in the eyes and eyesight, and no difficulty may be experienced with figures and sums. The condition is said to be uncommon, but it is highly probable that it is frequently overlooked. The following case is evidence of this.

A boy, aged 14 years, was brought to see me by his widowed mother with the object of ascertaining whether his difficulty in learning the letters of the alphabet and his inability to read could be attributed to some visual defect. The family had only recently removed to Dundee from another district of Scotland.

The following history was obtained. He was sent to school at the age of 5 years. At once his teachers noticed that he experienced the greatest difficulty in learning the written letters of the alphabet, and that he was totally unable to recognize written words, however simple. This peculiarity being attributed to backwardness or stupidity he was relegated to, and kept in, the infant classes throughout his school life, even although he showed no difficulty in learning figures and in being able to do simple sums correctly.

On examination his vision was found to be 6/6 in each eye, as ascertained by the figures on Snellen's test types. The refraction was emmetropic. The boy was undersized for his age, but healthy looking, bright, and intelligent. He had had no serious illnesses, and no history of eye troubles could be obtained in any other member of the family. When asked to read printed letters he only did so correctly after several unsuccessful attempts. He was totally unable to read even the simplest words, such as "cat" or "dog," but the pictures of a cat or a dog he at once recognized and named correctly. Figures and easy sums, such as are suitable for infant classes, presented no difficulty. He could write slowly and distinctly, but was unable to do so to dictation. He showed a marked aptitude and keenness for drawing.

The patient was shown at a meeting of the Forfarshire Medical Association in January, 1927.

The chief interest in this case lies in the fact that its true nature was not realized until the boy had reached the age when he was about to leave school and try to earn a living for himself, very heavily handicapped by his inability to read. Had the condition been discovered earlier special tuition in spelling and reading could have been instituted, with the hope of overcoming to a certain extent this congenital disability. Several successful results have been recorded by various authorities.

The condition, as has been said, may very easily be overlooked, the child's inability to learn his letters put down to mental backwardness or sheer stupidity. It is, therefore, highly important that all cases of children who exhibit a marked difficulty in learning their letters should be carefully investigated, and special individual tuition adopted if congenital word-blindness be diagnosed.

ANEURYSM OF THE LEFT INTERNAL CAROTID ARTERY SIMULATING PITUITARY TUMOUR.

BY

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AND

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LEEDS.

THE patient, a woman aged 52, consulted Dr. S. T. Rowling on September 27th, 1926, with a history of failure of left vision since January of that year. She noticed, as the first indication of disability, that she was bumping into objects on her left side only. In July, 1926, right vision began to fail, but there were no other symptoms except slight dizziness of one month's duration. She was admitted to the General Infirmary at Leeds on November 1st, 1926, complaining of headache and nausea in addition to the failure of vision. Examination revealed complete amaurosis of the left eye; in the right eye fingers could be counted at two feet distance, but in the temporal field only. The pupils were dilated and sluggish; the fundi were normal, and showed no evidence of optic atrophy. The patient was drowsy, and there was polyuria. It was thought that the hands and feet were slightly enlarged, but this was doubtful, and the general appearances rather suggested hypopituitarism, although without definite signs of myxoedema. It appeared that the condition was one of physiological block rather than of atrophy of the optic nerves, and that decompressive operation might restore some degree of vision. The urine was normal as to constituents, and sugar tolerance and the blood sugar were within physiological limits. The Wassermann reaction was

negative. Further neurological investigation yielded negative results. X-ray examination showed absorption of the posterior clinoid processes, the sphenoidal air sinuses being clear. A diagnosis of pituitary cyst was made.

At 4 p.m. on November 9th a cerebral catastrophe took place. The patient complained of severe occipital pain, and of flashes of light before the eyes. She vomited copiously, and gradually passed into coma. The pupils became contracted and sluggish and the arms flaccid. The abdominal reflexes were absent; the knee-jerk was absent on the right side, just present on the left. There was a bilateral Babinski response. The coma deepened, and death ensued at 7 p.m. Clinically it was suggested that the catastrophe was the result of haemorrhage into the tumour.

Autopsy.

At *post-mortem* examination, on November 10th, a firm, globular, pedunculated mass was found projecting upwards from the base of the skull into the region of the pituitary fossa. On further investigation this was found to be an aneurysm springing from the left internal carotid artery, the interior being filled partly with pale, laminated thrombus, partly with soft mixed thrombus, and partly with blood clot (see figure). The aneurysm was almost

Medial (antero-posterior) section through the central portion of the base of the skull, showing the aneurysm situated on the top of the rather flattened out pituitary fossa and hypophysis cerebri. A, Wall of aneurysm; B, pale, firm, laminated thrombus occupying a large part of its interior; C, soft red blood clot; D, posterior clinoid process; E, pars nervosa, and F, pars glandularis, of pituitary body; G, basi-sphenoid and basi-occipital bone; H, sphenoidal sinuses; I, left internal carotid artery.

exactly spherical, and measured 3.5 cm. in diameter. It projected deeply into the base of the brain in the region of the interpeduncular space, the under surfaces of the frontal lobes, and the anterior extremity of the corpus callosum. There was much softening of adjacent brain tissue, and the optic tracts and chiasma were stretched out ribbon-like over the mass, obstructing its forward extension. Recent haemorrhage, presumably from the aneurysm, had taken place into the third ventricle, and had extended from there both upwards into the lateral ventricles, especially the right, and downwards into the fourth. Escaping to the surface, the blood had accumulated in the pia-arachnoid, at the base of the brain, and had even trickled down the spinal canal. The pressure of the aneurysm had also led to much flattening of the sella turcica, with compression of the pituitary gland.

There were no other evidences of syphilis, a scar near the apex of the left lung being regarded as tuberculous in origin. The gall bladder contained a solitary cholesterolin gall stone.

Histology.

The wall of the aneurysm is composed of extremely dense fibrous tissue, with much collagen and few and flattened cells, and still bears some resemblance to the arterial wall from which it was derived. Some small foci of early calcification are seen in the inner layers. The contents of the aneurysm consist of typical pale laminated thrombus in the one part and a mixture of blood clot and early thrombus in the other. There is no evidence of organization of thrombus. The pituitary gland, which is slightly compressed, shows a considerable mass of colloid in the

pars intermedia. The pars glandularis is intensely congested; otherwise there is no evidence of pathological change.

The case is of interest as exhibiting the presence of ocular symptoms in the absence of glandular or neighbourhood phenomena. This incongruity fortunately delayed operative measures, and so prevented what might otherwise have proved catastrophic surgical intervention.

FAMILIAL PELLAGRA IN IRELAND.

BY

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THE fewness of the cases of pellagra reported from these countries in the past was due probably to the prevalent idea that the disease was confined to subtropical countries. Between 1850 and 1910 no cases appear to have been reported in the British Isles. The discovery of several unrecognized cases by Sambon and others in 1916 in England and Wales raised the probability that others escaped diagnosis. This and the fact that the disease must have become familiar to many civilian medical men serving in the great war combine to account for an increase in the number of cases since recorded. Even so the disease would appear to be of sufficient rarity here to deserve reporting. It is not unlikely that some cases still escape recognition, particularly cases of pellagra *sine* pellagra in countries of little sunshine. In this connexion, too, it may be pointed out that 1926 (in which year these cases were observed) and the previous year were years of exceptional sunshine in Ireland.

It appears probable that the first of the cases here recorded was an acute exacerbation of a chronic affection. Most Italian writers consider that the acute type is never primary, but always an exacerbation of the chronic. Wood and others, however, from their study of cases in the southern States of America, state that at least 50 per cent. are of the acute type. The view that the disease is due to an inability of the patient to use biologically valuable protein would appear to account for these two cases; in them such inability may have been a familial failing. The diet would appear to be a fairly useful one; it certainly is a very usual one in this country.

CASE I.

A woman who had been married fourteen months presented herself on May 27th, 1926. She complained of weakness and loss of energy. She was inclined to be sick in the mornings, and the menses had ceased. She was constipated; she wondered if she were pregnant.

She was of the melancholic type, and her mentality was sluggish; the pupils were very large. The face was greasy and dark, giving the impression that it required washing. There was marked seborrhoea of the nose and mandibular region. There was a rash on the forearms, extending about half-way to the elbows, and on the backs of the hands to the metacarpo-phalangeal joints. On the thumbs it extended to the middle joint. It was much less extensive on the flexor surface of the forearms, and did not come below the wrists. This rash, she said, was of recent origin. The pulse was a little fast. The knee-jerks were lively, and there was a suspicion of ankle clonus. No other physical abnormalities were found.

She was told that it was just possible that she was starting pregnancy, and asked to report later on. Her husband, however, was informed that no evidence of pregnancy could be found, but that her general condition strongly suggested pellagra; this disease was, however, so rare that I hesitated before definitely diagnosing it.

She returned on June 14th. She was then very weak and had had diarrhoea for some days. She had intense vulvitis, moist and red. During the next few days the diarrhoea became severe and was only partially controlled by opium or morphine in one or other combination. There was distressing retching at this time, due probably to intense salivation, as food was not vomited.

On June 20th she presented all the textbook appearances of very acute pellagra. The rash on her arms and face had diminished somewhat and now resembled very closely the coloured plates of pellagra in Dr. Norman Walker's *Introduction to Dermatology*. She was very inert mentally. There was still intense moist circumscribed dermatitis of the vulva. The anal region was red and excoriated, probably from the almost constant passing of liquid motions. There was vague tenderness over the spine; the abdomen was tender all over, but most markedly in the gastric region. The knee-jerk could not be elicited on the left side, and only slightly and with difficulty on the right. She complained of pain in her back and lightning pains in the legs. The pulse was 120 and thready, the temperature 103°. Perhaps the most striking symptom was the intense stomatitis. The tongue was swollen,

clean to the point of "beefiness" (Sandwith's bald tongue), ulcerated deeply about its edges, and the buccal mucous membrane was ulcerated and fetid. The fauces could not be seen owing to the swollen tongue and soreness at the angles of the mouth. There were enlarged inguinal glands. Prostration was intense. She died of exhaustion on June 28th.

In support of the view that the disease was an acute exacerbation of a chronic condition, a few notes may be added. Inquiries locally reveal that her neighbours had considered her "not quite right," and had commented on this at the time of her marriage. Her husband informed me that a couple of months after marriage she became "gloomy" and developed "vagaries" and unreasonable jealousies. She got out of her bedroom window one night and went to her mother's home scantily clad and barefoot. She had to be restrained partially at times from doing queer things, and there had been some talk of having her sent to an asylum. Her sister says she remembers her having to go to bed years ago because of "a rash about her neck." Her family history is given in connexion with Case II.

Her diet was that usual for people of her class in this country: bread-and-butter and an egg in the morning, potatoes, meat, and vegetable (usually cabbage) for dinner, and tea or cocoa at bedtime. This diet hardly suggests a deficiency disease.

CASE II.

A woman, aged 33, presented herself on July 28th, 1926. Her father had died of "heart disease," aged 56, her mother was alive; she had two brothers, of whom one was weak-minded or erratic, and three sisters, of whom one was living; one had died of meningitis, aged 27, and the other was Case I.

She had been married two years and five months, and up to marriage had had good health except for dysmenorrhoea. About eighteen months ago she began to feel weak. She had a miscarriage in October, 1925, and saw a doctor afterwards. She has been weak ever since. The periods have been irregular since, recurring every two months, lasting about seven days, and varying in amount. She has to go to bed at these times. In the forenoon she feels dizzy and has noticed that her mouth fills with water. The bowels move every second day without medicine, and the appetite is fair. She says that her speech is affected and that she cannot continue speaking for long because her mouth feels stiff and tired. When going to sleep she has noticed that her mouth is inclined to fill with water, and she feels as if she could choke. She believes she has been losing weight for the past eighteen months. She presented dermatitis on the backs of the hands, and said that she gets this every summer and that her neck, too, gets very sunburnt. The rash covered the backs of both hands and came forward on the extensor surface of the thumb to the middle joint; it was red, with a good deal of branny desquamation, and some scattered brown pigmented warty or psoriasiform spots on an erythematous surface. There was one such spot on the neck. Her face was seborrhoeic, especially the nose and lower cheeks. The liver was rather easily palpable but not tender; the cervical glands were palpable; the pharynx was a little red. The pulse was 88, and the blood pressure 90/130. There was a suggestion of ankle clonus and both knee-jerks were lively. All other examination gave negative findings.

She was advised to go to bed for a time and afterwards to avoid sunlight and to wear a veil. An iron and arsenic mixture was prescribed and instructions were given as to diet and general hygiene.

In February her sister reported that she was well.

The Registrar-General of the Free State has courteously informed me that two deaths from pellagra were registered in 1922 and 1923. They were of females aged 55 and 60 years.

TRENDELENBURG'S OPERATION FOR REMOVAL OF A PULMONARY EMBOLUS.

BY

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THE operation for the removal of a pulmonary embolus, first suggested by Trendelenburg, is one that the surgeon can but rarely be called upon to perform. As a consequence the number of recorded cases in which an attempt has been made to remove the clot is very small, and the results almost uniformly disappointing. In the case here described an opportunity was afforded of testing the practicability of this rather dramatic procedure.

On August 5th, 1926, a woman, aged 19, was operated upon at Charing Cross Hospital for a chronic right-sided pain. The diagnosis had been extremely doubtful and an exploratory laparotomy was performed through a paramedian incision. The only