and the second a man, aged 34, who had been successfully revaccinated eighteen years previously. The catarrhal manifestations in this case were very slight, and the eruption in places was inclined to be ecchymotic. The prostration was very pronounced.

REFERENCE.

¹ BRITISH MEDICAL JOURNAL, September 15th, 1902.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

CASE OF HAIR-BALLS IN THE STOMACH.

DR. SOLTAU FENWICK'S paper in the BRITISH MEDICAL JOURNAL of November 29th on hair-balls in the stomach leads me to record a case. C. H., aged 37, was recently admitted into the Norfolk and Norwich Hospital with a tumour in the left hypochondrium. This had been noticed about three years, and was slowly increasing. She was a brushmaker, and had been treated for ulcer of the stomach with hæmatemesis six years ago.

Her symptoms consisted of dull aching in the stomach, with occasional acute paroxysmal attacks, accompanied by nausea without actual vomiting. The tumour, which lay just under the left hypochondrium, was as big as a cocoanut, and felt trilobate. It occupied the usual site of the spleen. It moved with deep respiration, and could be displaced to the right of the middle line. In the absence of any symptoms of renal disturbance, and owing to the absence of colon resonance in front of the tumour, I diagnosed cystic disease of the spleen.

On October 3rd laparotomy cleared up the matter. The stomach was found contracted upon a tumour which was movable in it. The stomach was incised near the pyloric end, which presented, and a mass of matted hair pulled out with some difficulty; this lay in clear odourless mucus. On further exploration a second mass was felt; this was removed and a third likewise, the last two lying in the usual sour-smelling gastric mucus. The stomach was sutured by Halsted's method and recovery was uneventful.

The masses of hair together weighed 1 lb. 3 oz. They were faceted, and evidently the two upper lumps shifted their position occasionally, according to the distension of the cardiac end, which accounted for the varying shape of the tumour. They consisted entirely of black bristles, such as

she was in the habit of using for making brushes, felted together.

It is a puzzle to me why there should have been three distinct masses instead of only one. The age of the patient, 37, is greater than any recorded by Dr. Fenwick. To his exhaustive paper I have little to add. I think a point of diagnosis which might have led to a correct opinion in this case was the mobility of the tumour, which could be swung from left to right, its excursions being radial with the apex upwards.

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A CASE OF SPONTANEOUS DISAPPEARANCE OF A RECURRENT MAMMARY CARCINOMA.

THE following case may be of some interest, especially with regard to the question of oöphorectomy for carcinoma of the breast.

N. H., aged 48, single, in March, 1895, was operated on by Mr. Barker at University College Hospital for cancer of the left breast. Four years ago she had recurrences removed at the Samaritan Hospital, and again by Mr. Barker at University College Hospital about two years ago.

On December 4th, 1900, she took to her bed suffering extreme pain from recurrences around the scar. She continued in much the same state, relieved by hypodermic injections of morphine in increasing doses, till July, 1901, the cancer nodules slowly increasing. When I first saw her in the middle of July there were numerous red hard nodules, varying from the size of a pea to that of a walnut, and firmly adherent to the chest wall, all around the scar. The axilla was apparently free and no evidence of visceral growths could be obtained, but owing to her extreme pain a satisfactory examination was almost impossible.

One day at the end of July she refused further injections of morphine, and next day she was distinctly melancholic. Up to this time her menses had been quite regular, and this was the time for her period. It did not come on, however, and she has never since been unwell.

The melancholia persisted, unfortunately, and it was with extreme difficulty that she could be examined at all, but at the end of a month I was surprised to find the nodules around the scar nearly gone, and by November they had quite disappeared. Neither her mental nor her bodily condition improved however, and in June this year she was removed to the asylum as she was becoming violent. She has a continual craving for food, and eats ravenously almost continuously, but remains very thin, though stronger than she was six months ago. Her friends, of course, say her food does her no good, but "feeds the cancer," though there is no sign of cancer to be made out. Since the mental condition has supervened pain has ceased, and she, as a rule, only complains of vague pains about the body, but once or twice she has torn at the breast with her nails.

My humble apologies are due for these very rough notes, but until the cancer nodules disappeared it seemed but an ordinary case of approaching death from recurrent carcinoma. Perhaps I may lay stress on the fact that the menopause and cessation of pain were synchronous, the melancholia and disappearance of cancer nodules following almost immediately.

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INTERSTITIAL EMPHYSEMA BENEATH THE DEEP CERVICAL FASCIA AS A COMPLICATION OF ASTHMA.

IT is under the belief that the condition of surgical or interstitial emphysema beneath the deep cervical fascia is of rare occurrence during an attack of asthma that I venture to bring forward the following case:—

H. S. S., aged 17, well developed and muscular, also a good athlete, gives this account:

I have been subject to asthma for about eleven years, and on Sunday, July 27th, had an ordinary attack, so kept quiet all day in one room. On coming upstairs to bed I had a fit of coughing which left me with a pain in the chest and a swelling in the neck. I went to sleep for a short time, then woke, the pain was worse, and my neck more swollen.

When seen the patient was suffering from a sharp attack of asthma; the lower part of the neck just above the clavicles on both sides was swollen and puffy. On pressing over this