now weak-minded. She cannot read or be trusted with the most simple errand. Before the convulsions, however, she is said to have been bright and intelligent, and could say several words. It may be of interest to add that the mother attributed the convulsions to the falling of the child into a dirty stream two or three weeks before their onset. The child was nearly drowned, and after being pulled out vomited much dirty water. In this case it is obvious that blockage of the right external or common iliac vein is present, which may with reason be attributed to thrombosis occurring at the time the enlarged abdominal vein was first noticed. The evidence of thrombosis in one vein suggests that the associated cerebral symptoms were due to thrombosis within the cranial cavity. This thrombosis may have been of infective nature consequent upon the entrance of micro-organisms contained in swallowed dirty water into the blood.]

REFERENCES.

- ¹ *American Journal of Med. Sciences*, 1896, vol. cxi, p. 384. ² *Lancet*, 1899, vol. ii, p. 1563. ³ *Diseases of Brain*, second edition, p. 462. ⁴ *BRITISH MEDICAL JOURNAL*, 1887, vol. ii, p. 1325. ⁵ *Transactions of the Pathological Society of London*, vol. xxxviii, p. 40. ⁶ *Textbook of Medicine*, Pepper, vol. i, p. 694. ⁷ *St. Bartholomew's Hospital Reports*, vol. xxxvi, p. 31. ⁸ *Clinical Society's Transactions*, vol. xxx, p. 139. ⁹ *Edinburgh Hospital Reports*, vol. iii, p. 454. ¹⁰ *St. Bartholomew's Hospital Reports*, vol. xxxvi, p. 308. ¹¹ *Vide* a case recorded by Richardson, *Journal of Mental and Nervous Diseases*, 1897, p. 403. ¹² *Clinical Society's Transactions*, vol. xxxi, p. 5. ¹³ *Ibid.*, vol. xxiii, p. 101.

SYPHILITIC MENINGO-MYELITIS : ERYSIPELAS : RECOVERY.

By E. F. TREVELYAN, M.D., M.R.C.P.,

Honorary Physician to the Leeds Public Dispensary; Assistant Physician to the Leeds General Infirmary.

THE following case presents several points of interest :

History.—A woman, aged 23, had a miscarriage a few months after her marriage three years before the onset of the paralysis. Her first and second child died 7 and 2 months respectively after birth. She herself had been under treatment at the Leeds General Infirmary for syphilis, and her husband was known to be syphilitic. Six weeks before the commencement of the paraplegia she complained of pain and cramp in the left, and later in the right leg. This was followed by girdle pain. On February 24th, 1900, her right leg became weak on her way up to the dispensary, and she could only continue her journey with difficulty and with assistance. When she woke up on the morning of February 26th she had lost power in the left leg, and the paraplegia soon became complete. There was loss of sensation in the legs, and all the reflexes were slightly exaggerated. There was incontinence of urine, and a large sacral bed-sore was noticed on March 17th.

Condition on Admission.—The patient was admitted into the Leeds Infirmary under my care on March 17th. There was at this time an almost complete paraplegia with considerable rigidity, but no wasting. The reflexes were all increased, but no ankle clonus could be obtained. There was incontinence of urine and to a less extent of feces. The urine was alkaline, and contained a small quantity of pus. Tactile sensation was impaired. There was the remains of a syphilitic rash on the chest, as well as scars about the mouth.

After-History.—On March 24th an attack of facial erysipelas supervened. Two injections of antistreptococcus serum were given. The temperature became normal on March 30th, but there was a further slight rise of short duration on April 6th. On April 3rd it was noticed that she could move her toes, and the power in the legs began to return rather rapidly. Unfortunately, owing to the cleaning of the wards she had to be sent home on April 14th, and she was again attended from the dispensary. On June 12th she walked up to the out-patient room with the help of a stick. The knee-jerks were exaggerated, especially on the left side. All forms of sensation appeared to be normal. The bladder had recovered completely. On June 28th she walked up without a stick, and on July 19th the recovery appeared to be quite complete. On April 11th, 1901, she was carefully examined. She was quite well, with the exception of a slight weakness of the anal sphincter; thus she said that she could not hold her motions for more than a minute. The sphincter did not grasp the finger at all strongly.

The diagnosis of an incomplete myelitis involving the lumbar enlargement and part of the lower dorsal cord was based on the spastic paralysis, loss of sensation, paralysis of the sphincters, and bed-sore. The presence of pains and cramps in the legs showed that the meninges were also involved. The meningo-myelitis was believed to be syphilitic for the following reasons: (1) There was not only undoubted evidence of past syphilis, but the patient still presented manifestations of active syphilis when the paralysis supervened. (2) The presence of paralysis combined with rigidity and exaggeration of the reflexes, is known to occur in spinal syphilis; and (3) the absolute absence of any other effective cause. There was apparently some variation in the severity of the symptoms during the early stage of the disease, and this also has been associated with spinal syphilis by some

writers. It was imagined that the lesions consisted of an inflammation of the pia-arachnoid, most probably of a genuinely syphilitic nature, and that the disease had spread into the cord which it affected in a patchy fashion, and not uniformly.

A point of peculiar interest in the case was the attack of erysipelas, which was followed, at least in point of time, by improvement in the paralytic symptoms. There is nothing preposterous in assuming a direct relationship between the erysipelas and the recovery, as one infection has been known both experimentally and clinically to antagonise another and independent infection. By some curious oversight the patient received no antisyphilitic treatment between the onset of the paralysis and June 28th. There is reason to believe, though unfortunately the out-patient notes cannot be found, that the patient was under antisyphilitic treatment during at least a part of the twelve months preceding the paralysis.

The importance of the recognition of cases of spinal syphilis is twofold, namely, on account of its relation to (a) prognosis and (b) treatment, although the above-related case hardly exemplifies the latter statement. Williamson (of Manchester) in his interesting paper on spinal syphilis¹ mentions 32 cases of various forms of the disease. Of the 32 cases 10 recovered and 9 died, the remaining 13 passing from observation without any great change in their condition. Five out of 6 cases of acute syphilitic paraplegia died. While insisting on the importance of antisyphilitic treatment Dr. Williamson makes the very guarded statement that the prognosis of spinal syphilis is on the whole better than that of other affections of the spinal cord. Obviously the extent to which the spinal cord is involved in these cases is of the first importance in the prognosis.

Unless the actual lesions present in the membranes and cord are syphilitic (gummatous) in character or perhaps due to syphilitic vascular disease, little hope of any good can be expected of antisyphilitic treatment. As, however, we are mostly not in a position to say whether these lesions are genuinely syphilitic or not, a course of antisyphilitic treatment consisting in mercurial inunction and potassium iodide should always be had recourse to unless it is certain that the patient has recently been efficiently treated in this way. If no result is obtained in a few weeks such treatment should be abandoned, at least for some time, as it may possibly do injury instead of good.

I have to thank Mr. H. R. Cross, one of the resident medical officers to the dispensary, and Mr. Hirst, the clinical clerk to the case, for additional notes of the case.

REFERENCE.

- ¹ *Edinburgh Medical Journal*, October, 1900.

CASE OF CEREBRAL TUMOUR AT THE PARIETO-OCCIPITAL FISSURE.

By R. T. WILLIAMSON, M.D. LOND., F.R.C.P.,

Physician to the Ancoats Hospital, Manchester, and Assistant Lecturer on Medicine, Owens College.

THE following record of a case of cerebral tumour presents several points of interest with respect to the localisation of cerebral lesions.

G. P., aged 43, was admitted to the Ancoats Hospital on December 31st, 1900, complaining of headache and failure of sight.

History.—His illness had commenced nineteen weeks previously with troublesome headache and sleeplessness. At that time vision was not affected. After the headache had continued for two or three weeks he began to be troubled with slight twitches in the left leg; these continued from time to time all the morning and afternoon, and prevented him from walking about. The same day, about 5 P.M., the twitches in the left leg became suddenly more severe and rapid, and developed into a true clonic convulsion. The twitches spread from the left leg to the left arm and left side of the face. The face was drawn to the left, and the tongue bitten. After a few minutes the patient lost consciousness, and finally the right side of the body was convulsed also, but not so markedly as the left. The attack was therefore a true unilateral convulsion (Jacksonian epilepsy) beginning in the left leg. The duration of the fit was about twenty minutes. The patient fell asleep afterwards, and he remained in a semi-conscious state for four days. About thirty hours after the first convulsion there was a second of a similar nature, and again about twenty hours later there was a third. In all three fits the spasm commenced in the left leg; it then spread to the left arm and left side of the face, and remained unilateral for some time before the right side was affected. The patient recovered consciousness completely at the end of four days. There was no paralysis. The sight began to fail