commissure for about half-an-inch antero-posteriorly, $\frac{1}{4}$ inch in both the vertical and transverse diameters. It was a round-celled sarcoma. The lateral ventricles were much distended with clear fluid owing to the pressure on the aqueduct.

Fig. 1. Front anterior part of tumour, section passing through middle commissure

Fig. 2. Section through largest part of tumour.

Figs. 1 and 2 indicate the position of the growth.

Sections of the pons, medulla, and upper cervical cord showed degeneration of the pyramidal tracts, by far most marked in the tract from the right hemisphere. In sections stained by Marchi's method there was a well marked and definitely limited degeneration in the left cerebellar peduncle. This degeneration could not be traced on the right side.

This finding is of interest as showing the presence of fibres in the peduncle passing towards the cerebellum, and also in connection with the marked intention tremor in the left arm and to a less degree in the leg.

With regard to the causation of this tremor or of choreiform movements in the cases under consideration there is first the fact that of all cases of intracranial tumour they are pre-eminently found in tumours of the optic thalamus, corpora quadrigemina, and of the cerebellum. Of the explanations hitherto advanced Professor Ferrier in writing of tumours of the corpora quadrigemina,³ states, "in all cases in which tremors were observed the lesion was not confined to the corpora quadrigemina, but implicated also the optic thalamus, tegmentum cruris or frontis, or superior cerebellar peduncles. . . . In this connection it is worthy of note that Turner and I have described similar tremors as resulting from section of the superior cerebellar peduncles in monkeys. . . . If the tremors observed in clinical cases are in reality due to lesion of the superior peduncles, one might explain the crossed tremor in unilateral lesion by affection of the cerebellar peduncle above its decussation."

The other explanation of the tremors is that given by Dr. Sharkey, that they are due to pressure upon the pyramidal tract.⁴ The symptoms certainly follow the sequence given by Dr. Sharkey, namely, tremors, paralysis, rigid contracture, and, as in a tumour of any size in these regions, the pyramidal tract would be affected, it is difficult to speak with certainty.

But I think that, seeing that these tremors specially occur in tumours of optic thalamus, corpora quadrigemina, and, to a less degree, of cerebellum, the balance of evidence is in favour of their being due to implication of the superior cerebellar peduncle, the course of events being that the tumour first affects the peduncle, and later in the course of growth presses upon and more or less destroys the pyramidal tract in the internal capsule, crus, or pons, and that thus the tremor appears first, but later disappears owing to the supervention of more complete paralysis and of spasmodic contracture. Further investigation is required as to the implication of what especial fibres of the superior cerebellar peduncle the tremor is due.

REFERENCES.

¹ Brain, 1898, p. 311; ² Ferrier, Albutt's *System of Medicine*, vol. viii, p. 372; ³ Loc. cit., p. 340; ⁴ Spasm in Chronic Nerve Disease, Goulstonian Lectures, 1886.

ENTERIC FEVER COMMENCING WITH AND COMPLICATED BY AN ATTACK OF INFLUENZA.

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ENTERIC fever in the early stages is often difficult to diagnose in consequence of its insidious onset and the different disorders the early symptoms simulate. The following case is an example, where the early enteric symptoms were entirely masked and the disease not recognisable until about the eleventh or twelfth day of the illness. It is very uncommon and also a difficult thing to prove that two fevers can occur at the same time in a patient; but in this case the attack of influenza modified the course of the temperature usually met with in ordinary enteric cases, it being intermittent and remittent for the first ten days, and then the typical typhoid temperature continued. No doubt the high temperature, and the intermittent and remittent character lasting for ten days, was due to the two fevers acting together, and that it was only when the influenza poison was exhausted that the true typhoidal character was revealed. When I first visited the patient she complained of shivering and feeling feverish, pains in her head, back, and limbs, a tendency to sickness. These symptoms had come on suddenly; she stated that for the last week or ten days she had not been feeling very well. On examination no physical signs were to be detected in the chest; all the other organs were normal. The above symptoms continued for the next few days. Bowels were constipated; slight tenderness on palpation over the stomach. Patient had repeated rigors, and profuse perspiration was observed with each fall of temperature. On the seventh day a rash appeared on the abdomen, and this continued to come out in crops. The abdomen was swollen and tympanitic. On the eleventh day diarrhoea set in, the stools being pea-soupy and very offensive. The blood was examined and was distinctly of enteric character. On the seventeenth day great pain in the head was complained of; this gradually got worse, the temperature going up. The patient showed signs of acute meningitis, became delirious, and died on the nineteenth day. Temperature 107.6°.

The following should be noted: Previous to the illness the patient had been visiting in a house where influenza was present. There was an entire absence of physical signs in the chest, but marked gastric symptoms from the commencement, common to both complaints. The absence of any symptoms pointing to internal suppuration, which might have accounted for the early temperature. The peculiar intermittent and remittent temperature for the first ten days, this form of temperature not being typical of either disease, but probably caused by a combined action of both fevers. On the twelfth day a typical typhoidal temperature began to be registered, starting at 103.2°, which temperature in an ordinary case of enteric would probably be registered about the twelfth day of the disease. The present attack was now at the twelfth day.

The above facts distinctly point to the conclusion that both fevers commenced to attack the patient about the same time, and were acting for a time together, producing the abnormal temperature which was observed at the commencement, and which made the early diagnosis of enteric fever impossible.