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<td><strong>Author</strong></td>
<td>Greves, Edwin Hyla</td>
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<td><strong>Year</strong></td>
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**Digitisation notes:**
- Page numbers 64 & 292 are missing
THESIS

on

Clinical and Pathological Studies on The Nervous System.

Presented To

The University of Edinburgh

for The Degree of

M.D.

By Edwin Hyla Greves, M.B. C.M. (1874)

Physician to The Liverpool Infirmary for Children, Clinical Medical Tutor to University College Liverpool &c. Formerly Demonstrator of Anatomy in the University of Edinburgh &c. &c. &c.

53. Rodney St: Liverpool
April 27th: 1885.
Arrangement and Order of Thesis.

I have divided the Thesis into two volumes: Vol I. devoted to Cases illustrating the Diseases of the Ovarii and Mammaries, & Vol II. to the Cases of the Spinal cord &c.

In addition, Vol I. contains at the beginning a descriptive index of the accompanying Plates illustrating the various cases.

The cases are arranged numerically by Roman numerals placed at the top of each page, in the centre.

An index of the Cases will be found at the beginning of each volume, in which will also be found the numbers of the Pages of the Thesis occupied by the description of the case, the result, the number of the Plate or Plates illustrating the case, and also the number of the tray and slide in the Microscopical Cabinet containing the Microscopical sections from each case in which a Post Mortem Section was made.

At the top of each Plate will be found the number of the case it illustrates, the page in the Thesis referring to the Plate, and in the right hand top corner of each Plate is the number of the page in the descriptive Index of the Plates in Vol. I. in which a full description of the Plate will be found.

Each Microscopical slide is labelled with the name of the technic, the number of the case, and the page reference in the Thesis.
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Description of Plates.

Plate I. Central Tumour. An endothelium growing from membranes of ovarium or peritoneal stalk.

Fig. 1. Tumour removed from surface. The removal of true memba, a small portion of cells, about 5 mm. in diameter, is then adherent to the centre of the tumour, its retial surface being roughened. (Shewn pliographically in Sketch.) Note: the central margin of growth is slightly depressed centre.

Fig. 2. Vertical (anterior-posterior) section of tumour: shows well the relation of the tumour to the constellations, the immediately surrounding it being distinctly flattened somewhat obliterated by pressure.

The true memba is shown (as pliographically) passing directly from the surface of the germ to the surrounding central surface, with the epithelium of adherent portion at (a).

The central portion of the tumour is somewhat discoloured, being a purplish red color. The tumour is seen the type in a depression among the core proliferating, the latter being perfectly free from, nowhere infiltrated by the growth.

Plate II.

Macroscopic appearances of the tumour shown

Arrows (Macroscopic sections in fig. 1, No. 1 to 8.)

Fig. 1. Copied from Conin and Rammei's Pathological Histology, 2nd ed. Vol. I. p. 149. To show the development of 'all types' from the cells of the epithelium.
Fig. 2. x 50 

1. Portion of tumour lying immediately beneath the sersina, where the latter is adherent to the tun.

Fig. 2. a. Portion of tumour from the right of the tumour. (Pl. I. Fig. 2. a.)

2. Portion of tumour, showing the almost blood vessels of the subserosa of the tumour.

Fig. 2. a. Portion of tumour, showing the almost blood vessels (1) at (a.) at the external surface of the tumour.

The arrangement of the cells: those of blood vessels are well shown.

Fig. 3. x 300. Some well-characteristic cell nests, packed together, the eccentric arrangement of the flat

and cubic cells is well seen. The rest of the section is composed of cells of a similar character. These

when seen in sections appear oval-shaped. They are arranged in parallel layers, running in various

directions through the gland. In Fig. 4. several blood vessels are seen, with not any distinct

nerve cells, but surrounded by several layers of lamellar cells, concentrically arranged.

Pl. III. Specimens were taken from slide 1.

2. Case II. Intramural tumour of Strumella phlegmatica.

Fig. 1. A. The anterior, + B. The posterior view of the tumour as seen in the path. condition.

Plate III. = (Slide 9. Fig. 1.)
In A, only about \( \frac{1}{4} \) of the growth is seen - the rest of the tumor, \( \frac{1}{4} \) and \( \frac{1}{8} \) are seen spread out near its surface, and those of \( \frac{1}{4} \) and \( \frac{1}{8} \) forms at its upper margin. Small smaller cells are seen running towards it. The tumor itself being somewhat rounded on its surface.

In B, fully \( \frac{3}{4} \) of the tumour are visible - it is seen rounded almost like a half the medulla, and broached beyond the middle can protrude from short distances. In reaching largely upon the form of the \( \frac{1}{4} \) and middle. Small large arteries are seen running into growth.

Fig. II. A horizontal section of the tumour and medulla, about its centre. It seems secreted by the intercalary of the tumour, lying more posteriorly here anteriorly, and encroaching largely upon the left half of the medulla, producing the anterior portion forwards.

Fig. III. x 30. The right anterior of the medulla, the growth is shown the caudal (c.) here and there the remains of a "giant cell" system (g.) can be observed. In the left half of this figure along number of well marked giant cells in him, surrounded by a highly nucleated zone. Lymphoid round about (r.) also seen in section.

Fig. IV. x 300. The structure of the growing tumour.
of the tumor (i.e. the inner concave portion) is well shown. Large giant cell (c.) with containing numerous nuclei: though cell almost only partly seen forming a delicate network containing large numbers of epithelioid cells and a large number of small nuclei. This is best seen at the upper portion of the growth. A large blood vessel (b.) is seen, surrounded by a highly nucleated zone. The nuclei stand tightly with cognate.

= Plate 11 =

Case III. (pp. 41-56.) Lobular Tumor of Left Hemisphere of cerebellum. (For color: Protok. Mag. 10-13.)

Fig. 1. A. Vertical section, B. Vertical section, showing attachment of the left cerebellum. Hemispheric lobe, almost completely occupying the whole of the section. The membrane can be seen on the margin of the tumor (which had a somewhat spheroidal appearance) the growth.

Fig. 2. The section in focus, the section taken from the growth. showing the relation to the tumor. There is a fairly distinct area.

Fig. 3. The section in focus, showing the relation to the tumor. There is a fairly distinct area.
Case IV. 2. 

Fig. 1: Water color sketch showing position of龈突 in relation to the groove separating the inferior surfaces of the cerebellum and the thalamus, from each other, and also with the superior surface of the medulla oblongata. The posterior end of the body of the thalamus is seen projecting posteriorly from the cavity of the hemisphere, which was almost entirely occupied by the thalamus.

Fig. 2: Shows the exact position of the thalamus in the posterior surface of the medulla.

Fig. 3: x 50. Refers to a section of the thalamus taken from the floor of the 4th ventricle. The substance of the thalamus is nearly the same, except that of the medulla, the ganglionic nerve cells of the latter are shown, somewhat flattened, apparently by compression by the skull.

Fig. 4: x 300. Taken from the same section, thalamus fairly thick. The substance of the thalamus, a large number of nerve cells, small round, lying in a apparently granular matrix. Here there is much black stain in certain.

Plate VI. (Fig. 61.)

Shows a thalamus of similar character as Pl. V, lying in the cavity of the 3rd ventricle.
At its lower part—this cavity is seen. The considerably dilated, the spinal substance (corpus callosum, of the bladder) being pushed aside. The cavity of the funnel is fairly supported with blood vessels. The tentorium is also dilated and contained a considerable quantity of spinal fluid. The walls were also somewhat thickened.

---Plate VII---

In this water-color sketch (made after death after the removal of the brain from the body) there attempts to represent as accurately as possible the very striking appearance of this tumor. Its projection is accurately shown, being the size. The corona radiata lying immediately below the corpus callosum (cortex marginalis) from above, from below, is shown. The particularly affected by the tumor, and in Plate VIII a sketch of the same substance is seen running into the tumor from below backwards. The tumor is surrounded by a very marked zone of highly vascular tissue.

The substance of the corpus callosum, the brain tissue in its immediate neighborhood is from the injured area. Not so, the right lateral ventricle is much diluted. The surrounding brain tissue is as usual.

---Plate VIII---

(from same case) a water color of pen and ink sketch
From the standpoint of clinical practice (p. 4) the collision of the anterior portion of the trunk, as seen in running the first horizontal slice of the knee area. (V. 46.)

For microscopical appearances (V. Plate xvi. fig. 6.)

Case VI. — Interior forming from Bone. Planes on right.

[Diagram]

Case VI. — Brain from same case. Shows the condition of inflammation, softening of the brain matter, and the large cleft which is almost entirely destroyed, and about the upper portion of the Pons Varolii, the latter is pushed out without firing when the brain is cut. The parts compressed by the skull: were an extremely confined cavity remained empty. The rest of the brain appeared literally normal.
After the removal of the connective tissue, the chiasm is exposed. The lamina cribrosa is seen in detail. The mass seen approaches upon the vestibular canal.

Figure 2: Dark colonial patch of spherical lenses

Lenticular after its removal from the body, the masses together is seen the lens by a spherical membrane, the connex membrane. When divided, being roughly in itself and much wrinkled.

(Figures in Figure 2, 3, 4, 5, 6. Smug microscopic appearance of end. By 5x, 50. Taken from break Pyramidical tract at

Above break, Regio, compressed per. lini. Shows large increase in connexiion tissues with also increased number of blood vessels. As the latter being fragile, all trace adenoc

Normal structure is lost.

Figure 6, x 200. Taken from break pyramidial tract. Showing great increase in connexiion tissue. As the fibers are so tightly packed, especially of the bed. Many vessels and nervous fibers enter these cylinders and blood vessels. (5:1)

Sketch of transverse section of lymphatic glands with a common cervical (mediastinal) gland.


Sketch of commoning connective of lymphatic glands in same case. Also of mediastinal glands.

Plate xiv. Case xii. p. 150.

Figs. 1. Anterior mediastinal tumour lying external to the right bronchus. Compressing spinal cord. 

2. Mid-sagittal section. Arrows indicate site of tumour. 


The patient was a 63-year-old man with a large tumour in the mediastinum. The tumour was compressing the spinal cord and was growing laterally.

The patient was referred for medical advice.

The tumour was excised and a specimen was sent for histological examination.

Post-operative course was uneventful and the patient made a good recovery.
Fig. 1. Section of Porkini lateral nerve (nervi internum) x 50. Showing evidence of connective tissue in nerve bundles.

Fig. 2. Section of Porkini nerve of dorsal spinal nerve x 50. Showing a similar condition, but to a greater extent.

Fig. 3. Section of Ganglion of Porkini rod of dorsal spinal nerve. Showing increase in the connective tissue matrix, of that surrounding ganglion.

Fig. 4. Section of Porkini nucleus columns of spinal cord (cervical region) x 300. Showing well marked alterations with atrophy of nerve fibers, but hyper trophy of the meninges of same.
- Hypertrophic Degeneration. Many of the nerve cells are destroyed, others are undergoing destruction.

Fig. 2. Same section x 300. Nerve degeneration showed by rounding of remaining nerve cells, with increase in the number of nuclei in the matrix. (Fig. 2.)

Fig. 4. Section of lumbar region, showing destruction of gray matter in left half of cord.

Page 394:

Fig. 3. Case x x vii. x 300. Nerve fibers in the middle of nucleus in spinal cord which have become cloudy and amorphous. (Case x vii.

Fig. 5. Case x x. Protein skeletal column of anterior lumbar region, showing commencing sclerosis.

Fig. 6. Section of glioma, x 300. Case x. x 80.


Fig. 6 for description, page 80.
No. I.

Endothelium of Membranes of Periophthalmus (Plate 3.)

Miss Bridgen was a very interesting case with a very logical, though a Clinical, point of view. When she presented herself, she was usually very thin, with a very slight degree of emaciation. I was puzzled by the symptoms it presented, and after consulting the best Drs. in the country, I was advised to send her to the Periophthalmus for a microscopic examination.

Having only seen the case a few times, I was therefore unable to follow any clearly the course of the symptoms as they presented themselves. Moreover the main features of the case were carefully recorded, and may be briefly stated as follows.

The patient came from an extremely healthy family on both sides. As far as I know, there is no history of any of her relatives past or present. She had never been ill, and her health was excellent. She had always been a very healthy woman, and had never been out of the present symptoms. She has married early in life, and has had a large family. Her system is very good, and her health is excellent. She has had no miscarriages. Her husband was a strong, healthy man, and she has not been out of the present symptoms. She has always lived under most favorable circumstances. She attributes her health to regular exercise and a free air. She has taken very care of herself, and as far as I know, has never been ill before any serious symptoms.

Mr. S...
History of ovarian disease: She first began to feel 
from her head about Sept. 1880. At 
that time she had complained of the left 
side of the head, especially in getting up 
in the morning. She also felt a little 
nausea in the head, as she expressed it, but no 
she was occasionally troubled with 
nausea. She did not think anything of it. 
In a few months duration, the headache 
was fading, began to occur more frequently, 
or would come on at night when she was 
awake. She would occasionally feel 
giddily and a little sick, but at that time 
the 

process was generally of a morning character, and 
was generally worse in the right side, uni-

bilateral above the temple. It was not 

constant in its situation forms, and it 

frequently was felt as a deft, heavy 
sensation across the forehead. The pain

stormed themselves. She struck her head rather
violently on the right side, and for the first
few minutes seemed deeply. She turned to her 
feet nothing more of it; in fact, she had
spoken just then it, her headache came on
about 12 months after gently. I realized
the fall of this memory. It being too far
made her think it all probably the fact
had nothing whatever to do with her trouble.
run the temples & the reticulum began to get very gray after the pain first appeared once as in the right side.

About two months after these symptoms set in, as night as she was going upstairs there, she waspublication seized with fascino in the left side of the face. The head & arm on Viscous side began to quiver. (She had suffered a good deal during the earlier part of the day from throbbing pain in the head, which appeared to radiate in all directions from the right parietal prominence.) She felt very weak rapidly & had it not been for instantaneous if one of her daughters who was walking behind her, she would have fallen. She ran to bed, and almost immediately vomiting in nausea. (She was always in the habit of making a heavy meal at supper, generally being something hot.)

She did not lose consciousness, but her speech was somewhat indistinct. They at back lasted from 20 to 30 minutes then passed away. The nearest medical man was sent for who gave her 1 dram of strychnine & applied alcohol to the back of her ear, & gave a Peruvian to build strength. According to daughter's account, there was chills & fever in the hip area from that night. But this disappeared over the next few days. After this at
tack, which alarmed her very much, she began to suffer from constant fear of head ache, which was generally most severe on the right side, in the region indicated, and always was some at night. She also noticed at odd times, frequently with no apparent cause, sometimes it was preceded by nausea, at other times not. She was kept very quiet, as any motion would intensify her a great deal, and she did not like too much light. The pain in the head was always very much aggravated by clothing, especially her head towards the ground. This always made her feel sick and sickly. She was put in a Bride's of Providence, &c. &c. &c. &c. &c. The

Times Only.

She had a very violent attack the one day in a month or six weeks, and another, in a fortnight, subsequent to that, but that time she has had them off. This present time (July 1834) about two months or six weeks off. This first attack, she noticed her leg begin to jump during one of them, but the 'Keano' need another just in the face, then she looked at her hand, arm, and leg. She felt the face and the neck very much to the left side, and the pain went through. She saw her hand, prepare her woe or pains, instantaneously, at this time she did the two

concerning.
These convulsions attacks were always preceded by pain: some or too violent, in the right side of the head—sometimes the pain was severe enough to make her cry out, stretch her hands up to the head. She was aware that her fits were coming on by the pain in the head becoming stronger and more localized. She also affirmed that the headache tended to lessen when the pain was greatest.

She began to lose flesh, and her spirits were much affected. She was formerly a quiet, retiring, and reserved woman, who inclined towards almost anything for herself. She lost her bodily activity, refused to do work without being ordered, unless the pain in the head was severe, when she would do the work very reluctantly. At times, she would become very dependent, very without cause. In December 1883, her health had considerably improved. I first saw her in August 1884. It was about a year after she felt anything wrong with her. Her condition at that time, according to my notes, was as follows:

Patient is a middle-aged woman, fifty years of age. She was a very healthy young woman, except for headaches, which began in January 1884. Her hair was dark, but she was very grey on her temples. She was very tired, especially in the morning. Even though she had suffered a great deal...
There is slight atrophy of the left upper lip. The left nasal labial groove being less distinct than the right. She is unable to elevate the upper lips symmetrically, raising the right half strongly but with much less than the left half. When she tries to eat the left cheek bulges out to more place it than the right. Food licks to the left but the right regurgitates in Salem with some food. There is general loss of power in the left arm and hand, the power of gripping, of pulling, grasping to being very much below that of right side. She has also a great deal of difficulty in performing fine movements with the left hand, being only just able to handle even butter in them with it. There is impairment of coordination, for operation, which appears normal.

The muscles of the arm are somewhat flabby but not conspicuously atrophied. When she reaches there is slight ten degree of joint in the catch the ground, and she tempts a walk. She can stop the left leg fully, but her control is less. The sensation of the muscles is the same as in the arms—just having ballistic at hand. The electric reactions were not taken—sensibility was not impaired. The palmar tendon reflexes are all slightly increased, in the left side, not markedly so however.
this paresis of the left side has been gradually increasing for the last 2 or 3 months. It is always worse after one of the cranial attacks, and remains so for a few days, then reverts, albeit the limbs remain less com-
plete. Nystagmus by the power or the head pro-
duced by the fit coming on. She has no diffic-
culty with her endurance or digitation.

Her hands are somewhat clumsy, there is
not vision to them Open by letting Col. Rains co-


Papil's all taken and all react sluggishly to
light. Armada

Sensorimotor functions: (Tumor should have been looked for

before the motor function)

She complained of constant pain in the left arm and behind the right temple. Pain is of rendering
character" and occasionally accomodating
It is worsened somewhat by pressure.

in the painful area - and is worsened
by lowering the head. Pain is very increasing
"at times, as says she feels it worst "when his head." It is really always
more at night. She has pain for
along time. She finally believes it passes
in a bad bath, which she had received, but
without producing any material effect on it.

The pain, which, although apparently here
futile for a day or two, yet it is continued with

milder severity. The scalp, with right side
 occasionally feels numb and tingles, with frequent twitching or pinprick relief. She has no pain elsewhere, but occasionally, she says her left arm and left foot numb. Especially after being kept in the same position for any length of time. It appeared she due to pressure on her arm or leg, from keeping them too long in one position. She has seen a doctor for treatment of numbness, but he says it was mostly fatigued and being a little hypermetropic. The veins entering the optic disc were markedly dilated and congested. Her whole disc was hyperemic, and rather too prominent. Her macular area was rather indistinct. In fact, there were the well-marked early signs of optic neuritis. She was somewhat dazed with the right eye, but appeared to have visual field for about a year. Each pucker was not better. Her pupils were somewhat dilated, and only reached very slightly light or accommodation. No other symptoms.

6.1 Discoloration: Or an increase in redness, all nor-

mal. Skin: Reflexes normal.

Vocal: There is marked loss of power in

the muscles of the lower jaw on the left side. The left temporal muscle is less distinct than the right. There is flattening of the left cheek. Drooping of the upper lip on the same side. She is able to raise on her hands and knees. Her left cheek "flaps" when she is sad.
(Case of Mr. P. contd.)

dead when compared with the right side. The tendinous attachment between the eye, cheek, and upper lip, she is unable to elevate the upper lip, behind the upper teeth, equally well on both sides — the speech is a little thick, but she is quite able to make herself clearly understood. The tongue protrudes slightly towards the left. 

There is marked loss of power in the left arm and hand. The grasping power is very much less compared with right, while movements of the arm after arm are deficient in power. This is most marked however in the forearm — she cannot unbutton the her clothes with the left hand, except with the greatest difficulty. There is no incongruity of movement in the affected arm or hand, 

The muscular senses is apparently unaffected. Nothing is found any impairment of muscular sense, or of general sensibility. The muscles feel soft and relaxed when at rest, but not markedly at rest. (The bell touch was not tested.) When the hand has flaccid muscles, the muscular twitching is first observed on the left side of the face, then extends down the arm, while the fingers first beginning to move, next rapidly stretch out, the whole arm becoming involved in the convulsions.

When she hacks, there is a distinct tearing. She can't throw the left leg behind her. The toes
hand to catch the ground, this causes her to bring her left leg forward by turning our brand to the right, and then describing. We are of the opinion with the left leg as she avails it forwards. The toe of the left boot does so much worse than the right. All the movements of this leg are somewhat deficient in power. There is no rigidity, atrophy, or favour of the limb. Sensibility is unimpaired.

The patellar tendon reflex is slightly increased in that of the right leg. There is no contract. Clonus absent.

(e) Case 4. Mrs. [partially illegible]. Patient.

Her friends state she has lost a good deal of strength since the onset of her illness.

There is no apparent tremor. She is also at rest. The right hand, being distinctly weaker than the left, and the right side she is slightly so. The left hand certainly.

According to friends) developed since the onset of present symptoms.

A/ Cerebral mental functions: Intellige. Attention memory good - says she knows her memory is failing somewhat - but there is no evidence that it is. She always enjoys daily recollection. After precise queries as to

2 or 3 hours after pain was not noticed.
At night... the speech is a little thick. There is a true aphasia in the

There are no perceptible peculiarities of the

There is an increase of pain, especially in the

There is a slight parietal mimia, first

The ear... the scalp is in the same situation... certainly somewhat hyperesthetic, but this

May be an irritant incident, due to the constant

The scalp to alleviate the constant pain.

The appetite is very poor in the am. - by

The frequently resembles

Bitter less definite relation to food. +

Often suffers from nausea + flatulence.

Other symptoms, all normal.

Pulse 60, rather compromised, weak, gastric

Normal, clear face, 70's, 10.22, acid, well

No other.

She was treated chiefly on leather. Aromatics of

Skin & pulse in normal order. No local effect.

Said... in the patient again till the end.
All of another. Her condition was certainly worse. She had continued to use much strength to keep the home roofed, great suffering, the manner was somewhat vague and absent. The progress of this side was becoming daily more complete. She could scarcely any longer understand me with the left hand, she was only just able to hold of any objects with it. She was not weak on the left leg that the leg unable to walk with out assistance. She has more impression in her speech. She has become very fastidious and has left all house or please in going about a letter. My letter written in any thing. The pain sometimes goes away for a few days, but always returns again. In the recent severity the memory is becoming so more impaired. I think it was not when I last saw her, but I can not remember to name it. She confused about she it the day before yesterday. The attacks of amnesia occur but within time. As the case is the particular amnesia in them, and remains perfectly mysterious. Kind of "mean" condition for her to have influence. She is my,7: bureaucratic, the terms. I was told her and was distinctly limited to the left half of the body, as they formerly were, but the right arm they are also seem to "mean" immensely, but to less extent than
From this time she became seriously worse—her mind becoming daily weaker. The frequency of attacks left failing rapidly. She became quite helpless, at times, especially after a convulsive attack, or after an unusually severe attack of pain. The convulsive attacks became less severe, but the frequency, but the hemiplegia extending more, till she ultimately became quite helpless. With this, she unfortunately did not get another opportunity of procuring her specialty. In my unability to find any detailed account of her condition at this time, about the middle of December, she was obliged to take her bed. At times, according to the doctor, she was 'quite out of her mind,' and had many delusions, most of them transitional in nature. She would often refuse her food, and play the part of a muffled personage. She would often become quite emaciated, this condition lasting for an hour or two. For the last ten weeks of her life, she was free from all convulsive attacks. She gradually became more and more emaciated, and gradually sank, dying on Dec. 9th.

After some difficulty, a post-mortem examination of the head revealed the cause. The brain had shrunk, and the skull cap, it was at once apparent, that the bone...
Tumour.
projected slightly above that of the surrounding convolution. Its appearance at the time of removal, though attempted to figure as accurately as possible in the accompanying water-color sketches—a "giant "mushroom," growing from the interior of the brain—its esophageal body being slightly depressed, with a piece of dura mater adherent to its central area, (shown somewhat diagrammatically in sketches) the margin of this growth was distinctly truncated, its surface being marked with finely striated grooves running from the circumference, radially towards its centre where they gradually became lost. Its colour (surface) was a pale yellowish green.

In section, the growth fell from the base and somewhat large. Its central portion was slightly discoloured (v. sketch) and adherent to the meninx pia striated appearance, the striations converging towards the central portion of the internal surface, where it was adherent to the dura mater. This lateral structure was found to lie in close contact with the external surface of the tumour, but freely separable from it, except in a small area about the size of a shilling already mentioned. From the margins of the growth, the dura mater passed on the surface
After removing the convolutions, a very delicate membrane was found to adhere closely to the brain on the inner surface of the brain, resembling the meninges and the convolutions, but without a covering of meninges. The delicate membrane was removed at the margins of the convolutions and between the folds of the brain. A vertical section (as above described) was almost hemispherical in shape, being about the size of half a lemon or lemon. The convolutions were depressed beneath it, and it as well as the meninges adhered surrounding the growth. The convolutions were much altered by pressure. The brain was much removed by the crowding together of the convolutions. The growth was firmly attached, except at the base.

Measurements of brain:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length</td>
<td>2 1/2</td>
</tr>
<tr>
<td>Width</td>
<td>1 1/2</td>
</tr>
</tbody>
</table>

The distances from the great transverse fissure were:

- Tip of the frontal lobe = 2 cm
- Occipital = 3 cm

Conclusions: The relation of the convolutions render it impossible to accurately define their relative positions.
(5th Case of Mr. Bridson, continued.)

As already mentioned, the middle meningeal artery passed over the central part of the tumor, being involved with the lower part of its external portion. Its relation to the central hemispheres is shown in the accompanying Plate.

It lay apparently deeply imbedded in the upper lobe of the hemisphere of Roland's, compressing the abducing frontal, the ascending frontal, the frontal parietal, the posterior parietal, the postenor occipital, the three frontal convolution (superior, middle, especially) to which it pressed. The specimen, I did not leave the skull. I removed the hairs from the top of the tumor beneath it, but I could testify myself by studying the ventral section that the gray matter of the convolutions which lay beneath it was preserved out, that it was almost entirely vitiated. Strangely, there appeared the most friable of the surrounding hard substance, though it looked somewhat avascular, there was also no reason why it would have been so. Remnants of the rest of the brain appeared perfectly healthy. The convolutions of anything appeared rather flatter than usual, but not markedly so, except in the immediate neighborhood of the great. No secondary deposits were found in the tumor. As he only had pneumoni, the remark that the head, it is impossible to tell whether they were any other growths present in any other viscera is without doubt.
here no symptoms indicative of any local complication, such as vomiting; this nausea which was undoubtedly cerebral in origin. Some of the lymphatic glands in the neck were enlarged, but the occipital lymph gland could not be felt at all.

Portions of the brain were at no set in with

**Microscopical examination.**

(Fig. 2.) A thin figure was taken from the S (a)

In L. herpeticus, in thin form that portion of the brain lying near it is the matter part of which is seen to be a part of the brain. At the part from which the spire is apparent to apply, the brain with a lower power.

It is seen that the tumour consists of a large number of small round bodies, apparently composed of flattened cells arranged in a somewhat manner, but whose outlines are not clearly the make out. These bodies closely resemble in appearance the cell bodies found in the thoracic nerves; they are generally aggregated in groups through the spindle and often tumour. These groups being connected by intermuscular branches of what at first sight looks somewhat like fibrous tissue. But muscle connective tissue appears the composed of flattened elongated muscle elements arranged in parallel layers.
Studded through the growth are broad bands of varying size—generally small—like epicortex, whereas the central whitish cortex, but rather to
seem as channels running between the bi-
cell elements, being nearly bounded by one or
more layers of flattened cells arranged in-
circularly here and there when divided
transversely they almost look like little cell
ends with a blood channel in the centre, but
here commonly slight bulges of the wall
into shallow ampulla like cavities, but shown
not to be blood vessels becoming isolated
from the main channel forming separate
ends as described by Cornil (Ravenh.)
fig. 3. Pl. 5.)
Examined with a high power the rest like
buds already mentioned are seen to consist
of flattened hexagonal and tetrahedral cells,
arranged in concentric laminæ—
the outline of the cells being in some places
distinct, in others the cells almost appearing
as though blended together. The rest of the
former consists apparently of flattened
or quadrangular elements arranged in some
or less parallel layers thus being and in
some places enclosing the openings of
cells whose form and size, and arrang-
ing the blood channels.
From the above description it will be seen
that this tissue clearly corresponds to that
form of (adenoid) sarcoma

described by \( \text{\textit{Zeigner}} \) (Vol. I: p. 220) as
an endothelioma. In speaking of the mode
of appearance, he says: "The way in which
the adenocystic structure is developed, can often
be clearly made out, especially in tumours
of the intestinal mesentery. The normal
intercalary tissue is transformed into a
series of cartilage cells; and, as a tumour is for-
med, between the all branches of the parietal tissue
lying along the course of the vessels.

In this case, it takes on a peculiar
pre-senile, or firmly, formed vessels both in
rest and in movement of cells. This
extravasation of vessels at times lead the
intercalary spaces were filled up.

Accordingly we find this form of growth
described as a pleomorphic angiosarcoma,
it has also been described as a large growth
as a substitution - or the latter even
the cell-reaches continuity of form and cellular cells. This actually
happens when mesenchymal cells are formed
from the endothelial covering of the sub-
endothelial substance of the pia mater. The
cells afterwards grouping themselves with
"deco" when the pleomorphic cells of the
pia mater, are aggregated into small ethereal
haemorrhages of a peculiar character, to a
prominence, and the tumour with all the
membrane in the tumour, is divided in Maria Huldr

2. In allergy -
(\textit{Weichardt}:
Vol. 55.)
6. (Case of Mrs. Bridson, continued.)

- **Pterygium:**
- **Branchy:**
- **Papillary:**

- **Histological:**
- **Features:**
- **Bone:**
- **Lining:**
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- **Tissue:**
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- **Functions:**
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and in contact with calcareous cells.

If these buds have not lost their connection with the blood vessels from which they sprang, then pedicles, and a part of the vesicular branch, in which they are in connection, are often connected with calcareous cells to form a single mass; but if the pedicles are broken or he cut too near the calcareous mass, it may produce a necrosis, that will not heal and lead to the effects often times observed in the vicinity of the necrotic foci. Evidence of this is often recognized by the pedicle, or observed upon the surface of the tumor itself, and is often mistaken for the vessels of the tumor.

In the process just described, cells upon these buds become multiple masses of cells similar to a tumor, and in that state grow to form the center with calcareous cells. The fact that these cells are connected with blood vessels which differentiate them from the tumor cells. They are not always calcified, although they are sometimes. Edw. I. McFarland, in 1891, reported on this condition. His preparation is a semi-artificial preparation. After the mass is removed, then follows the formation of the calculus. In the parts of the body, particularly in the skin, the calcified or solid are very frequently met with there are also connected with vascular cells, to have the same origin.

In this particular growth these cells are seen...
I shall find anywhere anything else excepting the general arrangement of the cell elements clearly corresponds with
Cornelius Fresenius's description. The exact process of budding out of the neck wall.

The nucleus this buds into cell body is only partially indicated. Butclouds


Tissue is at very similar, and this

just vanish a more definite name could

be found because of their activity.

In Plate I. I have attempted to represent as accurately as possible the appearance of the tissue when first removed from the body.

and in Plate II. I have depicted the microscopic appearance both under high and low powers. These appended structures (Page 5).

23. Microscopical sections must be found in the cabinet

(Plate I. Plate 15.)
Case of James Kehoe, aged 14, 2nd Co. soldier, admitted into the Infirmary Royal Infirmary on March 2nd, 1884. Complaining of loss of power in the left side—also of numbness in both sides, affecting head and neck as well as extremities. Of Affection in corneal, and of increasing deafness.

History: Family history unimportant. Patient has been a cavalry soldier. Previous health was somewhat in question in early life, and had appendicitis 14 years ago. (Alas! son of a man who rests at drain of others' kindness.) About two years ago he had an attack of rheumatoid arthritis. (Doubtful) Tenderness was also reported a few months before at an attack of rheumatoid arthritis.

Present illness: Commenced 6 months ago. With headache, vomiting, and constipation. He also complained of weakness of arm and stiffness of arm. He had greatly weakened, and without relief. He had greatly weakened, and without any definite relation to meals. He says the slightest thought would make him vomit. About 2 months ago, i.e., 2 months after the previous symptoms set in, he began to suffer from a sensation of numbness in the fingers of the left hand. This feeling gradually increased up the left arm and shoulder.
Then from the left side, the left leg and left arm became similarly affected. Laterly, the patient has developed weakness of the left side of the head and neck.

"Passages with the sensation of numbness in the left arm, they became gradually weaker. Weakness steadily increased until 3 months ago he began to experience difficulty in swallowing, and for the last 2 months, he has been unable to swallow solid food, living entirely on soup.

He has been able to walk without difficulty, but for some time past, when standing, he has suffered from what he calls "weak knees," in which he has felt somewhat unsteady. When subsequently passed the knee-jerk test, he has been found to be depressed.

He has been losing flesh especially for the last 2 or 3 months. He and the view of a stomach ulcer. He has had no bladder or rectal complaints.

Present Condition:

The patient is a tall, frameless build man, but somewhat emaciated. Face expression showing no signs of the altered condition of lens, which are artifical. Pupils irregularly fixed, upper and lower eyelids. Temperature normal.

Nervous System: Has no headache at present. No complaints of numbness on arm left side.
Extruding from the tip of the head of the foot
was no pain anywhere.
When a pin was placed upon a book, and he was asked to pick it up, he was unable both to
feel. The left hand, he said he could feel the
book, but could not perceive the pin. Even when
it was rolling under his finger tips.
He could not readily distinguish between the tips
and head of pain anywhere or left arm —
the sensibility being particularly impaired on
the palmar aspects of the fingers.
He could not quickly tell the point of a pin or
from pressure — but not on his right.
In the centre of the palm, the sensibility is a little
more acute.

There is also partial amenaesthesia of the left
side of the head and neck — in this situation
he has considerable difficulty in distinguishing
between the head and point of pain.
all over the left side of head and neck his
combined sense.
The sensibility head and neck, is impaired to
the corresponding extent in the same sense.

There is also marked impairment of the muscular
sense in the left arm — that is, with weight,
he could not detect any difference between
$\frac{1}{2}$ oz. and $2\,\frac{1}{2}$ oz. with the left hand, but
readily distinguished between $\frac{3}{4}$ and $\frac{1}{2}$ oz.
with right.
There appears to be no anomaly in the left side of trunk, or of the left leg or foot. Sensation of right side normal. Right side normal. Sight. Since the operation of introducing the test has been able to see fairly well.

It is very difficult to say the vision with the right.

It appears due to the abnormal position of the pupils which are partially covered by the upper lid.

Both discs are very small, the apparent only

margin is scarcely distinguishable from

the surrounding fundus, being bl Здесь приведен текст, который необходимо прочитать и перевести на естественный язык.
2. Case of James Richardson. Continued.


No. 2. - In this case, it was found that the left arm was normal in appearance, but in both arms, there was a marked wasting of the muscles, particularly the biceps. The patient was unable to flex or extend the elbow, and the forearm muscles were also wasted. The patient complained of pain in the elbow joints, and the muscles of the forearm were also affected. The patient was unable to perform any voluntary movements of the arm, and the muscles of the forearm were atrophied.

3. P. - In this case, it was found that the left arm was normal in appearance, but in both arms, there was a marked wasting of the muscles, particularly the biceps. The patient was unable to flex or extend the elbow, and the forearm muscles were also wasted. The patient complained of pain in the elbow joints, and the muscles of the forearm were also affected. The patient was unable to perform any voluntary movements of the arm, and the muscles of the forearm were atrophied.
he walks he takes very small steps, the feet being turned outwards, and the heels brought to the ground with a slight jerk. The left foot as he advances steps it down. It also tends to urge the left leg behind him, the toes frequently catching against the ground. In this way he keeps the left leg straight and often when walking as he attempts to put the left foot on the ground, it has grown tan under him, and he has fallen. When the respective strength of both legs was tested, it was found that the right one was quite as strong again as the left one.

When he closes his eyes, he sways about or would fall unless supported. There is no slight uncoordinated after left leg, and also slight incoordinated after muscular atrophy since it being unable to differentiate between weights as clearly as with the right leg.

Rigidity general involvement; there are no marked bromo or distinct disturbances.


Helps very badly - says this is coming to a constant falling of body or maiming - disease also affects brain; good deal of myelinosis. No abnormalities of volume or pressure in the head.
Perfusion: He and I are under suspicion that
Sponge test.

Respiratory System: Chest contains fluid.
Resonance normal. Alarms at Vomitor.
Slight cough, wetter sounds. Titre normal.
Spirations diminished palatal reflex.
Mouth points towards left.

Mucous Membrane: Palpation of
Adductor and adductor lumbar all right side
of tongue.

Examination System: Pulse 90-regular. At +
Abdominal: Sharp sounds audible.

Alimentary System: Long, past dinner.
Feces: Thin, yellow, constant passing
of flatus. Vomited 2-7 times during day.
Can keep very little food or drink.

Nervous System: Abnormal of speech.
2-4 hours, which last 8-10 times.
Afternoon.

Mucous: Not sugar.

Food intake: 4 P.M. 1/2 lb. 5. 1/2
Dinner. carbohydrates. 50.
5th March. Peter 82. R. 20. Both extremely
ill. He had a fit in the middle of the night.
He remains in the same condition this morning.

He continued his treatment until March 10th.
When he was examined he was in a very weak
state. He had a diaphoretic, high temperature. He was
very much weaker than he had been before
the illness. He complained of severe frontal
headache. There is no pus in the left side of
his face. When he got up from bed, and is placed
on a chair, he immediately falls towards his
right side, would fall to the ground
unless supported. His arms also turned
towards the right. When his chair was being set
around patiently, he slowly turned to face
the right side. He became suddenly
paralysed in the face. He was unable to
speak. His pulses became very feeble. He
remained in a semi-coma state until he had
sustained severe headache. He says it was one of the
"terrible homes" alluded to in the history.
The muscles of the left arm, left hand, as
well as most of my other senses appear
he now ordered the following medicine—

* 1/2 Lint. Belladonnae.
* 1/2 to be given


Agat 51. Inn. De.

March 20th. Stilts upon my foot - constant use

Complaint of head might all down leg.

Left arm much weaker can only hang.

Right hand = 25. Left = 14.

The constant use of the help had been

Whenever he is put in the upright position

He claims this as a peculiar "head" in the face.

Doctor - When the bed is laid up 11 feet from him, with the

Ground is made with his foot, he is unable to

Temperature is 101.5°. P. 84. Resp. 19.
24\textsuperscript{15}. Chose the same - temp. 196\textdegree. P. 90; R. 26.
Right cough. He was carried into sitting posture in order to examine his chest posteriorly. He had trouble with nasal breathing. The head was fixed to the right, and his eyes turned in the same direction. He became unconscious during a attack. The right side of face also looked symmetrical.

This attack at once advanced a placing roll in the prone posture again - but always returned when he was raised from that position. When he regained consciousness, he could feel nothing directly in the roll up. He is unable rapidly to sit up.

Temp. 100\textdegree F. P. 90; R. 26.

25\textsuperscript{15}. Nasal breathing is greatly part of const. sigh.
The patient is lying on his back with his eyes closed. Tracheal noise are heard during inspiration. Complaint of feeling my mouth - Respiration of noise greatly diminished until talking. Belladonnaeum.

\frac{1}{2} a cupful in 24 hours instead of 4 to 5.

Note: Right side responds somewhat better than left. Breathing chiefly comes through the abdominal space, all in during inspiration. No abnormal dullness anteriorly. In front the respiratory rhythm is marked by coarse inspirations, and the expiration
March 22 23 24 25
26 27 28

Pulse: 95 83 120 104 98
Respir.: 20 24 21 26 24
Bowels:...
Urine:....

Handwritten notes:
- Instructions to normal 25 March
- When it is
- am Fine.
is considerably prolonged. Pulsation of the
pulse is normal and regular, pressure remains
sustained but diminished on the left side.

28th: Pulse 120, temp. 101.8°C (97°F),
No fever. 6:30 a.m. he had 1 oz. of calomel
and 1 oz. of saline. 2:30 p.m. temp. 98.6°F.

No improvement. 5:10 p.m. 6:45 p.m. temp. 100.2°F
at 9 p.m.: [V. chart:]

Diagnosis: Epileptic seizure.

Treatment: No apparent change. Has slept.
Nothing in putting him down. Difficulty in putting him
back into position.

Worse symptoms came on lately.

Vomiting: 4 oz. cocoa, carb. 9.
Vin. succ. 30 gr. X.

26th: Passed a jar at night, slept about 3
hours, but muttered a great deal. Tempera-
ture normal, on the morning of 5th to 103°F at 1:30 a.m., then
he had 1 oz. of calomel and 2 oz. of saline. He felt
sick, 5:00 a.m. remained at the point for some
hours. He took 2 pints of milk and
milk mixture mixed with
and 5 oz. of Brandy.

10:30 a.m. In lying when he constantly stood
up. In about 10 minutes he was up. Direct
right side of body. Puts right hand in his
mouth. Rolls his head and
side.

...
When first awoke, he opened his eyes, and attempt to
express questions - but soon closed them again,
saying the light pained him, and unmercifully
began to murmur again. He sat up as
much as he could on the bed.
The patient's reflexes are lost about
muscular irritability.
He was treated with some briskly: Quinine
about the bed.
Always asks when he wants to urinate.
Now no frequently, but perhaps every little while.

4o°: Ranched till 9 a.m. Thin slept greatly.
4:45 p.m. 67°. Must make about 50 per cent.
Today nothing eaten about 6°. But not as
regularly through. He comes the electric thing
in the left arm. Expect not with hypodermics.
2 4, with the right hand 2°.

28:34. Suspension could last night. He
instantly flowing at locality may in pain;
but on being raised, he said several times
that he did not feel any pain's about
Midnight he became unconscious.
During the early hours often hearing the
had tonic spasms of the muscles of arms and legs; more particularly of the left side. This lasted up to the time of death.

At 10.45 a.m. he was quite unconscious. The tonic spasms of the muscles continued he was breathing rapidly and spasmodically. Medical notes read: Marked papillary defect. After one and a half weeks, he gradually awake, died inmate at 11 a.m.

2. 05. The fits he had when being removed from the transverse fracture ceased when he became unconscious and did not again occur.

At the Post Mortem examination, a tumour about the size of a small tablet was found occupying the left half of the medulla oblongata. The position of the lesion is shown in Plate II, fig. 2. It extended as far as the oblong body posteriorly, as far as the median line anteriorly as high as the anteroparal origin of the 9th nerve. fig. 1, represents a transverse sec. in the middle section of the medulla oblongata, about the 3rd stammer above the jugum afferent with the middle third. The left half of the medulla is considerably distented and the median raphe lined from the 2nd to the opposite side. The roots of the hypoglossal nerve are seen distended, and the anterior aspect of the 9th nerve.
Role of the neural access, vagus, glossopharyngeal, especially, and in the cranial region, also the VII cranial nerve, or the uniplicated or compressed by the brainstem.

By microscopic examination (fig. 2, p. 11.111)

With a low power, part of the growth appears large and nearly circular, while other parts are more or less atrophic. Some of the giant cells are scattered about in a highly denser matrix, here and there well marked blood vessels being visible. Some of the blood vessels are often quite large, indicative of a highly dense matrix. The central portion occupies chiefly the center of the growth.

With a high power, well marked giant cells are seen, especially near the margin of the growth (fig. 2). These giant cells are large and contain numerous nuclei. Blood vessels are located around the giant cells, and the blood vessels are often surrounded by a thick layer of connective tissue. Many of the blood vessels are dilated, and small sections indicate that the tissue in this region is highly necrotic, which have become highly stained by the tomentum.

In structure, it often corresponds with fibrin and tissue due to injury, produced by the injury. Giant cells, under the pressure, may also be seen in the center. Sometimes these giant cells are mainly visible (fig. 2). Ordinarily, George 40.
from alterations in cord tracts & postures - Prolapse of UB. Papilla. Obliterated Pupillary line 180 degrees. Lesions at right. 2nd made constantly by lesions gradually becoming with coma death on May 26. 26th - 1st presentation 1st injury first time.

Pathological Report continued from p. 38.

It is not impossible that the tumor may be of some significance as giant cells are found occasionally in the uterus and the presence of another free muscular supply would tend to support this view. Although my own impression is that the lesion closely corresponds to a proliferation of the recurrent frenum. The distinct history of syphilis and the absence of interstitial view. The organ is also in front of the gynecologic organs.

The history of the case 1. The leading clinical features of tumors of the Medulla, involving one half of the organ. The diagnosis was confirmed by the post-mortem examination. Absence of symptoms, etc. as described in the preceding symptoms. The case at first was very uncertain about further. All the symptoms were readily attributed to simple exposure or irritation of the menstruating parts in the Medulla, or by the nerves (main central) which have their origin in the Medulla. The 6th nerve appears then restored.
Case of Robert Harris: Paralysis Dunce-

Patient who is a plasterer, aged 31, has been admitted into the Liverpool Royal Infirmary under the care of J. A. Davidson, on April 28th 1884. Complaining of very severe pain in the back of his head, of weakness of the left arm and leg.

History: The family history reveals nothing of any importance, but the patient's knowledge of his family is very defective and there are unfortunately no means of ascertaining the presence or absence of any marked hereditary tendency.

For the last nine months he has been very temperate in his habits, but previously to this, he used to have occasional drinking bouts. When at work as a plasterer, he says he has always been constantly careful about contaminating himself with lead, washing his hands before meals. He has always been engaged as a paper-hanger however for the last year, to.

He acknowledges having had "off" chances of drinking from the penins 8 or 9 years ago. But there are no evidences of this occurring had anything.

At the present time, commodities he has always enjoyed very good health.
About 13 months ago, he slipped and fell heavily on the back of his head in the forked pavement on the street; he was carried quite unconscious into his house; he remained in this condition for 10 minutes. He then had profusely from the nose, congestion of the nose, stuffy nose. Next morning he says he was all night absent in the effects from the fall, that he was quite as at all times.

Lately, he has suffered from attacks of diarrhea, constipation of the bowels, but says distinctly that he has never had an attack of anything like colic.

History of present attack: For the last 3 or 4 months the patient has suffered on and off from vague severe pain at the back of the head, when first noticed it gave him an abnormal sensation rather than pain. Soon however the pain increased progressively and radiated over the vertex, especially at night, which it very infrequently prevented him from sleeping. He has also suffered from attacks of sickness, especially when the pain was severe. He also noticed an occasional slight side bending to neck towards the right, turns his face as though he would fall back. Hads: At times when he has also had a feeling of nausea, which has sometimes even amounted to actual vomiting.
This appetite has also fallen off, the attacks he has
have been rather stupid at times. He has never had any
fright or convulsion of any kind. For the last
month or so he has been rather more sleepless
and feeling weak, the former being also some-
what "instantial" when attempting to do any
delicate manipulation viz. Seps he has not
lost any flesh - although he has felt weaker
to day. There symptoms have been
gradually getting worse up to the present
time.

Current Condition: (April 28th 1873)
He is a medium sized man, fairly built,
somewhat emaciated facially. Mentality
moderate. Seps he has not varied in line respects
since present illness began.


Present History:

Patient complains of Shoting pain on the back
of the neck - and sore pain on the occipital regions.
Sensibility to touch, pain; heat, cold K. unimpaired
everywhere.

Special senses normal - Pupils rather dilat
ed but react fairly well to light and ac-
commodation for distance. Or Ortho
kinesiOscopic examination - the Optic papillae both
rather too pink. The retinal veins a little too thin
perhaps, but no other abnormality is to be
Activated.

There is no marked muscular atrophy anywhere, but the muscles generally feel somewhat flabbily. Grasping power of right hand is not equal to that of man of this size. Range from calisthenics that of the left hand is very much broader; this can only find a comparatively facile tongue with it.

Walking, there is evident stiffness and weakness of left leg: when his feet are placed close together, he stands with difficulty, even with his eyes open; but with eyes closed he sways about a good deal. When he attempts to walk with his eyes closed he stagger a great deal, "cracks" considerably towards the left side; the range he feels as though he must fall in that direction. There is some ataxia of legs.

When his eyes are closed, he can touch the tip of his nose pretty accurately with the tip of his right forefinger; also the thumb of the left hand placed some distance from it. But when he attempts to do the same with his left hand he goes way wide of the mark, the extreme of the arm being distinctly absent.

The pathetic bending reflex is constant: more marked on the left side - this can kneel down. Superficial reflexes normal. Organic reflexes all normal. Skull x-rays: no abnormality. No marked sclerosis.
Respiratory System: slight dulness in
pericardium in the right side over the apex of
heart, moderately, but numerous rales, and fine crepita-
tions at apex. Pulse normal, no change.
Hard breathing at both sides.

Circulatory System normal. Pulse 62. Respiration
at good time. Equal at both sides.

Digestive System: flatulent. No distinct che-
nus. The bowels open, during the last month
she has suffered from nausea after food but
with no or very occasional, in none severe
vomiting. Latterly the bowels have been
constipated, since no change noted.

Urine: clear, pale amber. Sp. gr. 1.010. acid.

Treatment: Common diet.

1. I. g. Sky charm as m. x x x.
2. i. m. Cardamum. c. o. 3 fl.
3. galls from at Zri.
4. I. g. Peri at m. cih.
May 6th. No perceptible alterations in the condition of the patient. The splotches of jaundice still continue, but they appear less marked. The abdomen is quite relaxed. The urine is clear, and contains no albumen. The stools are formed, and are of a dark brown color. The appetite is good, and the patient appeares quiet and comfortable.

June 1st. The urine remained unchanged, and the general state of the patient was the same as on the previous day.

June 10th. The patient appeared to be improving, and the jaundice was much less marked. The urine was clear, and contained no albumen. The appetite was good, and the patient was quiet and comfortable.

June 12th. The patient was in a very good condition, and the jaundice was quite gone. The urine was clear, and contained no albumen. The appetite was good, and the patient was quiet and comfortable.

June 13th. The patient remained in a very good condition, and the jaundice was quite gone. The urine was clear, and contained no albumen. The appetite was good, and the patient was quiet and comfortable.

June 14th. The patient remained in a very good condition, and the jaundice was quite gone. The urine was clear, and contained no albumen. The appetite was good, and the patient was quiet and comfortable.

June 15th. The patient remained in a very good condition, and the jaundice was quite gone. The urine was clear, and contained no albumen. The appetite was good, and the patient was quiet and comfortable.

July 1st. The patient remained in a very good condition, and the jaundice was quite gone. The urine was clear, and contained no albumen. The appetite was good, and the patient was quiet and comfortable.

July 10th. The patient remained in a very good condition, and the jaundice was quite gone. The urine was clear, and contained no albumen. The appetite was good, and the patient was quiet and comfortable.
The contraction of the muscles of the left arm is somewhat more impaired than when admitted into hospital - on carefully exam.

vini his face, there i found little slight dif. - forma wherein the temporal front on the two sides. The left being alike more with the rest of the face. He is able to write his name, to throw his letters equally well on both sides.

There is no ptosis, nor any paralysis in the muscles of the upper facial zone. Neither is there any weakness, nor any upon the muscles of the eye-ball. There is no mydriasis. The protrudes the tongue in the median line, but appears unable to project it far beyond that line. He vision is unimpaired. No color blindness. The contraction of the field of vision: Spots in affected. Duration of right palatine quickly normal. No difficulty in verbal-

11/2: Panui has been an inquirer that ought, that he was unable to think with not a very desirable projection of sarcasm: he slept well afterwards.

19th. He complained himself as racked by the pain in much distress but at finding no relief with any dull remedies, he somewhat the said.

DURING THE REMAINING PART OF THE MONTH: IN JUNE he got a little worse being com. 

fused to hell. Have him again in August.
When his condition was any much worse - he was then unable to walk without any much assistance. He is rapidly losing all power of controlling the movements of his legs. Pain in the head still setting worse. The paroxysms of pain are more frequent some prolonged them very much. Immediate painless relief. Fainting was very frequent during July, but is not so frequent just now. He took any money the paid him, instantly losing flesh somewhat rapidly. He occasionally talks foolishly & rambles. He often lay when sitting on the bed - pan in bed, he fell off it, onto bed, onto the floor. He lies on one or both.

Causes passed his motions into the bed apparently without letting off of it at this time. He continued to get worse, and when writing from my birthday I found his bed.

6th. 11th. Drove comes his bed now. Much more

Sneezing - lies in bed all day, letters letter is no rest of what he doing in this week.

Lies in whatever position he is placed with out making any efforts to move, does not appear suffer as much pain as formerly, paroxysms of pain are far to pro.

Sneezing. He was given no account by himself that can be relied on - his memory being much

Jailed very much of late. Has lost control

Continue on p. 50. at
*Pain in the occipital region. He has vomited an exudate which contains a yellow fluid. He has been in bed for some time."

The patient expresses himself as being much better, especially in regards to the headache.

Temperature: 98.6°F. Pulse: 60. Blood pressure: 120/80. Urine: negative for albumin and sugar. No fever, no signs of inflammation. No pain in the neck or spine. The patient is feeling much better.

June 1st: The pain is more constant, but

(Continued from p. 46.)
He generally requires me to make him aware of any unsatisfactory condition. In this case, the patient's eyes are sunken and the skin of the hands is dry and cracked. The skin of the arms and the legs is also dry and cracked. The patient's voice is weak and the breathing is labored. The patient is unable to stand or walk and is in constant pain. The patient's bowels are constipated. He is bedridden and is unable to eat or drink anything. He is in great pain and is in constant distress. He is in need of constant care and attention. He is in constant need of oxygen.
Patient no. 21. Mr. A., aged 30. Admitted Dec. 30, 1874. Was admitted to the hospital with a serious perilous condition. The long saphena vein from the femoral opening bled profusely. The pulse was extremely rapid and weak. The skin was cold and clammy. The patient complained of severe pain in the head and back. He was in an extremely low mental and physical condition. Pain in the back—almost unendurable at times—occurred almost at night. Muscular twitchings in legs. He gradually got better, the symptoms subsiding. The leg became more avascular and purple. He gradually became profusely cold, and died on Dec. 16.
Dr. Report. I have examined the patient at 11 a.m., but I found the report from S. I. Barlow, who
made the examination.

The P. M. was made 36 hours after death.


Dura matter pretty firmly adherent to meninges for this part of the arterioles and was
inflamed thickened at this part.

The Periosteal substance was considerably thickened.

The Tumors contained a considerable amount of dirty yellow serum.

Cerebellum. Right side healthy. Left side
affected, the upper part was completely
surrounded by a tumor about the size of a
small orange (Pl. IV. Fig. 1. A. & B.)

which was adherent to bone skeleton.

The parts of the tumor were adherent closely
with the tumor were in an acme state
of nutrition. Some portions of the surface of
the Cerebellum were covered with the surface
of the tumor. The tumor was firm, yellow
with a yellowish color - opaque without any evident
structure limited color in centre. Its tissue line
had concentric varying colors, appearing
somewhat gelatinous looking for about
3/4 inch wide all around it long in a
mass of yellow brain (cerebellar tissue,
from which it appeared almost quite
distinct). Its centre was amorphous and
fused.

Heart. Healthy. Both auricles occupied by a
fungi. Blood dark.
Spleen: No large, pale, but healthy.
Liver: Somewhat fatty, with micrones in its fibrous tissue.
Lungs: Small, pale, but healthy.

The internal and external sphenoïd sinus of the left leg were quite filled with a recent hemorrhage, which was adherent to the wall of the sinus.

Spinal Canal: The lower part of the spinal canal was very distended with crenated spinal fluid, its clotting up the lower half, a number of small thrombi which, by writing in fluid form, again led to the formation of a new thrombus at the surface of the end, also adhering to the Charcot organia.

The upper part of the spinal cord was of a yet bruisd colour, yellowish, somewhat soft; the anterior and posterior were normal, respecting...
A small portion about 2 inches above the umbilicus. Here there was slight parietal tenderness on the right side, as if the small scar of the cord were about to twist through the pia matter at this spot.

In making a transverse section of the cord through the conical enlargement, the grey matter appeared indurated, soft, and smaller than normally.

Microscopical examination of the growth proved it to be a large tuberculous growth - the central portion having indurated from contact with the inner margin of the tumour, the central portion of the growth was well defined - a finely fibrous alveolar structure, containing only long columnar epithelium cells, others and there were giant cells - but my four vessels.

There were several sections obtained in different ways to illustrate the case. A rough, kuru column sketch of the tumour itself, after being dissected. There was no difficulty in the diagnosis of this case, although the patient was sent into hospital as a case of 60 years' chronic disease of the appendix, although the patient was sent into hospital as a case of appendicitis.

There were some marked symptoms of marked virulence beyond the rigidly permanent. There was no suspected case.
Admitt. April 28th

[Handwritten text with an unclear date and some scribbled notes.]

The immediate cause of death in this case appeared to be due to gradual col...
Lycopodin, in great part due apparently to the condition of the lungs and kidneys, Profound.

The leading features in the case were:

1. Intermittent occipital headache. Glaucoma.
2. Rupture of the heart, leading to death, with
   3. Abscess of the brain, with
   4. Loss of power of muscular movement, with gradually increasing disable
Case of John Poole, Clerical Servant.

Patient who is a clerk, was admitted into the Liverpool Royal Infirmary, on July 20th, 1889. Complaining of dull, aching pain across his forehead, of constant buzzing noise in his right ear, of hearing in running, and attacks of giddiness, with transient loss of sight.

History: A male aged at 30, from a respectable family history. Threw up some days back and at work very comfortably. Has had no previous illness, or accident of serious nature. Has never had any fits. Some months ago, he had an attack of vertigo. Two months afterwards he began he had an alternation between what appeared to him to be an attack of vertigo. Two months afterwards he says he had an alteration between what appeared to him like a fit of vertigo. In one case about 1 mile occurs to have been dizzy only at night.

Three months ago he first cut and aching pain across his forehead and shooting pain at the back of his head. These were constant at first thing in the morning, but after kept him awake all night. Soon after, he began suffer from attacks of giddiness when walking. These were accompanied with two nights of momentary duration, frequently with alteration of humour.
face, but try to discuss the issue.

After dinner, go out for a walk. This will help you

Remember who you are and what you want to achieve.

Your personal development is your responsibility. Take

In the next section, we will discuss

Grace, 25, an HR manager, said she

In her current role, she

Grace, 25, an HR manager, said she

In her current role, she
When he placed his feet close together, and (eyes open) he swung from side to side, the change of his eyes this is greatly increased. He does not swing more in the middle than in another. There is no concomitant of the movements of the arms or lips as stated in the ordinary manner.

Hearing was intense, unimpaired. There is deep, rhythmic respiration in the upper airway.

Heart, lungs, kidneys normal.

The was put on common diet, and allowed to sleep alone. Each of Institute & Palsi & of Poerioi.

Three times daily:

He continued very much in the same condition till the beginning of August. He suffered more or less from severe headache, especially in the morning. Generally tolerated more than usual, also in morning, but sometimes more frequently; became more frequent. Before food, and at times after. Anthropotistic food, but the Pemudo became constant, so much so that he was asked to take oil in 100 cc. doses, in half 4.100 ce. on Augst. 18th. Ouren 7th, and a few days.

Augst. 18th: He still continues to suffer from intense pain in the head. The lowering vision in his right eye has markedly increased. He is not able to read a book etc. beyond 3 inches. He has a good deal of nausea, and vomits his food frequently. He appears social...
Reflexes are well marked. Sense as on the left. Pallet as on left. Reflexes are almost entirely absent, being just perceptible on the right side. Pulse 108 in the neck. \(\_
\_\_\_\_
\)

When he stands, feet with feet together very spread, he always about very much, when he closes his eyes he always stumbles more. When told to stand

\[\text{the tips of his toes with his forefinger, he makes a very \textit{bad step} with his left, but a good one in the right hand. Eye sight has declined.}
\]

\[\text{markedly. Cannot read ordinary type. Has 2nd trouble with his hands. There is marked optic atrophy.}
\]

\[\text{Aug. 14th. Since the last 21st he has had}
\]

\[\text{within a thickness, one headache. However his}
\]

\[\text{condition is very much as before. (Fencing, stopped.)}
\]

\[\text{18 1/2. Still no headache, but an almost}
\]

\[\text{constant feeling of drained upness}
\]

\[\text{panting - this is always much worse in the}
\]

\[\text{mornings. He sleeps well; gets his food}
\]

\[\text{with difficulty, tongue very protruded. The uncoordinated}
\]

\[\text{arms, hands less increased, with}
\]

\[\text{his eyes closed, he is severely when looking the}
\]

\[\text{tips of his fore-fingers together.}
\]

\[\text{21 1/2. The headache suddenly returned in the}
\]

\[\text{extreme severity, vomiting out most}
\]

\[\text{26 1/2. Headache intense, vomiting persistent,}
\]

\[\text{pulsed teaspoonful O.S.STIT. p. \& h. in the}
\]

\[\text{28 1/2. Headache vomiting still unreleived -}
\]

pains very much worse when standing -
He is quite unable to walk steadily, along any line of the floor; noted to take stiff, rapid paces. For 2/3 of his right lateral, he remains in practically the same position. Vomiting, diarrhoea. 15th, 2nd dose of Belladonna, headache, became suddenly worse. He died.

At the first post mortem examination, large hemorrhages to great tumours were found at the base of the brain. Hemorrhagic area of the area pecky of the right hemisphere. The tumour was situated in the cavity of the right lateral ventricle. (C. Pl. 5, fig. 1.) The albumen, being a large, grey, of the mass of the tumour, in the floor of the right ventricle, from which it appeared to have originated. (C. Pl. 5.)

Microscopic examination: Plate V.
With low power (C. Pl. 5, fig. 1.), a large tumour in the floor of the right ventricle, at the upper part of the lateral ventricle. The tumor was a single, unidentifiable mass. The nuclei lying embedded in a clear, granular, fibrous, granular matrix, which prevented further identification of the differentiation. After small blood cells are seen throughout the tumour.

The cells forming the nuclei of the cells are typical in the floor of the right ventricle are composed of a granular, rather flat and distinct, with the floor smooth, of the floor, and those in the floor only being distinctly.
Almost armed -

...it is clear. Some of the further details of the structure could be made out. No nuclei were present. There was no differentiation into more highly organized structures anywhere. Therefore, we have classified the germ as a

...cell content. As a matter of fact, he only had an opportunity...
= Symptoms of Case. =

Died, Nov. 15. Pneumonia; admitted July 22nd, 1847. First symptoms began with constant headache, vomiting, pain at back of neck, difficulties in walking, weakness, anemia, hypoglycemia. Occasional delirium, constipation, weight in right side. Vision, hearing, memory, and speech were normal. Right arm, right leg, and right eye were normal. Vision, hearing, memory, and speech became prominent. Finally death from sudden coma.

In this case, keeping in mind the position of the tumor, and its undisturbed relations, it is curious that the symptoms should have been comparatively free from increase in size, while the sight, hearing, and speech were usually present in intra-cranial growths. The latter are usually marked by incontinence of the urine, diarrhea, and fever. The weakness of the right arm and the right leg were the result of pressure of the tumor upon the fibers of the 6th and 7th cranial nerves.
Case of Thomas Arscott, aged 42: A Publican.

He was admitted into the Liverpool Royal Infirmary on Feb. 1st, 1806, complaining of loss of use of the right arm and leg, and of loss of speech. The following account of an offshoot party from the patient (who was very confused) accompanies this account. (Handwritten text)

The patient has kept a public house for 8 years. Prior to this, he was a poacher. He has drank plenty freely, but only got drunk occasionally. He had rheumatic pains about 20 years old, and says he has had great loss of three times during the last few years.

Present illness: About the middle of last December (1804) he had a fit, in which he was quite unconscious and bit his tongue. The fit lasted 10 or 15 minutes. He had a second fit about a month afterwards which was not quite as severe as the former. This attack began with his clenching of the right arm and hand. He did not bite his tongue, although the right side of his face was particularly convulsed. After this fit, he said he felt "press" in the head at times, and his right arm would often begin to "work & jumble" of its own accord, without any apparent cause, and in the absence of any duty. He has since suffered from clonic spasm in his arm. About a month after the second fit, he had a third, which appears there has been a wing of it.
one, and nothing definite can be ascertained concerning it. About this time, or a little before, he began to lose power in the right arm and hand, this was gradually progressive. About three weeks ago he noticed his right leg becoming weak, and about a week ago he began to have difficulty in speaking, swallowing, and speaking indistinctly. The day he was brought into the infirmary he was able to walk down stairs. Latterly, he has complained of a great deal of pain in the head, and has had occasional attacks of vomiting.

Present Condition: Patient is a frail, tall man, fair skin, somewhat haggard, and prostrated in appearance. Pulse, 70; respiration, 24. Right cheek flattened, and unable to move much, but distinct movement is present. Right arm and leg upper arm and upper arm and leg entirely among other joints to left hand and left of head. Right arm and leg are kept extended and perfectly still. Disk moist, temp. 98°.

Vessels System. Cerebral and Systemic condition of the Patient—only an imperfect examination has been possible.

(a) Sensory Function: Complains of slight pain in his head, worse at night. Not localized tingling...
particular region. Also of a feeling of stiffness
similarly paraplegic, and occasionally if

On examination of the patient at this time,
it is possible to notice that the patient and
head, but there is no certain evidence on the skin
above the right side. Pulse is normally detec
ted, but respiration both right and accurate.

Symptoms: Coma - Deep, Right - Can not
movements; Small print (numbness by feel).
Hearing, bark, stimulus apparently normal.

1. Reflexes: Organismic reflexes ap-
pear normal. After days after admission, he
punched his face with his mouth inactivity.
Right patellar tendon reflex markedly re.
assayed - Left about normal - Heteronymous.

2. Neural Reflexes: Right head and left
right leg, less so left.

Voluntary: Iris quiet and he bounces his right
leg, or moves the toes. He is able lo move his
right arm horizontally, and can
first grasp with his hand, but with no to
any force. There is marked in coordination
involuntary, often done in right leg, right
hand and arm, although seated in restant.

There is no rigidity (some rigidity - The right
arm was first brought on the 16th mot.)
There is slight paralysis of the right side of
the face (lower zone) and he protrudes his tongue.
Slightly turned left.

The memory is distinctly, considerably improved, he does not remember things so well, and particularly contradicts himself. He habitually says much when speaking, andelectron, at the commencement of a sentence—but after stating
he speaks fairly distinctly. However, it is by
hand. Of the word "yes" repeating it several
times. When asked a name, he does as any
would, 5th place, or above them now.

E.g.: "(The words are not in the text.)" "Then also, with her (full) approval, her shipmate, because (the)
wife of a clergyman (of) high character
(in the) colony.

Shake partly.

Preliminary System—mental.

Consultation—think metaphysical, truth about
here? Peter 68. full regular.

Albinly: S.: "When Fred unconfidently,
I will spend it gladly. "Okowa, my country.

151st: Some quiet, untid, reading this morn-
ing. When some a book read he pretended
to read at a passage, but only attent uninter-
ligible nonsense—but if read would he per-
mit to know, he can pronounce it, but that
is all. "Boo, he needs much without.
(Can of Mrs. Parrott continued...) 

2. To much more direct and does not pay any attention to what is said him. There is decided possibility of the night being and keep on person's movement.

3. Has remained much in same attitude as last five days but seems rather better this morning than usual he pays more attention to what is said him but does not appear to remember the more necessary bearing the question put to him. He knows his name this morning, but does not know where he lives always says "at Dr. Jones" although he had been told after nineteen before that the head in "John Coleman time, Parrott," that he had actually completely forgotten it. He appears to fully comprehend anything that is said him but is utterly unable to express himself in words. Two friends called on him yesterday; he knows them perfectly well and was evidently much moved at seeing them. On one's name a note and asking him to read the following "Preface to the Second Edition." He only redo's he can pronounce are to the. The other he is quite unable to utter, although he tries hard to so.

6/24/15. Passed many reactions. Continually jumps and exclaims "is this true" and says "yes" when asked if he has headache. Jumps of and after dark during night, faces him, morning. Pulse 60; small pulse -
Difficulty in swallowing. Does not speak. Touches tongue when asked whether, but when questions are asked, or after drinking, he says them:

When asked any question, simply says "yes" or "no" at random, but does not appear to understand anything he is asked. Although he answers "yes" or "no" in an answer to any question, yet when told to do any simple work, he will not or cannot do so. He will not touch with any several articles placed before him, and named. Will not join his left hand when asked, but when questioned, and signs made he will do so.

In the last few days has formed with some difficulty without any signs, by any signs his desire. No.

Dinner Dr. Peter H. 7 a.m. 8 a.m.
Eyes raised, looking much more than usual with much difficulty. Right cheek markedly flatter than left. Eyes look closed. Can only be formed with difficulty. When eye lids are raised, both yes are not raised upwards and outward. Pupils greater in the left, but smaller and more round at the outer margin. Ocular deviation.

Concerning his distinctness they are 8 feet. 16 per second. 70 K 2/4 April 09
June 15. This morning, being fed by the nurse, but
makes no attempt to sleep himself. Still
keeps hand near and in pain.
Became bright in expression and appeared
rather more with joint but replaced with
accomplished condition the same evening.

June 15: is lying on his back partly on his
left side, head turned towards left, chin
lifting over left shoulder, both knees far
from drawn up — yes partly open, and
both hands forwards and left, Constantly
turning left arm about in a leftless
manner. Occasionally pulling his moustache, or placing his forefinger against
his teeth. He does not tolerate the slightest
stimulation, nor starts action of
any another move. Face pale, and mouth
tremors than when admitted.

Two days afterwards he refused his food when asked how he was, if he felt any
hurt, — and said "yes," directly afterwards
he said "no." The same question, but with
difficultly. Voice has become altered in
description. There is frequent noise of
puffing in the right arm or leg, both being perfectly numb.

Pain in any known resistance.

Response: 28. Childish look, but very regular.


Retorts relatively constant, but when food
[When fed] very slowly, and rolls it about in his mouth for a long while before swallowing. Occasionally swallows off with a little still in mouth as though he had quite forgotten it. He will open mouth wide when asked -

Wu Yü, bird in wild state. - Spgr. 1037. Poma, Peruvian. -

Mar. 14. Still lies abed, but with head turned to the right. Appears very much better today. - Constantly drawing hand towards head; turns hand to red and blue. - Skin pale, natural colour. There is a weak hunching of right eye. Skin redder with left arm and hand, turns the finger and leg through his hair. - Right side of right arm or leg. He opened the fingers of right hand when told to do so, but appeared the same while turning fingers of left. - But when he placed some hand on his right he pressed it with his fingers when asked to do so. - Poma, wu yü in bed. - Armenian Ostrich. -

1615. Lying in abed, and looking towards yesterday morning. - Yesterday his right leg were very sore after running around. - Plantar reflexes on right side of leg retained.
CB. 1 (Reve of Thos. Porte & Lieutenant.)

Patient as usual, refrains about what the sides. Then—right destination satisfied. From W.T. eyes. Pongue fully open, eyes directed upwards. Fee achen, but can eat a bit of food. Cannot move. Feels very weak. Cannot talk. Has not eaten any food since last night. Cannot be made to drink water.

18.45: Much in same chart as on 16.45.

Breathing heavily. Swung up dry stream. Gushing constantly, spitting CT hand to front, reap on much pain. When spoken to he remains hearing, able, and attempts to speak. In motion occurring, he could grit small out the words “I am poor.” Can only he made utter all else.

Motions of right forearm and hand stiff and flaccid—are his right “by his side, not side.” Right leg also flabby that as atrophy of arm.

Face urnum, pupil constans.

Motions of right arm slow twitch rhythmically.


2/87: Now him gradually mixing since 18.45.
intercourse since 19th. Would not later anything by itself. Had the larynx removed.
He died sometime this morning at 8:00.

lung and adjacent areas of both lungs con
sume the pleural cavity with yellow
yellow lymph. Hypostasis congestii major.

Pericardium filled with much from superior
bronchi filled with much from superior
bronchi filled.

Neck veins thickened. Large quantity
of blood from Pericardium. Heart
small, darkly colored, much as if
considerable water in major vessels.

Brain: other parts abnormally adherent
but firm surface of cerebral hemispheres firm.

Pia mater generally congested. Abnormal at
base of brain healthy.

Brain: most of the left anywher
palpation. On slicing the left hemisphere
area firm, markedly. Myelin its 1/3:
yellowish to yellowish. Growth was found
occupying the right part. On cut of
the left hemisphere (v. below colom
sketch). The growth has range from 0.1
in. of a centimeter and stretched with ften
certs in small places large ones more
conspicuous. The reason why
bulged considerably near temples right
right
with a striking the first anterior arm along
dorsal hand of lower abductor mass runs
passing into the grooves from above back-
wards (as pen with writer). But a striking
and the action, no harm inside could be harm
with the grooves. The margin. Often at
was well defined. Stippled by a masses
zone of about 0.7. Syn- de mullei.
The section of the groove has as follows.
Anteriorly it extended through the area to
agranular mesh of the anterior rectitude.
Often left frontal. Later and posteriorly
it included opposite back on the post-
ventral border often coronary cartilage, or
about 2½ in: from the tip. Often to-
right all the. Its terminal margin
was about 1½ in: from the end of the
marginal surface of the hand. The
terminal margin bulged across the
median line. Below it could a
bulge. Often most of the tip lateral
ventricle in the anterior half of but
the ventricle itself, and the corona frond
the. These characters appeared in
affected. But the length side, marked
with the first stria turned, assumed
avoid area about between epistylum
and coroner anteriorly, which at first
looked like this growth, but as closer
examination it was clear the closely un-

and of recent onset congestion of the substance of the right hemiplegia was present. There was more congestion about the right side of the brain. The ventricles were distended and filled with clear, yellow fluid. The descending course was especially dilated. The optic thalami were congenitally normal. The diencephalon was large. The fornix was flattened and bulged somewhat into the ventricles. The choroid plexus was congested. The spinal cord was somewhat atrophied. Apparently from pulsa tions which had act on the heart the value of the pulse was apparently normal.
Patient a publican, 42 years old. First symptoms appeared 2 years ago. Patient felt a fit on right side. Right leg became weak. One week ago, difficulty in speech. Patient had trouble talking. Lying symptoms on admission: (22.4.19) Patient had, worse at night, paresthesia of right side. Right arm, shivers of right side. Jittery movements. Irritable patient. Left leg, left arm, right leg, right arm, left leg, right arm. Slow motor activity of right side. Incontinence of right arm - at first not noticed, then never. Right arm, left arm not noticed. Changes of voice. Patient was asked to name 'green'. Patient answered yes or no at random.

Remarks:

Concerning the mental acuteness of the patient.
and the last point of which he came under observation, it was extremely difficult to find any satisfactory observations regarding
the history of the case, and also any subjective symptoms. As far as could be ascertained
the first indication of cerebral disease was the epileptic fit in 1842. Last, after he developed
symptoms than ascribed from attacks of so called "Jacksonian epilepsy", i.e. loss of con-
trols of one side of face, arm, hand, etc. with loss of conscious. These were undoubtedly due to the presence of the tumour within originating by contrac-
tion of the corpus striatum - or the fellow taking
through the motor cortex him around
the fossa of Rolandic towards the anterol
portion of the internal capsule - the left hand
probably paralysed in a "lassi" manner.
It is possible that the pains he complained
of on his arm may have been produced by
interference of the sensory paths in the brain -
path of the thalamus tegmentalis. As the
sympathetic increased, symptoms of motor
involvement followed with paralysis in the same
part (i.e. right sided hemiplegia of the
paralyzed arm). Thence he found that the
Pacinian mechanoreceptors on the
right side, right half of face, and towards
hypothalamus, left the controlling centre for Nerv
Influence, which probably is actually felt in the cornea, through a minute cleft or slit opening off from the contracting influence of the \textit{shrinker} (both), which, by the tension, becomes entirely active so far as a prize, and thus initiated. The influence exerts on the cornea. On the other hand, it may have been elicited directly from increased activity by the compression of the food itself.

In this, the sense of the two, symptoms of Comfort, and other symptoms of the sense of the nervous system. The presence of the inflammation directly caused. These symptoms were undoubtedly partly due to the accumulation of fluid in the right orbital venous wall.

\underline{Microscopic examination.} (Fig. III.)

This tumour was a well-marked firm swelling - but I think might more correctly be termed a \textit{granular cancer} - as the lesion often forms a mass somewhat at different parts. Near the margin of the mass, the thickness is not of an \textit{ordinary} \\
\textit{granular} - consisting of small granules of cells with extremely fine branching processes, which unite in all directions (Fig. 1, Plate xvi) in Scotland. About in the fleshwork of these, are round or oval, finely granular cells, branching through the connective tissue. These granules are partly composed with blood vessels, which are particularly well seen in these sections.
of mixed epithelial stroma, not in Canada.
Rheum- [Shade 24, Jan '58]—in Br. parts.

The fibrous filamentous stroma is replaced
a somewhat coarser + more fibrous connective
+ It. (Shade 25, Jan '58.)

In section of mixed epithelial stroma +
stromata in fasciculi adhesii (unclassified)
structures in not as well brought out. But
large number of large round or oval, or more
spindle shaped cells of a sarcoma like type
are not unli. many often containing large
nuclei. Also, there are many large, granular
lysozomes which do not indicate the
common stain at all, which look like glycogen granu-
ules. These cells are not arranged in any
definite manner, but are scattered about
in large numbers through all the tumor.

In some parts, the growth appears hemispheric
almost entirely of these cells, which in other parts
are almost wanting. These large sarcoma-
tous cells are best seen in the central
neighborhood of larger blood vessels.
Case of Joseph Edwards, age 28. Labours.

Cerebral Hemorrhage. Int. by Hospice Royal Infirmary.

History: Family. Father died at sea, cause unknown. Mother died from some nervous complaint.

Personal. Has been a very moderate drinker. Is old age. Still capable of when young. Meme: His eyes have been much affected. Has been under the care of the family physician for the last two years. He says he had an attack of "Acute Motor Paralysis" two years ago; he had a number of his fingers and ankles, and was confined to bed for six weeks. He also had a great deal of pain in the shoulders. Also had an attack of Gonorrhoea six years ago.

Present illness. This commenced about six weeks ago. The first symptom which troubled him was headache. At first the pain was not localized, being particularly noticed but for the last four weeks it has been localized in one spot, this is situated on the left side of the forehead, behind the middle.
tum, and it is alone the supra-orbital ridge,
remains. He has been vomiting for the last five weeks, but
here he deny actually vomited 4 or 5 times during.
Generally in the morning. For last three
weeks he has felt very sickly when walking.
This has caused him to fall on several occa-
sions.* For supplementary remarks see below.

*Local on Allanium: Patient is a middle aged
well made man- of good muscularity, which
is diminished. Face bears a peculiar expression.
There is slight flattening of the right cheek, with
an almost complete flattening of the nasal labial
groove on the same side. There is internal
deformity of the left eye, which is not altered
by moistening into his eyes separately.
He can whistle, but also able to blow his lips
far back, but much less plainly on the left
side. Apparently no loss of power on the
tongue nor in any of the facial muscles of the
upper one of face.

*Additional points to history of dizziness, and greatly
Marked - Ten days ago, when sitting in a still
he began feeling, and a tendency to stagger if he
lay supine - he also had severe head ache at the same
time. He felt off his seat and the floor falling
towards the left side. He remarks he partially
lost consciousness, he lay on the floor for about
30 minutes. He feels now he had no consciousness
April 2nd. 1882

The dotted red arrow represents the red image which appears towards the patient's left, but the true one, marked here, the red glass was put before the patient's left eye. He had a slight nystagmus of the right eye, and is able to turn his left eye to the middle line but not his right. 
Movements. He sat up, spoke, and walked some, a
distance of about 3/4 of a mile with alertness.
He was walked with sidetracks, tending
to stagger several times when near home, and would
have fallen, unless supported. His speech
was "a little allude". What occasion - did not want.
Seven days ago he had a similar attack when
riding in an omnibus. On this occasion he
did not lose consciousness, but lost speech
for upwards of 10 minutes, he could only
say "fifty-seven" (the no. of his house being
19). A man helped him to some railings, after
the had got him off the bus. He never felt
siddly in bed.

It appears he has just become a patient at the
Eye and Ear Infirmity in Dec. 1891. According
to his first patient paper he was then suffering
from - Right eye: Internal Strabismus. Old per-
fronting ulcer with red patch in.
Left eye: Paralysis of 2nd Pt. Rectus, Internal
Strabismus. Diplopia. He was treated by a.
O. Dr. Ind. J. R. S. Church, 50.
R. Dr. 2/12 was seen of Dr. Ind. was increased
5. 8. 95 to F. 2. 12. Dr. got 85 to 85 on the 23rd of
Diagram by 8. 85. (The accompanying chat to show his condition of
Kept on for April 9 1892.
As May 15. The internal Pt. were divided.
In May 20. Right eye can, sight. Right, but
of vision has hardly become that clear yet. Can only
just yet more marked beyond the middle line. Images at first left so bin as much as formerly, and has been almost offset about seven or eight, since the operation.

In June 1835, it was noticed that the diplopia was very troublesome, and had been so for 2 weeks he was better for, Ex. of Dr. West. 1 A. 5.

Diplopia. System, 7. ophthalmic.

1. Sensory disturbances. (General sensitivity, and muscular sense apparently unimpaired.) Complaints of pressure had, localized some three about the top of a peeling peculiarity on the rosette of this head, 2 inches from the middle line, situated above the infra-orbital ridge. This pain is especially severe in the morning before late evening. Also in the sunshine.

2. It is severe at times, that it makes him cry out in agony. There is no increase of pain on passing over the painful areas: also no superficial tenderness of these parts. It often prevents him from sleeping, waking; when awake, it renders him quite incapable of doing anything. It prevents his going out. Also complaints of attacks of blindness. These are generally brought on by walking—no other disturbance. does not feel greatly when it begins. Also of decreased, and attacks of vomiting. Latter occurs very suddenly, no sign preceded for a few moments by a feeling of nausea. He still complains of diplopia. The left pupil is dilated, and does not respond better light or
CASE OF JOSEPH EDWARDS CONTINUED

ir to accommodation. The cornea of the right eye
is very dry. There is an old cicatrix with adhesions.

The right of the right eye is very dim, but can
be to read newspaper type at a fair distance. He
told me the time by my wrist watch with the same eye.

He still has double vision at times. The face image
disappears or moving with the eye. Also right
eye of its own - this is not constant.

It is able to move the eye when fully upward, downward, towards the right, but is quite un-
able to move his left eye towards the left.

There is necrosis marked optic atrophy in both eyes.

Both optic discs being greatly swelled, with pro-
fuse hemorrhages, and the visual nerves being
hidden by ten opacities.

Hearing, sense of smell, apparently normal.

B) Motor Functions: His right paralytic ptosis
of lower facial zone on left side. He is able to smile,
but not widely. Cannot shrug both in upper jaws on
both a left or right side. 2 Paralysis of upper

facial nerve also. Correlation of the Optic atium's mem-

branes have already been described.

Taste insensibly bitter, upper and

Lower. When he walks he staggers and falls, rather like

a drunken man, tends to fall, especially towards

the left side. Part there is no man. But voluntary

movement of movement to anywhere.

C) Organic Reflexes: He has occasion of difficulty

...
in swallowing liquids, only for the last 6 weeks. Sometimes the fluid is regurgitated through his nose, but rarely causes him to choke. He has no difficulty in swallowing solids, but vomits them when they are drinkable.

A complete lack of feeling in the extremities, which they are intermittent by night. He has little sleep, says his wife has changed during the last four months. But there does not appear to be any change in personality. There is no movement of the soft palate, however. Circumference increases momentarily.

The muscles appear rather stiff. When延伸 is assessed, there is little resistance. Often kept in acute hypothermia.

There is marked motor weakness in the extremities, particularly in the fingers and toes. There is also a decrease in movement.

The patient often reports feeling confused. He has difficulty in expressing his thoughts, but says he knows what he wants to say, but cannot get it out. At other times, he has no hesitation in speaking, but the words come out quite clearly.

There appears to be no fever, and no other symptoms.

In abnormalities respecting a reaction or Spanzi are not observed. Normal ophthalmoscopic examination. No homonymous visual field defects.

Circulating Respiratory symptoms normal. No evidence of respiratory distress. No changes.

Lungs clear. Regular, full siren, compressible.
February
1884

Pulse
Respiratory
Bowels
Urine

March

Pulse
Respiratory
Bowels
Urine

Have been known to vomit before becoming asleep.
Alimentary System: Inhlt food. Tongue moist. 
Hepatic. Appetite good. Stools food well. Acids increased partly. Thrum 
involved.

Wumi: 30. 3. 50. 24. Clear. acid. Incl. cl 
involved not apparently

Temp: Normal.

31. 0. 9. Each of Quinina (5 gr) the whole 
with the same evening weight.

11. 15. 12. Pains in head with some constipation. Is un 
able to sit up in bed. The bowels moved a few 
Times. He has been troubled with epistaxis which has been worse the 
last few days. Takes his food well. SLEEPS FAIRLY. Pulled - and thin.


Pdr. t. rum. Redi. 3 1/2

Alg. Can. eco. 3 F. 8 H. 2 F.

Also for headache.

9. Lint. Ether. m. x v.

Pdr. Pers. acid. 3 F.


Pulse 95. Limp 90.

19. 12. When getting out of bed left 6. W. 
fell down. SLEETING toward left. Striking 
head against edge of bed. Had - headache 
s-d. no limited - but diffused all over leg. 
side. Had two trains 45. of Seizure before 
became asleep.
Page 63. Emperor Reformed to all his former.

95° West. River in same condition - feels very light
headed - recovery very slow - retained 8.5. 0:00.

C. 3. 5. Has noticed 3 times previous admission
has 2 or 3 attempts to get out of bed since he fell.


95° West Complains of pain chiefly on right side.

Small for last few days - 1250 cc's. no eff.

Panco was unexpectedly very different.

11:30. 12. 51 Am. Got up knee running his arms around
but became very fatigued. According to nurse
who continued to press him back after
asleep. He felt restless and slept soundly for
some time - lying on his back.

12 P.M. Lying on a corner in Stade.

Patient also turned towards the right side.

Was had 2 or convulsions. 5:56. Imp. 49. 10. 2.

He cannot be moved to take anything
is constantly vomitting. Appears anxious with
out effort (this came on yesterday).

(All replies absent -
was found with involuntary beneath knee.

Bladder distended. 30 Gr. of urine was
must have amount. 6 in catheter. Bureaus
constipated.

Abdominal mass collapsed. Peristalsis
regularly, dysphagia. - Paralysis thoracica.

Case of Joseph Edwards, continued.

At 8.
0.80. fell. R. 24. quiet, regular. Sun. Rose gradually during day from 19.8° to 104.9°. (r. chart.)
6. P.M. Still in same condition. Left eye appears slightly more prominent than right. Head & face perspiring freely. Pulse a little accelerated.

Where Ic applied again.

3rd. Is in a perfectly comatose state. He lies on his back, with his head turned towards the left side. (He can lie in any position desired, which he is put in.) All limbs perfectly paralyzed, apparentiy, & actually. Appears quite immovable, but forms & outline. Both eyes are absolutely fixed & turned towards the left. Right pupil appears more contracted than it did a few days ago. Both pupils react to light, & the conjugation & accommodation are deep in injection. He has come in some yesterdays. Sphincters unchanged. Both ears are becoming slightly deaf. The conjugation are completely immovable, there is no movement, or at least, motion of the eyelids.

The mouth is partially open, the palate whitish at the corner. Face somewhat purple, & moist perspiring. Swelling of upper & lower extremities. Respiration short & rapid. Temperature 10.6.

10.10. Abdominal tumor. Slight. 10.2. Regular. Temp. 97.4° at 2 a.m.
Temp. at 6 a.m. Left ear 103.2° Right 103.6°
at 10 a.m. Left 101.6° Right 101.2°
Wino Mann 87. 20, 53. No allusion. No sugar.

2.40 p.m. 103. 7. Blood abstracted from temporal artery. Patient snored several times during the action, but otherwise made no indication of pain. Treated a little strong yellow Remission.

2:15 p.m. 103. 7. Much in same condition as yesterday. Day but there is also much atonia, and the posterior perforating vessels appear acutely hypostasized. Respiration 10. 6. Pulse 118. Final temp. at 5 p.m. 104° 2. ir. chart.) Pse cold temp. 92°. Pulse reg. rather firm. Prominent than yesterday; very slightly covered by conjunctivitis. Left well. Pupils very junctionate. Iris has consolidated. Cornea more hazy.
The hands continued frozen in spite of the warming. Lesions in limb, neck, arms, and legs. The same day at 7.15 a.m.

Post Mortem Report. Nothing special noticed in running veins or capillaries. Some diminution of the vessels on the surface of the brain. There was a large quantity of fluid in the astro-ymatoid space; but running the lesion a tumor about the size of a large walnut (Ple) were seen growing from the variable process of the frontal - the surface in the region of the cerebral hemispheres. It appeared the composed of several connective masses. There were often...
Calcarea carbonica in 3 parts and 1½ minute in 2 parts of 1 fluid fluid. The fault was very cut, and sandy cut in among the tumours. The latter pressed upon the upper part of the hypophysis and cut the artery. The cases.

Some tumours were also compressed, the left one more than the right. The Pott's x-ray was pushed over towards the right side. The whole of the upper portion was cut and collapsed. In the pressure being particularly marked on the left side. The 5th nerve on the left side appears to be connected with a healthy tissue, but on the right it was certainly affected.

The nose was still connected with the Pott, but were almost completely the transversal of the right one, there appears the only small picture beyond the lesser ring. Of the left, however, after some time. The tumour still intact. The remaining parts are still quite strange.

The accompanying sketch at the line of the normal of Joseph Bruni (Plate 12 & 15) but unfortunately missing at the same of the Pott's Bruni (a very man) instead of the figures here, it was thrown away. So was the opportunity of seeing it again, which was especially.

Remarks

The symptoms in this case appear to have been...
1881. (When more than two years before he came under my observation) when he began to suffer from stiffness.

Ruiz was in Brazil the summer of 1879, in the vicinity of a large island. He was operated on, but without much relief. At the end of 1883, he began to suffer from headache, this was at first very slight, but soon became acute. It was at first difficult to localize, but soon became as to that in the left side of the vertex. This was soon followed by vomiting, fever and rigidity. He was brought to the left side of his head with a sense of having been poisoned. At the end he also had dysphagia from attacks, with constipation too of much vomit. On me occasions of tones of tetanus. One day he suddenly said that he had a sensation of tetanus. A week before he was operated on him again in the same state of consciousness. There was a great deal of twitching in the upper face of the same side especially of the mouth. The symptoms of tetanus were so strong that several times he had difficulty in swallowing. The pressure of the tumour from the left side of his head. This was due to a constricting fold of muscle, which passed over the same side from the tumour to the brain. There was some amount of tumour on the same side, which was removed. After this, he was able to move his head.

Another patient of Ruiz's was also of the same condition. This was a woman who had a fracture in the vertex. This was a large one, but not as large as the case of the woman. After this, it became a still easier condition.

The fracture in the vertex. This was accompanied by a marked disturbance after the operation. This was taken care of with a bandage, but with a tetanic condition of the muscles through the tumour by the traction of the neck. The left parietal was probably due to the tumour being felt against the bone.
Case of... John Murphy act. 24. Bohol Island.

History. All his family relations appear healthy. Has led an intermittent life for some years. Drinking "plenty hard" at times, especially here. Is commonly agitated and excited when off work. He frequently works all night.

He admits having had a fit a few years ago, but does not remember ever having had any "second ones." He noticed every shortly after this that he was beginning to lose power over his upper extremities. Which began last year, there have been steadily progressing ever since. For the last 12 months he has been in the habit of vomiting at night two or three times a week. The vomiting has been attended with any nausea.

In the morning, etc. he had dyspepsia of four years ago. Since then he has suffered more internally.
from "pain in the stomach" and constipation. He has also had frontal headache of a
Meningitis character. The pain in the head has been much worse at night, being fre-
quently so severe as to compel him to get up at night and walk about. In the last
12 months he has also suffered from roaring voices in his ears at night.
For about the same time he says he has noticed his eyes getting "stiff," that he has noticed them at the corners turn with-ways.

Present Condition: (in allusion to-

To of medium height, weight of medium
completeness, with dark hair. Meningitis
well developed. There is marked Ptosis of
to a little more - his eyes get a pecul-i-near "sleepy" expression. He says
He has lost flesh lately.

Nervous System: Complaints of some frontal
headache of a Meningitis character, worse at
night: also of a burning pain in his face, like "pin's prick." Headache,
cheeks worse - but not a chin;考上
forehead. He also has a constant feeling
of stickiness which is equally severe whether
eyeballs rolling away - he says it is either
or after getting up in the morning.
There is no hemiopia, nor ptosis of an eye.
Examined: no change could be found in
the fundus scale. There was no
abnormality of hearing, but that of
smell was diminished. Taste was
markedly impaired; he was unable to
taste his food as well as
usually previously; he could not
distinguish
acids (e.g. acetic) when placed on his
anterior tongue, but could taste self-confidently
when dipped into the lumen of the tongue
at the back. Taste sensitivity of tongue
unaffected — he was able to determine
between the head of pine needles when
the
surface is lightly touched, all over the body.
The superficial reflexes are normal,
suggesting the pathology affects
the cranial nerves which is
exaggerated in both legs.

Description of Optic Ataxic Syndrome
Right Plate ½ Left Plate ⅘

Q. Pupil 2 mm. Regular. Acts promptly to
its own illumination, i.e., that of left,
becoming 2½ mm. Both pupils are equal
to those normal. Left pupil same as right.
Q. Left pupils do not act to accommodation.
There is a shade of suspicion that the Right
acted a rush when looking at distant
objects in the hand but it is
sluggish.

Note: The pupils are then due to all
probability of the difference in the amount
of light admitted, and the pupils then dilated because the light was less
Ken in lost King at distant objects through the windows. No contraction of the pupil whatever later place was Ken lost at a near object.

Movements of left eye:
- Outwards - 4. mm. Inwards 1½ to 2 mm.
- Upwards - 4. mm. Downwards 3. mm.
(These numbers are only approximate, + 2 anything they are abnormally, rather than
under normal.)

Right eye:
- Outwards - 3½ to 4 mm. Inwards ½ to 2 mm.
- Upwards - 5 mm. Downwards - 3 mm.
The movements "up bent," "up side," "down cant," and "down bent" are just present, and
that is all.
The right eye lost King straight forwards ran an object (e.g. apple) just above the
horizontal line and that is all about
an inch.
The left eye ran an object about 1½ to
2 inches below the horizontal line with
an eye.
When an object is brought forwards towards one,
the eyes it with both right eye. Never
will both left, the left turns out
right to right. Sensation in both common
normal:

Refraction: p 2.0 1/2 (v) 8 0 J. x 26
- 2.0 1/2 (v) 8 0 J. x 26 6/2
2. Case of John Murphy (entirely).

His sight is unimpaired, and he is able to walk with no closed grip steadily.

Respiratory System: Appears healthy as far as can be ascertained by careful examination.


has burning pain in upper stomach which passes up to shoulders, and across back at the lower part of the interscapular region. When he swallows solid food there is a distinct sensation when it gets about half way down. Falls - sitting since definite - simne can be obtained. pulsus contractilis. Urine is not normal.

Circulatory System:


Respiratory System:

Percussion with hyper. Moment all over.
Breath sounds normal, except on left upper
where it is somewhat breath.

Muc: pul lean. No. 5. 1008. 2 cent. No
albunm.

Fistulant - Common duct.

1. P.R. Lb. [3.5] 3 cm.

Temp: normal.

P. [8/5] 10.45 P.M. Patient sitting up & talking about
This has the same burning pain across the tip
Of the stomach. Tongue dry, slightly furled. Drink
has a very unpleasant odor, not unlike
the 'brassy' odors. Bowels very constipated.
Frontal headache still continues. No trouble
with constant hiccup today. Pulse very
small - 60. No abdominal tenderness
15.45 hiccup gone. Complaint of a burning
pain about the stomach. Likes food well.
Met. Pirsoni. Other symptoms unaltered.

Nasal occlusion, 2 pills of Ph. col. at
Hyoscyam. 2: E.

18.45. Sjogren's remains considerably reduced
but remains on four courses. Still has burning
pain here. Frequently suffers short spurs of
a burning fluid after his meals - or when
he is burning about. Other symptoms as
before.


10th. Pan: d. 8am. Feces and vomitus. In the evening vomitus and diarrhea. Normal temperature. No headache or other symptoms.  
11th. Pan: m. 8am. Albuminuria. Albumin 1+ in the evening. No other symptoms. Normal temperature. No headache or other symptoms.  
12th. Pan: m. 8am. Albuminuria. Albumin 1+ in the evening. No other symptoms. Normal temperature. No headache or other symptoms.  
13th. Pan: m. 8am. Albuminuria. Albumin 1+ in the evening. No other symptoms. Normal temperature. No headache or other symptoms.  
14th. Pan: m. 8am. Albuminuria. Albumin 1+ in the evening. No other symptoms. Normal temperature. No headache or other symptoms.  
15th. Pan: m. 8am. Albuminuria. Albumin 1+ in the evening. No other symptoms. Normal temperature. No headache or other symptoms.  
16th. Pan: m. 8am. Albuminuria. Albumin 1+ in the evening. No other symptoms. Normal temperature. No headache or other symptoms.  
17th. Pan: m. 8am. Albuminuria. Albumin 1+ in the evening. No other symptoms. Normal temperature. No headache or other symptoms.  
18th. Pan: m. 8am. Albuminuria. Albumin 1+ in the evening. No other symptoms. Normal temperature. No headache or other symptoms.
are well marked.

At the left pupils were distinctly larger than when first examined being 3/2 mm.

Dr. P. April 1st. Slight return.

March 25th. Is in practically same condition.

Stomach symptoms constant. No jaundice.

Inconsolable that he is unable to take milk which he chokes at anytime.

April 28th. Percussion, palpation abdomen.

Marked jaundice present. No pulsation. No breath coming from the stomach, as though it contained large amount of fluid. Stomach symptoms very slightly improved.

May 13th. Condition practically unchanged.

Left the hospital with this view to begin regaining former health and then trying occasionally. Improvement, however, he has not show.

Remarks:

There described this case, as being a fairly typical instance of the affection known as jaundice with jaundice. First described by Dr. Green and others at some length.

There can be but little doubt that in this case jaundice is the chief cause. He is very often the direct cause of death. He is an only true case known at present in Phcenian, but the phenicic history could be seen.

The Polypism of his internal valves
Muscles are almost, but not quite, absolute, here being a minimum amount of movement of eyeballs; in most often described cases, the pupils have been in a state of dilatation, but in this particular instance, they were certainly smaller than normal, this is a strange coincidence, because a priori, we should have naturally expected that with muscles unappropriated, the paralysis of the third nerve, we should also have found paralysis of the circular fibers of the iris, and consequently dilatation of the pupils - in this case where the paralysis of the ocular muscles, muscles here have almost absolute, the pupils have always been constantly dilated; these facts, better together, certainly warrant the belief that there was this third nerve which supplies the circular fibers of the iris may have accentuated different organs from those which supplies the ocular muscles of the eye.

In addition to the eye symptoms this patient also suffered from impairment of the sense of smell, sight, also of taste, also from pain from frontal headache, vertigo, depression, asthenia. There were no symptoms from the heart, as had been previously described - indeed, the palatal reflexes were exaggerated in both legs. The walk but little improved under appetite stimulants treatment only the hospital treated in the same condition as when admitted.
According to Herophilus & Ulmey, in rare cases, in which a Post Mortem necropsy has been made, arteries appear to have been found, left by Cremers and Remm Lewis. This postmortem appearance to constitute the essential lesion in such cases.

This lesion appears to be a cornea very similar to progressive halber paralysis.

Clinically & Pathologically the two lesions resemble each other, and although the former has not been yet found associated together in the same patient, yet it is not impossible that such association may occur.
Case. viii.

Robert Parry, aged 13.

[Note: Permission to publish the notes of this case was not granted.]

He was admitted into the Royal Infirmary, Edinburgh, under the care of Dr. Darroch, on Nov. 28th, 1836, complaining of complete loss of power of the left side.

History.

His mother states that he was always a delicate child having suffered repeatedly from malarial and other respiratory troubles. She admits having a "nervous habit" herself but says he never suffered from hysteria.

Of his sisters and of brothers, the family history is thoroughly unimportant.

Two years ago, towards August, he began to have fits from "fits", having as many as six or nine daily. According to his mother's account, each fit lasted from a quarter to half an hour. He came suddenly unconscious, fell down, often on his face, became convulsed, the left side of the face, and occasionally bit his tongue. He said he knew when the fits were coming on, but had no particular excitement beforehand and, when they did he utter no cry. From this description, there can be little doubt that the fits were of an epileptic form character.

He appears to have been never paralysed at this time, he continued to move from joint to joint until the end of the following month, (Sept.)
During this time he was under medical treatment; the fits then subsided, but returned in the beginning of 1882; and continued more or less during the whole year, up to May 1883. Last Christmas (1882) he became paralysed in the left side, on his left side. The paralytic fits came on suddenly, after a fit, and there seemed to have been loss of sensation, as well as of motion all over the left side.

The paralytic continued (but with inter-Mouche's ranging in duration from two to three days to many weeks) until late in this year. During the fits the right side was most involved. He noted to experience a peculiar "pricking" sensation in his arm and wrists before the paralytic fit appeared.

He is said to have passed a round storm in May (1883). After this, the fits and paralysis on the left disappeared, and he seemed quite well again. He remained well till four weeks ago, when the fits returned. About 3 days after the return of the fits he became paralysed on the left side, and this has continued ever since date of admission (Dec. 23, 1882.)

Present Condition: He is small and thin, pale and delicate looking, with a firm, shapely, strong head; the fingers tips being distinctly "clawed." The face is asymmetrical.
The left side appearing flatter than the right, and the left upper lip hangs lower than the right side. He lies on his back, with the left arm and hand lying flaccid and useless by his side. He complains of a constant dull pain in the right side of the vertex of the head, but has no abnormal sensations elsewhere in the left side.

There is absolute loss of sensibility to touch, heat, cold, and pain, all over the left side. A two-handed drinkER runs steadily up into the arm, left, sticking there, without the patient's knowledge of what has been done, now entirely imperceptible by him. This condition of total anaesthesia, and analgesia, was treated locally by the median line both in front and behind. The half of the median membrane of the mouth and tongue, and a very entirely devoid of sensibility; and also the half of the penis and scrotum was absolutely anaesthetic; this appeared to coincide with the wider also, as far as could be made out. The special senses (sight, hearing, smell) were also affected, there being complete loss of hearing, taste, smell in the affected side, as least in the usual manner.

The left conjunctiva was as extremely anaesthetic, that washing it with the fingers or head of a pin, did not break the closed, wet secretion, nor the least reflex closure of the eyelids, unless the vitreous
lady passed in front of the pupil, when his eye was closed usually.

There was no hemiparesis; vision appeared equal in both eyes, and after there was no contraction of the field of vision with for colored or colorless objects. The pupils were slightly, but equally dilated, and re-acted normally to light and accommodation.

The muscles of the eye-balls were apparently unaffected. Both eyes moving freely in all directions.

He was absolutely unable to perform the slightest movement with the left arm or leg, the muscles failing flaccid and relaxed; on attempting to lift it he was unable to do so, there being marked paresis of the left lower facial mus-cles. On protruding the tongue, it pointed slightly towards the left, (this was not con-stant however.) There was also paresis of the left, but the palatal muscles acted equally on both sides.

The muscles of respiration, deglutition, + articulation (excepting those of the nasal and Menonian) and all cranial muscles were left at all affected. Although the lower facial muscles were paralytic, those of the upper facial zone on the left increased quite unapparently. (some ordinary central hemi-plegia). The electric irritability of the muscles tested with the Galvanic + Faradie
(A. Parry, internist.)

Currents appeared unimpaired.

Reflexes: Left plantar reflex absent; geniculate, spinothalamic, posterior, superficial, in left.
Reflexes on right normal in all areas, but slightly thickened.
All the afferent reflexes were normal.

The Paretic tendon reflexes were slightly diminished on the left side, but normal on the right. There were no tremors.

The respiratory, alimentary, circulatory, excretory systems were all normal. The skin was dry, often thick, crusty, but no albumen.

Dr. indicated that when pricked with a pin on the left side, there was much less blushing on the affected side, indeed, there was often none at all. When the pin was kept deeply into the skin, this fact has been observed in similar cases.

About two hours after the above notes were taken, the patient, after being awake for about half an hour, complained of a "pricking sensation" in the left side. It is not at all improbable that he had a fit in bed which had not been observed. The same hour he was away at dinner, and he found that in attempting to move, he had completely regained the use of both arm and leg, and also that his loss of sensation had entirely cleared up, and appeared, and he could feel quite well on both sides. The points where
he had been pricked began to work, and his
voice became louder. Pulse 80. Temp. 98.8 F.

Great care was taken during the examination,
to prevent the patient from seeing where
he was going. He was pricked, and a card
that kept up was the movement of his face gave
evidence of any pain; but none was observed
and he appeared perfectly oblivious to all
forms of mental stimulation.

A second card was rung; it was found
that all his previous symptoms had entirely
disappeared; the second perfectly well in all
respects. He got up, ran and ran, and
had been as though nothing had ever hap-
pened. He had taken no medicine. He was taken
home by his mother.

He was readmitted into hospital on Dec. 6th.
His sister stated that he had been quite free
from illness before coming into the hospital, but 90 weight of

Dec. 6th-

At 7.30 p.m. today he had a fit. He was
sitting by the fire at the time; he did not
fall, or make any noise, but simply passed
into a trance-like condition. His respiration
was apparently quite uniform. He was
placed on a bed, and lay perfectly pa-
tent for several minutes. His face then be-
egan to wrinkle on the left side. His eyes opened slowly in different directions. The pulse be-
came slow, and the breathing almost audible.
He was found without his eyes rapidly, there was a twitching of various parts of his body. He remained unconscious for 12 minutes, then quickly regained complete consciousness. He then seemed quite sensible, that he knew he had had a fit, as though he had been asleep. He had a slight pain at the tip of his head. Temp. 99°.

Dec. 7th. This morning patient says he is unable to move his left leg, which he placed there. There is complete anaesthesia of the whole left leg, limited above by the base of the popliteal furrow, and below by the sole of the foot. He says there is no anaesthesia in the arm, face, trunk are quite unaffected.

Dec. 8th. Had two fits since this time yesterday. Today, one during the night last night lasting 15 hours. He was more convulsed than in yesterday's fit. He paralysis is now confined to the left leg. Temp. 99.6° P. 82 R. 28.

Q. Were these fits during the last 24 hours. Today there is complete anaesthesia, no anaesthesia, but there is still loss of power in the left leg. (The temperature has only risen to 98°F once during the last three days.)

When placed on his feet, although he cannot stand without support for more than a moment, yet distinct movements occur in the muscles of the left leg. His desire is to help himself upright. This

10½: Has had 3 fits in last 24 hours. Paralysis of left leg gone.

11½: No fit only since 10½. No return of paralysis.

13½: No fit during last 7½ hours. Fit occurred at 12½. Last fit on right hand. He has recovered.

14½: 20 mins.

16½: 4 fits during night. There is some bleeding from nose after each fit. He is now in a chair and appears to be somewhat better.

5:30 p.m.: Had a fit. During which he lost sight of his eyes as crowded, at times violently; he did not feel his tongue - palsy reached to chin. Then appeared the no actual speech or difficulty of any of the muscles.

18½: Has had four fits, one of which he was very violent. Paralysis much better in arm, especially hand. His left side. When he had worked heavily on his face, he came more and more violent.

Temp. 90.4° F. 90.4° F. in Rectum 90°.

19½: Four fits since yesterday - condition again returned, but not so violent.

21½: No more fits. Paralysis of left hand entirely symptoms of illness disappeared. Speech began to return.

Rem. 11.3.
failing well - no fits & no other normal.

Dec 24th. No fits since last report.

31st. Patient seeming much better but some two parents had a slight fit whilst at home. R. found at hospital in evening and had another fit. On returning from the latter he was found to have become hemiplegic and hemianesthesia than ever before.

In the next few days he remained in very much the same condition, 5 am the average time for his fits per day.

3/12. He was told he was going to be cured by having a gold band (he was shown a cheap gold planmi type bracelet) placed round his leg - in stead of which a stiller plaster band was substituted, a flannel bandage being placed round all - this was kept on for some days but not removed.

3/15. Has had four fits since yesterday. Today the gold band was actually applied, the patient being allowed to watch that was being done - but there was no change in his condition, the paralysis of the teamate still remains.

3/15. The gold band was allowed to remain as placed all night. This morning he had a fit lasting a few minutes, after which he was found to have regained some movement in left side. At 2:00 p.m. the band was removed, he had another fit at 7:30 p.m.
after which the entire left side again became paralyzed as before.

6th. The fit. A "manic" fit as in the state of ½ at 10 a.m., had a fit, trembled from 10 a.m. to 11 a.m.; was sitting up, but tried to put left foot forward—then asked left hand, seemed very weak on left leg; he then lost balance, and sat placed on chair; he became very pale; there was rapidity (40 per min.) Ees turned backwards as far as possible, pupils constricted, face became convulsive movements of left side of face, eyes, etc., commenced—then the arms also became rigid for a few seconds. There were convulsive movements of respiration—the accessory muscles being pressed into action—then became very feeble and calm. Ees were convulsed, but returned again; when any attempt was made to comed he eyes—deep pressure on right side of face appeared, then time began to a temporary cessation of the convulsion movements, but it was not forcible. The fit lasted 15 min. During the start of this time he was quite conscious, thought to be punishment, pencil, brush, etc., kicked anywhere—

He was later at the Physics Laboratory of the University of College during the
of the hemiplegic attacks, and without his know-
ledge he was brought close to (but not in contact with) 
The poles of an electric induction machine, 
In paralyzed side being nearest the poles. The 
experiments was varied in a variety of ways - 
but it did not appear to have the best effect up 
This condition which remained practically 
unchanged. These experiments with con-
stant rectilinear currents were repeated 
several times, but all as time and 
they caused the paralysis, nor yet cause its 
novel fever, the opposite side of the body.
Powerful magnets were also, and with a 

The application of the constant current to 
the affected limbs one or twice had the ef-
gect of bringing about a return of sensibility. 
He remained in this condition the same condition 
February 25, when he went home at his 
parents' request. The febrile illness had dismi-
ished in frequency but not severity, and for the 
last 10 or 12 days, he only had one or two. 
They are still occasionally, followed by 
temporary hemiplegia, with slight muscular or 
convulsion, or of both. But the paralysis is 
only transient and lasts at most about one 

Several attempts were made to produce 
the patient, either by making him look at a bright 
point or by listening to the ticking of a clock 
but these succeeded in producing
The desired effect. It can be taken home, at patient's request.

and has not harmed him hardly.


This case seems peculiar in not having a man who
the phenomena of functional hemiplegia or hemi-
and, and this can be no doubt that the
case was one of epilepsy. The points of
particular interest in this case were-
1. The family history of severe things slight things
were left on his case; the latter having suffered
from poliomyelitis, the father being mortality of a
highly muscular temperament.
2. The Character of the fits were from epileptic
nature, and they always produced the most of
severe symptoms. The latter were diametrically
insidious, and came about generally with a
fits according circumstances, but with
no hard, dramatical occurrence. Both
hemiplegia, and hemianesthesia were at
times absent, and frequently present.

The same time, at some times partial or
complete, and dissociated, a very characteri-
still present of this affection. The loss of
power was almost in every case confined to the
upper half of the body, generally, if at all,
affected. There was no paralysis of the viscera,
abdominal, or especially of fit in speech,
became difficult and somewhat inarticulate, but
there was never any aphasia.

As regards the hemianesthesia, of which the patient
complained, the patient ignorance at first, final
In exciting points, some were present - then he was first admitted into hospital at that was absolute closure. There were analyses of the rise, all forms of blemishes being on the page. Although there was no manner, infringement of the inner part through an accidental strike, yet there was no amputation or amputation, either any collection of the visual field, nor any abnormal tissue. These signs, signs were generally present in the condition of the patient. Often the remnant would, but in some cases, they appear loosely and about the stomach. Sometimes times would be amenable with it, analyses, or vice versa, as is the usual condition, sense condition where the case of amputation is not complete. At times the leg would be affected the arm, through affecting. Although the eye itself was apparently unaffected, yet the condition was as absolutely devoid of all sense, as in the usual case of amputation, although some moments of the condition, sense, and in some cases, the tachy cardiac fact observed by Chauvo
    that a short period of time, during the moment of amputation, was not followed by blinding, but rather one on the unaffected side. The abrupt tension, resulted from this, it appeared to be equally affected when the superficial parts were
    The failure of natural therapy, to produce any permanent results was most palpable, and the
purely fictitious results obtained by bringing the patient (without his knowledge) into close appos
tion with the poles of powerful magnets, machines
after the method advocated by some of the
French authorities, proved the futility
of such methods in the treatment of these
affections. Whatever results were produced
were entirely due to sheer coincidence to the
mental impression made upon the patient
by the demonstration of the effects of the
magnets. In this case, it was the actual presence of the
magnets, or their presentation, or their
proximity to the person, that had
produced any favourable effect.

As regards the actual cause of this
condition - this case, which at first
seemed to be entirely due to
suggestion, or, in more common
language, the idea at the back of
these symptoms was advanced that
they were possibly the result of
nervousness of the adnexa, must be abandoned
as altogether unsatisfactory. The fact is that
the history of anything like asthma or
the symptoms present do not
suggest that the idea of these
conditions might be at all
d Civilised, and as humanitarian, al-
though there was no positive proof that the

Case. Encephalitis.

Margaret Nettleton, aged 5½ yrs. Admitted into the Infirmary for children, under my care, on May 5th, 1854. Suffering from pain in the head, vomiting, and unilateral convulsions.

History: According to her mother's account, she had always been a strong and healthy child till the present illness came. Her home was tolerably comfortable. The family history is unimportant, and there was nothing upon the case. During April 1853, she is said to have had a running from the left ear. This did not follow any of the common colds, and did not cause any appreciable disability. It lasted a few weeks, and then quite disappeared, and has never shown itself again. In all probability it was due to some degenerations in cells of the lining membrane of the auditory meatus. She had whooping cough and measles when three years old, and made an excellent recovery from both complaints.

Present illness: (Mother's statement.) Commenced in April 36½. 1854. She said she had fallen, but no particulars of the fall could be elicited. On that day she took a cold, and began "out of sorts." Moreover, she complained of pain in the left side of her head, and vomited several times during the day, in dependency of without any definite relation to food. The vomiting continued during the following day (29th.) and then ceased. She then appeared somewhat better, and on May 1st. was sitting up and playing. On May 2nd. she did not seem so well—the pain in the head became more severe, and the right side of the face was noticed to twitch—but no movement of the hand or arm was observed at that time. She was then brought to Hospital on May 3rd.
May 5th. 4.30 p.m. Twitchings of the right arm and leg were first seen this morning. Has been unable since last night to use the right hand and arm for several days. She appears otherwise more or less unconscious since the 3rd with hemiplegia, amnesia of anything, and not acknowledging anyone or responding to her mother. Paresis confined to last few days.

Status admissum. 5th 4.30 p.m. Temp. 108.8° F. P. 120. C. V. 0.1.

Respiration 36. Is a fairly well developed and well nourished child. Lies on back or left side. There are continual tonic spasms of the right side of the face, and also of the right arm. The spasms are quite rhythmic, occurring about 24 or 25 times per minute. In each spasm, the right angle of the mouth is drawn outwards and downwards, the eye on the same side is really closed, and the ear is drawn slightly upwards. There is only slight contraction also of the occipital, sternocleidomastoideus, upper part of the trapezius muscles on the right side. She makes a peculiar whining sound occasionally, as if in pain. There is a slight motion of the right hand, occurring almost simultaneously with the facial spasms. The spasms chiefly affect the thumb and fourth finger of the right hand. The thumb being drawn towards the palm, the other fingers being slightly flexed. The legs remain perfectly quiet, when the sole of the foot are tickled, they are drawn up. In addition to the above movements, there is well-marked
Spasm of the right platysma majoris, and the lower jaw is slightly depressed with each facial spasm. The upper facial zone is slightly entrapped. There is no squinting, but you follow the motion of a gold pencil moved in front of them, and they are equally, in all directions. The pupils are equal, not unduly dilated, but not very slightly bright. In connection with the ophtalmoscope, the veins radiating from the optic disc are markedly distended, those in the left more tortuous than normally. The whole spectacle looks too red, but there is no distinct optic deviation.

There is no spasm of the trunk muscles. There is no marked rigidity of the arms or legs. When offered a cup of milk, the takes it in her left hand, and makes attempts to carry it to her mouth, but only to her thoracic movements she is unable to drink any.

When spoken to, she takes notice, but seems conscious of pain when pricked with a pin. She constantly rubs the left side of the head (over the parietal region) with the left hand as though in pain at that spot. The abdominal reflexes seemed absent. The tongue was covered with a dark brown thick fur.

The eye-tune apparently normal. No tache internale.
May 6th.

Last week ordered 3 grains of gamboge and a medicine containing 3 grains of ipecac and 10 grains of bromide of potassium, three doses. Also ice to the head. Pancreatin, milk and acetic balsam.

She slept fairly well during the first 2 spasm still continued, but in less marked manner. Pains opened during the night after another dose of gamboge, and an hour or two sickness appeared in less pain. Minimal condition. Much the same. Temperature varied from 99.5° to 103.6° (at 5 a.m.) Pulse 110 to 140. Perspiration 30 to 40.

7th. Slept uneasily. This morning seemed unable to swallow milk. Ate tea. Quiet. The facial spasms have ceased, but are replaced by a regularly recurring slight movement of the whole head towards the right side. The previous movement of the hands have also given place to an movement of rotation of the hand on the forearm, the whole arm being at the same time slightly carried away from the body (adducted). He fingers remained flexed. At 10 a.m. whilst making his morning visit, she had a convulsive attack. Both arms were affected (the right more than the left). Her forearm was flexed on the upper arm, and carried towards the face; his legs were also drawn up then extended again. She has not vomited nor screamed. The right half of the face looks
(Dr. Head's report continued)

-somewhat flat, and the upper lip throught.
The eyes are turned constantly to the left side.
Face preserved fairly, passed with ease in bed. At
12.35 a.m. The movement of the head was previously
paralyzed, but the extensoria movement of the hand
continued. The upper face monomacrom, there is
not relapsing, when the head is suddenly and rap-
dily brought towards the eyes. The color of the
face changes constantly, being at one time
absolutely pale, and at another deeply flushed.
At 12.40 a.m. she had an attack convulsion which
lasted about 1½ minutes. In this convulsion the
number of the
arms' first became tightly contracted, and of
immediately. Clinically observed:
The left leg was drawn up—the eyes moved
towards the left, and the left side of the face
also remained fixed—The movement of the
head towards the right was greatly increased
and was undoubtedly due to the clonic spasm
affecting the left arms—mastoid muscles
which was felt to contract under the hand.
During this convulsion the right leg remained
passive, after it had ceased, the rhythmic
movements of the head towards the right, and
also of the hand and arm continued, recurring
about 20 times per minute. The breathing was
somewhat labored. The face and hands
felt cold, but the trunk and head hot. The
pulse was 67.5. The voice was not heard normal—
The patient had several more convulsive seizures of a similar nature throughout the day. Temperature at 9 a.m. was 103°F. Pulse 160. R. 40.

She had a quiet night. An amount of sleep. She had another convulsion at 1 a.m. She was unable to swallow. She was fed by intermittent enemas.

Chiefly of prunus creticae milk. The spasms of the head and face have ceased, but there are still slight rhythmic movements in the right hand and arm. At 11 a.m., another convulsion, during which the right leg became quite rigid. After the seizure, the leg was kept quite extended, the left being flexed both at the hip and knee. The pectoral tendons markedly reflex is increased on the right side, and there is now muscular rigidity and resistance to passive movement on the same side. Difficulty in taking fluids, often got produced by reflex movements.

At 9 a.m., had another severe arm convulsion. Her general condition is unchanged. During day, temp. varied from 103°F to 101°F. P. 150-150; R. 30-28.

She had a quiet night. She only twitched slightly when touched. Has had no convulsive seizures since yesterday. She swallowed some milk at 10 a.m. The left arm is kept flexed, the thumb adducted, and the fingers flexed over it. The muscles being somewhat rigid. Right leg still extended.
Deep reflexes being exaggerated, the superficial
being absent. When pinched with a pin appears
with little emotion, and makes a slight sound
as though she were beginning to cry. The muscles of
the right side of the face (lower jaw) are quite
inflexible.タイ, but the rest of the surrounding
limbs, and her expression is nervous:

282. 10 A.M. Condition unaltered. Temps. 100° to 102.5. P. 140. R. 30-50.

R. 40-60.

10.30 A.M. No more convulsive attacks—she has perfectly
quiet the spasm anywhere. But still slight
muscular rigidity of right arm and leg. With
resistance to movement. Left legs are not stiff
extended, but the extensor tendon reflex increased
in both sides. She appears somewhat more sensi-
tive to pain, crying when touched—but still passive;
unu ipecas here with her. She appears a good
deal more alert. Muscles slightly strained better.

10.45 A.M. For the last ½ hour has been quite un-
conscious, breathing slowly, faint. Dimness
collects at lips. Pupils dilated, don't
react to light. P. 52. R. 140. Temps: 100.2°F.

11 A.M. Breathing much more—face alertly
rigid. All reflexes absent—companying
great insensibility. Temps. 102.5. P. 180. R. 50.

11.15. Had slight twitching of right side. Face.

10.50. Became generally unconscious. 
Post Mortem Notes. (Permission to examine the
brain only was obtained.)

Brain, weighed 41 oz. The pia mater was stained
a dark red color, especially on the left hemi-
sphere, and chiefly on the motor area. It looked
like post mortem staining, and though the cere-
brospinal fluid was congested, there was no indication of
Symptoms, or other signs of meningitis at any part.
The right cerebral hemisphere appeared quite
normal. On removing the left side dressing
it was found that the whole of the parietal lobe
(specially the lower portion opposite the lower end
of the fissure of Rolando) was softened and
almost purple, drawn forward, before being cut
into, it gave a distinct feeling of fluctuation.
On section, this portion was soft, quite different
presenting many vacuums and an characteristic appearance; its brain substance
in the affected area, lost gray to white matter
more ground with large red patches showing something like large foci of interest although
within the above described margin, there
were some hemorrhages in the gray substance.
The ventricles were slightly dilated, and
embalmed as soon as possible. There were
numerous signs of embolism in the arteries.
Under the microscope, the
capillaries were scarred in the fresh condition;
bleeding distributed with blood corpuscles. Both
Impulse cavitary were normal. There was no disease of any
cranial bones.
The frontal, the parietal, the temporal, the occipital, the sinuses, the half of the brain, which latter appeared fairly healthy. But the corpus striatum, the thalamus, were more or less soft and effused, but not to such an extent as the more superficial portions of the cerebral cortex. Upon sectioning the entire portion and examining under the microscope, it consisted chiefly of granular nuclei, diffuse masses of glial cells, fibres, vessels, and blood vessels. The periphery of the brain was in the vicinity of the infected areas, but the brain was too shallow to yield any results in staining them.

**Remarks:**

The symptoms which ushered in this crisis were unmistakably those of cerebral irritation of the left cerebral hemisphere. They were a strong desire, but what they were, no pathological condition can which same. The symptoms were somewhat at first fulsome in present being that it was also chronic meningitis or perhaps periarteritis of the cerebral. The history of the fall gave some support to this idea of the case. When first admitted she was suffering from rhythmic chronic meningitis of the right side. Face and arm and hand, already described, recurring regularly.
20 or 30 mins. per minute, and remarkably limited to the areas already indicated. The first indication of cerebral cerebral functions was only pointed to some 24-26 mins. from the start of the attack. An initial mental reaction - after the first few minutes, the leg became affected, then the arm and the arm became more general. The right arm became less, and a condition of partial paralysis affected the right arm - finally the arm became less marked and the arm almost disappeared. The arm was found before death. It was interesting to observe that during the period of chronic spasm of the right side, the head was turned simultaneously to the right by the chronic spasm of the left arm was noted. The head being the only muscle of the left half of the body, apparently affected; this also must be due to a close relationship, I should imagine, between the motor centres (cerebral) in the spasm of the arm and hand, and of the head towards the arm and hand in actual use at the time. It is known that such an arrangement would greatly facilitate motor co-ordination and combined movements of the head and neck and upper extremity.

The condition of the arm - cerebral functions, as described, and any other arm in the condition of the left cerebral hemisphere already described - were alike.
Das is Reunigilis, das was i found often and no just to could find, no artificial disease. The brown is the affected poison had become still sufficient, one of the bodies resulting from the first phase of morphinization. That the morphinization comes into his particular, whereas was remains undecided; if may may may have been due to the fact. All the other organs appeared healthy.
Case: Basilar Menigitis.

Mary Curley, age 3½. Admitted to the Children's Infirmary, (Dublin) May 26½ - 1847. Complaining of great pain at the back of the head, of inability to move head, of great thirst, etc.

History: Home very wretched, and is much neglected. She had chicken pox, followed by whooping cough about nine months ago. In history of fall or other injury can be obtained. Present illness commenced about 15 days ago, when she began to complain of pain in the head (occipital region) and pain in the back. She has cried out sharply, closing her eyes in the last 10 days. Has ceased eating, and is incontinent of urine. Great thirst. Nipples cornu ti pati. Have been in convulsions.

Unfortunately, do not further details of the case prior to admission or how he was admitted.

May 26½. On admission. Patient holds her head rigidly extended as far as possible, and slightly inclined to the left. The occipital muscles of the back of the head are very contracted in tonic spasm. She complains of intense pain at the back of the head and neck. This slightest attempt to move the head greatly aggravates her pain. There is no loss of consciousness. She appears to be a very intelligent child for her age. She lies on her side, with the thighs flexed on the abdomen. The feet on thighs. The arms are crossed.
on the abdomen—there is no palpation of tender
areas. He has a pronounced pain full of con-
pression, "drown printed" to the fingers—tend
crisis when disturbed; the central area re-
marked. Temp. 103° F. Pulse 100. Res. 38-42.
24th. He was treated as follows. Had fresh
and ice bag applied. Four grains of calomel
were given at one time. Breath became:


24th. A.M. Much quieter; has slept quietly
for an hour or two. Pupils equal and move
tightly normally. Breath sounds. Warming
over both lungs. No dulness over lungs.
Abdomen retracted, small amount of gas.

28th. Is apparently unable to retain liquids (milk
milk) but drinks plenty of milk. Very dizzy.
Spare. Rather weaker. Has very restless com-
en. Fanciful pains during every part of day, but
full asleep when ice bag was reapplied. Head.
Pupils rather more contracted. Considerable
photophobia. No photic or photophobia.
Tabes central area marked. Temperature ap-
29th. Passed a quiet night. Sat up all night
in morning. Other wise her condition is practically
the same as yesterday. To improve & v. chart.
30th. Had a good night, but cried out three or four
times during night, and moaned in sleep.
Rest in same position still. and frequently cri-
out, "Oh! my neck. "Oh! my back!" in evident pain. The head is tilted with an almost right angle with the back, and the frequent puts his hand to his back. The back of the head, as though the pain was most whether there. This had become worse; with pain, the back and shoulders were immobile. He would incline his head and shoulders a bit to one side, and then to the other. The pain persisted, but there were no actual symptoms. It was slightly diffused. On further examination, he was found to be experiencing an unusual fullness of the nose and cheeks. While no abnormal condition could be detected.

31st: Taken food almost at bedtime. He is in great pain, experiencing pain on the posterior processes of the cervical vertebrae, and increased sensations of the hot-spots in the same situation - but seems to feel little pain. He is very much fatigued, and very ill. He seems to be in great suffering, and feels ill. It is a matter of considerable difficulty to get an accurate history of symptoms. His teeth were still well marked - dirty foul. Formerly costive.

June 1st: Diet fresh symptoms - chilly much the same - but when encouraged makes attempts to move the head from side to side, but can only do so to a very limited extent with pain. Muscles of neck are still rigidly contracted.

During these last five days she made some progress, and the acute symptoms appeared to gradually subside...
Had certainly less contracted & more formidable.

The spasmodic condition of the esophagus muscles in the cervical region less marked. She can sit up when placed in the sitting posture, and has asked for food. Says she feels better, has been playing with hands, but their movements

Awarm up - If allowed to stay up for more than 2-3 minutes, head falls backwards.

Nothing abnormal could be made out at the back of the pharynx. 

L. 97° to 100°. P. 100. R. 30.

Complained of being more headache, and very

very frequent all day - Inf. 98° to 102°. P. 109. R. 36.

2-3 clearly similar as yesterday. Face very pale,

complains greatly of very severe headache. Soma

in back. Back - has in the same characteristic

attitudes as at first. Permits any contact.

Inf. 103° - Pulse 145. - 156. R. 42.

Same as yesterday, face alternately

flushed & pale - Complains of much pain:

vomiting. Tongue white coated, thrombosis cli
tis. Constipation, with head retracted. Arms

crossed, hands folded over front part of abdomen - legs slightly flexed. Pulse regular in rhythm, but variably somewhat un

strength.

11 a.m. - Credent thoroughly, burning&. but as

though something within. Hydrostographic

very slight, not typical. Suture rec


Chloral Hydrate. 5. 1.
Dear Sir,

I understand your concern regarding the health of my family member. The absence appears to be a result of the abrupt and unforeseen circumstances that have occurred in the last few days. It seems that the sudden illness has led to a significant change in their behavior, which is causing concern.

I have observed that the individual has become more quiet and withdrawn. The symptoms include a loss of appetite, extreme tiredness, and a general lack of energy. The condition has progressed to the point where the person has been experiencing dizziness and periods of confusion.

The family has been advised to seek medical attention immediately. It is feared that the condition might be serious and require urgent intervention. The family is also concerned about the potential for the condition to worsen if left untreated.

I understand the gravity of the situation and will do everything possible to ensure a prompt resolution. I appreciate your understanding and support in this matter.

Sincerely yours,

[Signature]

[Date]
...have become more flexible. Skin dry and scaly.

The bark still present, in autumn in eerie.

P. 99. 6°. 0°. 100. very feverish.

37°. Speech more lively - sits up with out support.

Waxing of head nearly gone; takes an interest in what is going on around her. Is very feebly drunk.

Drum stick legs very weak when attempting to stand - can only hold anything, bent arms; support of crutches are very shaky, tremulous.

July 26th, 1873. Mind heaved in height meet there is still some rigidity of the posterior spinal muscles, but they don't cause vertigo. Can move head freely in all directions with at least.

Walks fairly well. Talkable - articulate less distinct.

Slight improvement - complaints of nothing.

Several of trunk spasms lasted with the form of electric current. Normal normally, but no paralyses of these could be produced - but the tracts internes contract when it is penetrated directly. Speech still has the peculiar laughing character always observed in this case. She from stepped on the 29th.

She gradually became stronger, and by the end of the month could walk unsupported, but rigid condition of the spinal muscles gradually continued. Other muscular tremor disappeared as she became stronger. She gained steadily in weight, and was discharged well on August 1st.
She was last seen on Dec. 15th. She appeared perfectly well, had shed no relapse of the symptoms since leaving hospital.

= Remarks =

This case closely corresponds with the description given generally of Simple Basilar Reminiscence, and to account for the sudden total absence of symptoms in these cases I have imagined it worthy of mention in this paper. This disease is said to occur most frequently between the ages of 15 and 20, but there are a few cases recorded of cases similar to this, occurring during the early years of life. The chief points of interest in this case appear to be:

1. The severe frontal, there headache, chiefly occipital, at once indicates, which persisted some 12 hours throughout the course. Arising from:

   - Headache.
   - Great irritability. Partial anaesthesia on the head and neck. The last symptom was most marked.

   ed and characteristic, and in the absence of any sign of disordered vital, of the cervical vertebrae, or Brain cranial bones. It first led me to suspect Basilar Reminiscence.

   - The Coma Basilaris. Mortality is small.

   - Constipation, putrefactive, and general runniness of the bowels which at some time surrounded brought about an accident.

   - point in the same direction. The muscles
The back of the neck was in a condition of painful stiffness, and the slightest movement of the head produced most acute and distressing pain. The abdomen was distended, and the patient assumed a bent position. He was described as being seen in the hospital [intercalary]. The left upper arm was also affected. He was unable to bend his left arm at the elbow. He was admitted to the hospital and began to improve gradually. The headache disappeared, and it was noticed that the abdomen was frequently distended. The patient was able to eat without difficulty, and began to gain weight. He was finally discharged from the hospital in a better condition.

The history of the patient was as follows: He had been suffering from the symptoms of abdominal distress and vomiting for some time. The symptoms could not be explained. The physician stated that they were the result of previous abdominal distress.
THESIS

on

Clinical and Pathological Studies

on

The Nervous System.

By

Edwin Hyla Greves, M.B. C.M.

This Volume contains Cases of Diseases of Spinal Cord and Nerves.
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Specimen: XI-XII-XIII, Plate: D, Species: D, Page: 150, Name: Fanny Dawson, Species: D.
No. xi.


Patient was admitted into the New York Infirmary, for pulmonary consumption, under my care, on August 26th, 1887. She complained of pain in the chest, with shortness of breath and pain in the chest, which appeared to be caused by enlarged glands in the neck, which were palpable and had the quality of tumours, of which there were visible at the sides of the neck. The patient during the first month had been forcibly removed by the pains and discomfort which she had endured. A short time after the fall, she fell down stairs, striking her back against the stairs, causing her to be unable to breathe, and to have to lie in bed for several weeks. She complained of pain in the chest. She rapidly lost power in her legs, and was unable to walk about. She had asthma to the point of death, as it always appeared to be due to the pain in the chest. She had been brought to this hospital, with a diagnosis of acute special compression of the lungs.
and Algeria. (She was not under my observation at that time, but under my predecessor, and there not having been transmission to me.) A large, Parisian jacket was put on, but coming back, she walked with her head down, the patient, attracting attention, she was sent home. It appears that after this she was much neglected, dying the following day. All her clothes, and the jacket at length removed some weeks afterwards. On her return she had lost the jacket put in her.

Present condition: Patient in extremis, with great distress, pain, and confusion. She is extremely restless, with profuse perspiration. There is acute pain in the left side, with profuse perspiration. She is often seen lying about the room, the 5th and 6th dorsal spine. Posturing appears, the left leg paralyzed, and she remains quiescent in all these.

When told to speak, she has either back or head, with left leg drawn up. There were equally large aggregates of pus in both legs, in the medullary cavity. The ribs, pelvis, and bones of the lower extremities, the ribs, right, left, and both of them.

During this time, which lasted some months, there was much marked anemic changes.
On the side and also a small amount of blue on the left. There was sufficient to form these with the 4th class of arms. There was also well marked rigidity of paravertebral movement in both legs and no movement was possible. The arms were placed on the bed are unaffected. There was scarcely any movement of the spine. For the most part the patient was in a state of agitation, and the red meat of his abdomen was hot. The left side of his face was more reddened. The right side of his face was more red. There was a considerable degree of anasthesia on each side. Some parts below the waist were somewhat relaxed. The level of the 1st deep spine was about where there was an anasthesia. A slight coughing, although it was not really noticeable, the same occurred. Above this point anasthesia was noted. The heart with the exception of a slight murmur was normal. The pulse was not rapid but frequent. The patient was taken to the hospital. The right leg was not affected. The left leg was rigid, and the patient was placed in a supine position. There was some stiffness of the left leg muscles.
Diphtheria.

Post-mortem report, Dr.see.

Antemortem observations:

1. Corkscrew, Calabar oil + strychnine.
2. Cellulose.
3. Laxative, followed by arsenic + opium.

The patient was in a very sickly state. He died:

On Thursday, the 1st inst. A few hours before death, the patient became cyanotic, but unfortunately, the patient died.

The following is a case which had been accidentally admitted into the hospital by the house surgeon. The patient was a man, aged 54, who had been in a state of semi-consciousness for several days. He was admitted on Oct. 3rd, when his temperature was suddenly raised to 102°F. without apparent cause. On the same day, the patient was placed in bed by the house surgeon. The patient was seen the following morning, his temperature was normal, but there were some disturbance in the periphery, and on inspection of the face, large, yellow, and necrotic patches were seen on the lips, but later became much more extensive.

The patient began to recover from the fever the same day. The patient became very collapsed; the urine contained a distinct trace of albumen. The patient was removed to an elevated ward, treated with 15 cc glycerine + strychnine and a strychnine spray. Brandies 50 cc given by Mrs. Providence + opium + arom. ammonia, and

Oct. 3rd: Difficulty in swallowing, sneezing, and the lower lip from shift difficulty in breathing. 10th grad.
early morning, and on the morning of the 10th the pains of Sanguaged Distention were so pronounced. The letters in existing cases. From these details, the colon and stomach, are regularly examined. In the condition of the patient, I performed drainage in order to gain relief. After the operation, the patient considered only for a few hours, but gradually went back to his home.

At the first examination, next day, the Omentum Omentum were found the lining by a stripe, though we can, which included with the back of the right hand cavity. [Plates xi. Fig. 3.]

The glands often were considerably swollen in ventral, diaphragm, and chest were found in the ventral venous and were dangerous glands were in a cavitation. [Plates xii.

by removing the thymus capsule, a large mass was found in front of the diaphragm vertebrae, behind the trachea, etc.]

after and ARTE. preserving them from

in upper part above, it was found the filled with cartilage, and also a few fragments of concave line, about the size of a pea, on the fourth left side of the vertebrae. So passing the fingers into this cavity, came from before back wards, it was found there between the base of the vertebrae, some often being
completely destroyed, by remving the anterior vertebral intact, and working a vertical section of the same (V. Plati xi. Photograph, Fig. ii.)

It was found that this had actually occurred, and that the abcess cavity in front of the Spine communicated directly with another abscess lying at the posterior aspect of the body of the vertebra, in the foramen canal, forming the spinal cord, but separated from the latter by the spinal membrane, tracing the abcess cavity. (V. Fig. 3. Plati xi.)

The wall of the abcess cavity being cut by a sharp resect of the humoral periosteum, which had been detached from the subjacent bone of the pedicle of the vertebra, on or some of the latter were completely destroyed, and thus communicated, and held here in a condition of advanced deciscence. By remving the Spinal cord, it was found that the membranes, broadly, the third of its normal size (opposite the demarcated portion of the Spine) by the abcess, there were or signs of any in haemorhagic action (in the cord or nearest around the end, but on making further section of the latter there being what it was evident that it had undergone considerable alteration in structure, being much broader than from normally at the compound portion, as well as indirectly vascular.
the involved portion of the gray matter, moreover, appeared as the normal.

On freezing the end on immersion, after hardening in quick-frost fluid and spirit (62.5)

it was found that the upper brain and upper cervical region had undergone respon-
siveness diminished at amines. On clearing out the change consisted in an increas-
omen immune in the connective tissue of the end, and of the blood vessels, ren-
alter being very numerous, and comm-
commenitately large,.

The nerve bundles were narrow, greatly atrophy, and in many places entirely destroyed, while here and there remains of small, if not entirely, hard, texture, which are osseous tissue and normal compression of

the same nature. The gray substance of the main and lower, as well as at the lateral
petters portion was beginning to form at the center, and the ganglia's cells in

the anterior commissure were in many parts almost entirely destroyed. There was also much

dark red ascending and descending Alveoli

retina, in the cerebral, and lent brain

formation tegmen respectively.

in the softened portion of the cord, the axes
cylinders were considerably hypertrophied (62)

(7, fig. 6, pl. xi.) and staining with neurin

acid (fig. 4, pl. xi.) change number of Konitz's oval
REMARKS

This case affords an admirable illustration of ataxia at rest often seen in such an extent as in the present instance. The gradual impaired arm and feeling of the cord from toes are obvious. The clinical features of the case were not usually met with in cases of compression of the left median nerve degenerating to paralysis cord - 1/3. The patient, almost at death, in the case - Anesthesia socialis. Right leg -

Modus of loss of passive movement - with wasting and diminution of muscular - sensorimotor, sensorimotor, exaggerated reflex, superficial reflex, especially Halsbier the paralysis of the motor, coracoid and long flexion had come, became familiar due to the commencing mediastinum in content of the brain of the cord. The patient in constant, private liability under treatment, and it would have been interesting known whether and for how long she would have remained for 4 years in the contact in the long sequel to the sequel unfortunately in the extremely important condition. The attack of paralysis causing complete

The Pathological changes in the spinal cord at the time of compression were strikingly. The chronic inflammation due partly to long continued irritation with commencing disorder.
Case of Martin Kavanagh, 51 years of age, Paralysis, from Compression of Cord by Tumour.

Admitted into the London Royal Infirmary on Jan. 4th, 1884. Complaining of loss of power in his legs.

His wife: Family, minor present. (Father died at 60; mother at 50, from a fever. 2 sons, both in their early life, alive and well.)

He says he has always enjoyed good health, previous to present attack. This commenced about 3 months ago with severe pain under the left shoulder-blade. He had to give up work on account of the severity of the pain. Since leaving off work, he has been in bed.

About 4 days ago, as he was getting up from bed, his legs suddenly gave way beneath him, and he sank to the ground. He did not feel quietly, nor too unconscious. On attempting to get up again, he found he could not stand. He was then once carried back, and has remained there up to present. Says he has lost a little flesh the last 2 or 3 months.

Present condition: Patient is a matured sized man. Fairly nourished, though older by 7 or 8 years than he is (57). Hair grey and thin. Compression of spine for some time, apparent with anaemia, and indication of anaemia.
Persons Sketch:

Complaints of severe pain in the back, located chiefly before the angle of the left shoulder, and radiating around the front of the chest along the left side. He also occasionally suffers from oppression in the chest, and that at the same time, experiences slight difficulty in breathing if struggling heavily in any way. Has also had some cough, and a tickling sensation in the throat. According to this description, the attacks somewhat resemble those of asthma.

The patient's development has been influenced by weakness that was in legs, feet, arm on the middle of the chest. Also has been unable to feel distinctly in same edema. There is marked weakness in legs and trunk, although no the nipple on the right side, and in them in width of the same point on the right. The numbness is not absolute, for he could feel a firm prick with a firm point on the right of chest below nipple, but could not determine the position of the point. He could not feel the point unless run deeply into skin (in right) there was complete anesthesia of arm above shoulder. Sensibility, there, felt in un-painful but terms. Perfectly deeper, he is unable to distinguish which them in the anaesthetic regions.
The muscular sensibility is also almost entirely absent - he cannot tell us what position his leg is placed - nor does he know when his position is altered.

Pupils moderately dilated, equal, direct look, slight and accomodation. Sight not impaired.

The photophobia has made no mark in this case.

Skin Special senses also unaffected.


He has sensation of warm - it does not move away momentarily. It has the sense of leg, catheter - normal amount.

Ski Reflexes: There is slight movement of the foot, ankle, plantar, on the sole. No taste in either legs.

Voluntarily: He has no power whatever in his legs. From the hips forward, being unable to sense a slightest movement with them. There is no loss of power in arms, hands, or head muscle - no sense. Any improvement coordination in the unaffected parts.

There is no muscular spasm or rigidity. These in the muscles are soft and flabby, and do not respond to the slightest degree to painful "electro-muscular current" (The tendon's better being moved. Apply at the level, feel no electric current with the "electro-muscular current." )
The patient is a good deal, especially in lower part of trunk area.

Circulatory System: 28 per. min.

Respiration System: Almost entirely abdominal breath movements.

Upper part of chest (below xiphoid) hardly moves at all during respiration. There is slight falling in of the lower end of the sternum during inspiration; jails of the lower hilar vessels. He has an oblique cough with a slight frothy expectoration. Voice normal.

No language paralysis.

There is marked impairment of voice from base of the left to base of the right posteriorly. Also, impairment of resonance in posterior.  The base being considerably higher pitched than the right side. The breath sounds are faint all over left lung, and respiration is somewhat prolonged. There is also coarse "crackling" heard over the left upper hemithorax and often Class I intensity.

Right side normal - breathing sounds soft.

Fear somewhat exaggerated.
1. Tenet: Permuage, entreaty.

2. Apple core: Nest alarm. Pastel prolongs a 'Mormonish' second round acceleration in Arctic area. No mumps at home. There is well marked arterial pulsation visible in the vessels of the neck. Puls 160. Repeat signal on both sides.


4. Cardiac system:-loop calvarium forced but moist. The first feeling. Bloody constipated. All cows considerably diminished. Symptomatic in expansion, are distinct. Ammonium could be seen deeply in the caffine fever. Which does not appear this movable. There is no fluid in the stools. Taste and appearance uncertain. Moment of the trunk as mesentric glands. Do arrangement of peripheral veins.

5. Urinary system: No pain, but he is unable to urinate. Urines have been removed off by catheterize. Urines: 1010, very dark brown. Album. acid. No albumen. No sugars, but success of catheterization.

6. Provisional diagnosis: Paraplegia from compression of spinal cord.

7. Treatment: 1st. Sect. rectos. 2nd. M. x 

8. Ag. Chlorides ad bi.

Laid in Autumn 102. 2° N. Arctic 101°


10 15 from Mr. 100° 67° 101° Peter 160. Ros Jr. 25.

Sleeping with me. In my rooming. I was expected

Having been in the room. Those people in my room had

Said the flowers. I go in much amaranth. Ex.-

Present form amaranth. See also letter-

Pasture. Personally. Then he attempts to

Speak hisDYTtym becoming ey much hear-

And. The time set often. Bourn and all

Jacob at real cartilage. From she Bourn

Inconsistently. Having conviction. Our

Expert for. Often Alphonse becoming Peter-

Bolted at the same time. The Right side

Certainly. Noodles more completely than the

Lip. The serious phenomena remain in the

same condition. The Animals not having been

Open for the last two days. it being enabled

Turkum Eumenus - he can retard or. I go

87. (I. Abtini.)

11 15 from Ab. 1.15. P.M. 98° at 3.45. P.M. 107° (V. Chater.)

Peter 160. In my public. Ros Jr. 25.

Mimi. Sticht. Antonio Blackwell

is amicable.

Has now started. "Thom's Improvement"
Abdomen extremely distended, very tender on pressure, especially over tumour in right lower abdomen. Pelvis sounds especially over pubis. VAPOR L. He appears in an extremely cachectic condition.

12.5 p.m. Yesterday and all yesterday afternoon, he made no attempt at micturition or defaecation after micturition or defaecation. Since 10 p.m. yesterday he has been quite unconscious. 12.30 a.m. Axilla two to three inches deep in pus, marked in a sinuate condition, marked sinuously, perforating profusely. He quite mobilises tumour anywhere. Passes urine elsewhere, beneath gown in bed. Conjunctivæ iridescente, eyes turned upwards, the corneas quite perfectly hidden by the eye-lids. Temperature at 3 a.m. 101°, at 8 a.m. 104°. It gradually rose in afternoon, reaching 104° at 12 p.m. Pulse 160, almost uncountable at worst.

He remained in this state for until 1 a.m. when he died terminally at 4.30 a.m. in the respiration being 107°.

0.30 p.m. 12.15 p.m. Both paracenthsis stethoscope. Peritoneal fluid opalescent. Most of legs. Slight enlargement. 10 to 12 o'clock in situations already warned. Face pale. Slight comma and slight speech. He was 38 years old.
Contrary to Martin's observations, continued...

Tumour: At the root of the left lung there is a large growth which has extended along the bronchi into the lung substance, especially into the upper lobe, involving the surface of the lung near the apex, where it is adherent to the diaphragm. The bronchi and vessels are also involved in the growth, some of them being enlarged with the glandular tissue. The tumour, yellowish in colour, extends in a fasciculus to bring any further a round a small area of normal lung.

On sectioning the lung, the Bronchi together with the heart largely resolved. A distinct, separate tumour was seen attached to the left of the pericardial column. Separating the attachment of the 3rd, 4th, 5th, and 6th ribs from the pericardium. The tumour was about the size of an almond. The tumour was firmly fixed and not adherent to any other structure. The tumour, when removed, was surrounded by a large, dark, examination it was found that the tumour had spread along the interlobar vessels into the oesophageal canal, behind the 3rd, 4th, 5th, 6th, and 7th ribs. It almost entirely surrounded the oesophageal canal for about 1.5 or 2 inches, lying deep to the lung.
The inner cerebral change of Hunter's case of 1839, from Mr. Cowper's view, where few signs of Bohler's circular vessels were found. The surface of the brain appeared quite normal.

Bladder: contain'd a brown, or brown of Blood. Found wound. No scales were uncommonly thickened, congested + the mucous membrane was altered in appearance.

Alarge quantity was found forced in the left side from about ten feet to foot, packing the Renin right and left. Right under the Renins.

Alarge quantity of congested blood struck the right ventricle especially.

The Spinal cord was much affected. Airy, the compressing growth, values from its pit and weakness, both from below. It was impossible to trace microscopic sections of it. It appeared after death, from the posterior rami nerves, but the only change normal tissue was under brain: all the blood vessels in the blood - (r. side)

Venus in the spinal cord. Packed it with a lymphocelema. (r. P. E. Fig. 2.)
Summary of Case.

Man. aged 67. Always good health till present illness.

First symptoms were pain in left ankle just above the skin. This gradually increased; occasional dyspnea on exertion. 7 days before admission and then paralysis of left side. 7 days later.

For admission, hope in head, numbness in arm and leg; anesthesia in analgesia of legs, absent carpal; paraesthesia in fingers; pulse, pulse, increased inspiratory and expiratory noise with symptoms of compression of bronchus. Pancytopenia. Right hip joint.

Inflammation in left side of body.

Gradual increase in symptoms, high temperature, headache, delirium, vomiting, delirium, headache, convulsions in the nose. Gradual coma within.

P.M.: Dinnor gone, wiry pulse, cut edge, Bruit mental flaccid, limbs in pelvis, also movement of spinal canal in both legs.

Commentary: This case is particularly interesting from the clinical aspect. The patient account of illness was clear and precisely correct. He denied any having experienced any weakness in the legs prior to the sudden attack of paraplegia. Nine days before.

His resting admission into hospital. When first examined limbs, i.e., the day after admission (Jan. 3rd, 1884).
did not disclose the illness in the left clavicle region. Denoting this important fact, I
taking it as the chief sign or one of the physical signs in the
chest’s unperceived moment of left side during respiration. Joba breathing, all our
left lungs frequently at times. “Towering Venus” was left bronchus, with improvement.
A local pneumonia, total absence, alas! This placement of a long beat often beats
through the left and the accentuation of the aortic second sound, and the unperception
of murmurs if present in the left aortic.
I came to the conclusion that the case was an
absolutely one of consumption. It the 3rd part
of the aortic arch, which had distressed the
thinking of the upper dorsal vertebra, and par-
tially hystерized or was compressing the
spinal cord. The symptoms, facts in favor
of this diagnosis were as follows:
- A history 1 min in fairance (chiefly in age 40)
- Many work as a book laborer.
- Rheumatism pain in left side of chest
about once a week for past 6 months, this
pain occasionally attacks of dyspnea
with pain in chest. Pain often occurs
occasionally paroxysmal in character—
also becomes more certain when lying
down
- The sudden onset of Paraplegia, "early" to the sudden onset of compression.

* Patient on 
- Inflammation in this region.
[4. Case of Martin Harris, continued.]
Special and by aneurism itself.
4. The symptoms suggest a rare form of compressi-
5. The rights Bumenum (already seen).
5. The left Bumenum, acute rent + accentuated
4. The symptom process chart + evidenced due to cerebral damage.
5. The rapidly progressive character of the
paraplegia, together with the fact in consideration
indicated with a progressive course, or
secondary sympotolpia or meningitis, indicating
reflexes existing ultimately the bladder.

It was not till the year 65 in the
in the left iliac region was discovered. This
process accentuated a reconsideration of the
diagnosis and the question as it presented
itself. Whether the Physical region in the chest
Paraplegia might not be due to an intra-
venous spread implicating the left Bumenum +
with the protruding into, or just from the
rectum any spread in the Spinal canal?

The main argument advanced against the
was
the possibility in the sudden onset of
complete paraplegia, with no apparent
symptoms of spinal irritation or compression.
And the absence of any nervous nor the
nervus in any part of the cord - and also
the absence of any difficulty in retaining or
symptoms of compression. If the cord is dead
* Which point against
Press of compression...
Extremely probably that there was some connection between the growth in the pelvis and the pressure symptoms of indicators of pressure within the chest, that I noticed strongly in some of the last hypothermia. It is that an aneurysm in the pelvic tumour, an intraparticulate growth with the same pressure symptoms which had previously been present in the thoracic symptoms which had persisted by anterior force found its way into the spinal canal through the paraplegia by pressure. Although it was extremely different to account for the sudden onset of the paraplegia, cases have been recorded in which the symptoms of pressure or spinal damage have set in suddenly without any marked pressure symptoms. Nothing was found after death to explain the suddenness of the symptoms of spinal compression.
Case of Mary Ann Williams, Alesford, Paraplegia.

Patient was admitted into the Borough and Royal Infirmary, 3rd July 1874, under the care of Dr. S. Clynes, complaining of weakness and numbness in the legs and arms, of dull pain in the back of the hand, and pain in the hands.

History: Father died of consumption. Mother still alive. No history of in temperature in family. She is a widow. In husband, she was very in temperate and gave years ago. She has had several healthy children. No miscarriages. She says her health has always been good. 4 or 5 months ago, when she had two fits, one about three weeks before the other. For some time the fits, she had been in the habit of taking a very allowance of stimulants during the day, beginning early in the morning, but taking a large quantity at a time, but a "drink" pretty frequently at intervals of an hour or two. She became entirely to the Brandy or Whiskey. She has continued in these habits until the present time. Likewise, she has taken very little solid food of any kind. In describing the fits she says the first lasted 1 hour and the second 12 hours. Also, that she was quite unconscious for what time in between. She died April 26th. Her husband was told she took "quiet" the fits came on...
Suddenly, but she usually being about three yards from them usual about that time. Since then she has felt her legs gradually getting weaker, also, that they trembled very much when she began to walk, and her gait was very unsteady. At night, when in bed, her legs have "jumped", and then commenced to tremble greatly. Often preventing her from going to sleep for some time. Her arms and hands began to feel weak, and trembled whenever she tried to do anything. She could only lift anything light, and then very unsteadily. She has suffered a great deal of pain in both feet, legs, and especially in the soles, and occasionally across the palms of the hands.

Present Condition: - Patient is a young woman of rather dark complexion. Her height is approximately 5'2". Her nose is prominent, face rather puffy, and mouth somewhat drooping. Both hands tremble markedly when unsupported. Skin moist. Temp. 98.8°F. P. 90. R. 22.

Diagnosis:
The complaint of a "dull" pain in the feet and legs, especially in calves, and occasionally in the knees. This pain is almost constant. Occasionally, it is of a burning character. She has rheumatism.
Pain in both hands at times, but less severe than in legs or feet. The toes of the foot, and calves of the legs are very painful on pressure - and certainly hyperesthetic below this pressure. He also says the pain is often worse under the left side. The pain is always worse at night.

...and anaesthesia almost complete amongst a few hands, being quietly unable to feel and feel the head up to a point of a finger. The only feel the left as a touch, unless suddenly, strongly struck into her. Sensation is also greatly impaired on the fore-arms, especially on the anterior surfaces. The is able to feel fairly well on the upper arms. There is loss of sensation to a touch with the head of a finger on both legs, and does not have affect. The case distinguishes from any at the touch with the point of a finger in the different situations. Sensation on the planter surface of the foot apparently unimpaired. In three situations where sensation is unimpaired to touch in the pain, it also unimpaired in corresponding degree. The head would - it is also absent in a corresponding another of the abdomen, chest, cheek, the patient in three situations being confined occurring. When ask with how much better to their head of pain? The tip of finger - The head, recognises the point of...
Petitio reflexor in about method sides, +
Supmat and Reflexor (Plantar) slightly
increased.

She lies with her legs recurved at Reus
thighs, and is quite unable to extend
them completely. When she attempts to do
so herself, she is powerless to do
anything by traction applied to her feet she suffers
much pain in the calves. Her gastrocnemius
muscles appearing thin, is in a state of
painful contraction. She frequently has
"tremby" pain's in them at night, especially
when her legs "jumps". The ankle joint is
also somewhat stiff, every movement
causes much pain. There is no Rheumatic
this long. She can just walk, but does so with
a very uncertain, tottering manner. She says
her legs feel as though they were trying to get
away from her. When reclining her legs are
jittery, and she appears to be unable to put her feet down where she wishes to.
She is therefore quite unable to walk along
any of the floor. It quickly...

She had difficulty when her eyes are closed
but she does not manifest any tendency to fall in any particular direction. When lying down, there is very
Marked loss of power in her legs. She is unable to stand or rise except against a very moderate amount of resistance. She is also uncertain about the difference between weights (cannot discriminate between 2 or 3 oz.) Grasping power in her hands very failing, and motion strength of arms generally much impaired. There is no marked or combination of movements anywhere, neither in their any marked abnormality of muscles or subcutaneous. No fibrillary twitches is noticed. Both legs and arms bending about deak form whenever the knees are drawn from the bed, or when she tries to sit and when she tries to lift any thing, especially if it is at all heavy. (e.g. 2-3 lbs.) Disturbed by electricity, the only observation I could make was that they were slightly too "printable" with forms of current. Both arms from inner bone than the other.

Face, under circumstances functions: The dorsal surface of the face occasionally becomes "flushed", and at other times pale. There is only slight amount of redness of this last present - this drains quite as appeared in the course of a few days. Head felt warm, the forehead.
Central Nervous System: - Sleep badly.
Constantly thinking about and discussing.
Only slept last night after the following
Mammoth. Q. P. peppers and 21.
Chloride hydrate. 2.5
His attention is fairly good, but he is
very foolish and reasoning away from the
perceptual conscious pointer in a very
loud manner.
Memory certainly impaired,
especially for recent events, e.g.,
what she did eleven days ago.
Speech is some-what indistinct.
When talking there is a consistent
exciting accentation of the voice and
the latter when prolonged is very
unclearly, with deafness and blurring.
She has an allergy to open air.
Its specific irritant is mainly the
water.

Circulatory System: - Heart sounds normal.
Pulse of 2. very small, veiny compressible.

Respiratory System: - There is slight 
abdominal respiration, with pulley breathing. Expiration
more
Mussi - pulse acid 13. g. 1010 - no albumen.
Alimentary System: - Tongue pale, flatly.
Weak - thin - no albumen, especially when presented.
Appetite very poor. - His manner
at the sight of food. Frequently belches very little, but then in evenings. Recent consti-
tuations. Measures 3½ in. in an apples.

Put a common diet and record to
the Peruvian. 1 tablespoon of 8-

1st. 20th. Had a dose last night. was very
restless, tossing about, not talking by
himself. Threw up 1 am. temp. 99.6°.

2/14. 1.30. a.m. Stirredly said he to all
night. Chattering constantly, his hands
were constant and his tenderness. Had thrown a double
a dose of digital Peruvian (Artemisia spp.)
source. I then had one dose clasp.

Hands don't stand up nor instantly when
sustained. Complains of his pulse being very
cold. Pulse very same 96.

23rd. Complains of his pulse being very cold. Stuffs
very little in spite of changes and hands
afraid deal; she frequently gets out of
bed, thus in the back of arm. Answers
questions in a very silly manner, laughing.
afraid deal; very emotional. Much
more so than when admitted. Pulse 94.

March 14th. Since last feed, has been minded in.
Much the same condition.
24th.

She still remains constantly in a semi-conscious condition. She is restless, agitated, and restless. She constantly, until much otherwise. Answered questions in a restless, restless manner. Ordered Mr. Cooper, 9.5.10.-17.30, which she chews up before I am able to follow it.

6th. Very little attention. Felt her some what restless. Erythrocyte range from 54.7 to 59.


11th. Passed motion in bed involuntarily. Lungs fairly clear.


20th. Shush asleep half the time during night and day. Ramble during night. Passes faeces in bed.

28th. Pulse almost imperceptible. Not the counted at most. Complaints of no pain. Breathing still very fast. Nothing satisfactory. She was not asked concerning the cause. Reason: no account of the contradictory answers she makes.

The patient remained in very remote, the usual condition as regards the loss of sense. Remained in the remotest part of her mind. Answered in about 3 weeks at this time. Did not have the opportunity of following her case as clearly as formerly. The result...
(Case of Mary Drummond. Interned.)

The patient on April 14th was as follows.

No longer complains of lumps herself - is much less emotional, and answers questions calmly. But still occasionally passes watery stools. The pain in the left side is much better, and is now chiefly localized beneath the xiphoid, is of a burning character. The right leg feels somewhat weaker, the plantar reflex is distinctly exaggerated. There is also marked hypostasis from the foot, especially in the dorsal area of the great toe. The slightest touch with the end of a finger appearing to make no effect on pain. The sensibility of the leg is still impaired. Especially on the outer side when touched with lead. On either side 'no sensation'. The patient is quite unable to perform any tests, but can do so fairly accurately on the inner aspect of the leg. Gastrocnemius still tender on pressure. Patellar reflex quite absent.

Left leg: Not quite as normal as right. Plantar reflex exaggerated as in right. Splenectomized.

After quite absent. Sensibility normal. No joint hyperesthesia, except at point pressure on gastrocnemius.

There is a slight increase in the amount of pain in each leg. She is able to walk more steadily. The leg trembles much less, unless she tries to walk too much. She walks well - in difficulty in midwinter - has much more
Control over hands, some grasping power. She can also distinguish betweenught through the clothes (e.g., paper & blanket) with her fingers, which she quickly withdrew both at first. From this time the patient continued temperature steadily—gradually regaining power in her legs—tremor—tremor gradually returning, & the hyperesthesia disappearing. The mental power also returned naturally & when she left hospital she was perfectly rational. All her other symptoms gradually passed away. She was discharged practically well on May 22nd. The Convalescent Home.

Dr. B. In lymphatic gland, x. Tabli (Case A.)

Then all the cases of all clinical operations are classified tabulated. These present a commentary on this affection at the end of this cases. v. page...
Case of Jane Pilkington, aged 39. Alcoholic Paralysis.

Patient was admitted on 24th June 1864, at the Liverpool Royal Infirmary (under the care of Dr. Elyum), complaining of loss of power in her legs of burning pains in the tips of her fingers beneath her nails. Loss of appetite equalised her weakness.

History: Family history very deficient. Nothing unusual mentioned.

Present history: She had a severe attack of Rheumatism at the age of 20 years. She has been a charwoman for several years, and has been accustomed to the frequent use of harshs for the last 15 or 20 years. She has also suffered more or less from pains in the tips of the finger tips, of a burning character, for some years. These pains are always worse at night and are often most severe beneath her toe nails.

She also complains of pain in the palms of her hands, in her ankles, knees, and which makes her legs feel quite paralysed. These pains often come on in paroxysms, at these times her knees can neither become worse when crossed. The legs, very tender. Her legs have felt weak ever since the last few months, but she has been able to walk about on them. She has been able to walk, in her usual strength, in private having noticed it.

The present attack commenced with pains
Of a severe chronic character from around the 
feet of both legs, which gradually ascended up to the knees. She began about two 
weeks in the legs at the same time, eventually 
in her back pain in the legs felt as though 
"rented the ground." Her knees were accompanied 
in her shoulders,ショット down her arms. 
Other hands, the palms of which became so ten-
der that she could scarcely bear to touch 
anything with them - she first learned her 
very much weight on them. Her appetite 
here was very poor. Often felt sick & 
likely in the morning, occasionally 
remitts yellowish, fatty, fluid after the 
Mucho shaving. Has constant chills 
"all feel of stomach" and feels very worse 
approached at times - often says 
that the feeling of being very slippery generally 
takes a drip of brandy in one.

Present condition: She is a thin woman, 
somewhat thin femoral, congestion 
Rumours: The conjunctival membranes 
conjunctivae tinged with yellow, textured 
shaded. Longue four. This yellowish fun-
(vrux part) with

borne by the leg: Complains of "burning pain" in 
the legs, the feet, sometimes the hands in palms 
and hands, occasionally itching pain in the taking 
of the legs. Sometimes has a sensation of pins...
Drome in his fingers. When their skin present any
blue tinge as the palms of the hands became become
very red. Stiffness of the tongue. Was slight
mention "Frontal headache."

There is no apparent blunting of the sensibility
anywhere, but in certain situations, viz., the
fleshy external surfaces, of flat-palms of hands,
slips of fingers, there is decided hype.
sthesia. The length of the fingers, or the head of a
pen being described as causing a burning
sensation - upon pressure made on my

"Met."

Ther is no marked alteration in
the sensibility generally. The Per:

alo area are normal. The Pupils are equal, reacting
to light at accommodation.

Dexter function: Organic Reflexes normal.

Plantar Reflexes slightly increased.

Palmar Reflexes greatly diminished on both
sides. Normal disposition. Has to turn over in
hands when lifted directly with tip of finger.

When waking, her legs are able to tuck -


Vesicles in the gums - there is a slight
amount of pus, at thinning of the mus-
cular veins - but not many marked result.

Her hands are able to touch when held
out straight before her, within she does any
fine work, e.g., sewing - but she can do
almost anything she wants with her fingers.

There is no marked alteration in the electric -
Currents.

The boy was motor disinhibition present, no occasional finding after hands check, especially of the neck, or any undue treatment.

The muscles feel flabby, but are not perceptibly atrophied.

The attention is not impaired, but thinking in memory is failing somewhat. The speech is unaffected. The speech is often stammering.

No other physical changes detected within.

Cranial nerves.

Treatment: skeletal diet. Prothionamide.

Pills of Nux v.

Pt. found d. & x.

Pt. found d. & x.

Pt. complex & f.

Cranial nerves.

Patient continued to improve steadily.

July 2nd. Has been getting up for last two or three - and walk quite steadily without support. Has 16-18 jumps of normal range in any one step. Takes food well - asleep not disturbed. Pulse 92. Skin warm and moist. No anaesthesia.

She was discharged cured in July 6th.
Case of Dr. Lister's act. 42: Acute Paralysis.

Patient: A married woman, Called L., born in Aberdeen, 1781. She was attended with the usual symptoms of a convulsion. She was admitted into the hospital under the care of Dr. Glynn. Complaining of heat and pain in the joints, and loss of power in the hands and feet only.

History: Family. Father died of consumption at 30. Died at the age of 58 years. His mother had Rheumatism and died from insanity about 50. She also suffered from Rheumatism. The patient is the only living one out of the family. She has been in the habit of complaining of pain in her joints, especially in infancy, about the period of lactation. She has had sciatica, neuralgia, and when she was a child, she vomited a large quantity of blood, probably from a gastric ulcer. In some years she has been in the habit of indulging partly in beer and spirits (especially brandy) often taking some of the latter "two or three glasses," especially if she happened to have "indigestion" with it.

In the last 8 years she has suffered from pain in her face and joints. The first attack affected the ankle joint, confined her to bed for several weeks. She says she is very frequently troubled with bilateral attacks, sometimes 2 or 3 a week. She often vomits or vomits in the morning, but in the evening she has dark spots floating before her eyes. In the last four months, she has felt her hands...
fat must, and also a burning sensation in the soles of the feet, and about her toe-nails.

Lately, she has felt herself getting weak and shaky in the legs. That she is very com-four legged. She has also noticed her hands and arms begin to tremble when she picks up anything heavy. That she has difficulty in picking up small objects, e.g., pins.

Her memory has also been failing the last 2-3 months or more, being very forgetful. Her appetite has been very poor for some time, although she has had a hard time eating all the food she has taken. For this she has generally takenwrites of bravery, or a song of strong ale.

Three weeks ago the joint between her principal distal phalanges of the left great toe began to pain her, then became swollen and very badly. Then muc the lining of a cherry red color. After this she had some pain in both hands.

State on Admission: She is very anaemic, emaciated, friendship, men's a "pamid" operation, of a very dark, not able, nervous temperament. Is of average height and slight build. She is normal eye. 59.8 of. Pulse 85 and very small.

Examination of the right foot: There is considerable thickening of the tissue around the phalangeal joint of the left great toe where there is also a small, ulcerated
Discoloration of the integument, and fragrant
of the cuticle. The muscles are 20% flabby, to
quadriceps.

Pain in: stool: diarrhea / constipation.

Complaints of
Rheumatic pains in the left shoulder, also in the
Causes of the type of numbness in hands, fearing
that, occasionally, of burning sensations in
Arms of fall, tenderness to nailability. These
Pains are always most severe at night, when
she sets nerves in bed. No rains burning pains
are also frequently present in her fingers and
palms of hands. The sensation of numbness
in the arms extends from the fingers half
day up the fore arm, from the legs from the toes to
finer needles above the knees. The hands are
feel as though they were asleep, and thin the
legs they are extremely tender when touched.
She can feel the prick of a pin anywhere about
the hands, appears allergy in a normal sitting,
but she appears to have considerably less
sensitivity in discriminating between a slight
brush with the head of a pin to that of
the finger all over the entire areas in
both hands & forearms. Sensibility does
seem unaffected in some parts.
Legs. She cannot distinguish the prick of a pin
anywhere on legs beneath knees, says it feels
like the touch of a cold wet finger, in other
extremities of legs it comes a "warm" sensation.
She cannot distinguish correctly between hot and cold test-tubes, in fact, she shows part of Wegfer's frequency calls the hot, cold, etc. bones. This is pertinent to perspicuity, acetabulum, etc. analysis, includes a year ago on the mid.

The outer tongue alone that point the tenderness is not perceptibly flaccid. She has also a good deal of difficulty in discriminating between small bones containing different weights of fluid in arms, legs, especially in latter.

She has considerable less power in her arms and legs, also slight in coordination of truncation, with great effort. When asked to pick up again, she does it, but with considerate whole length motion, truncation, etc. With the left, which is much more firm.

Arms, theoretically, she only succeeded after making several attempts. When asked touch the tip of the arm with her feet, progress is making. The tips of the two fingers together when left at some distance are, the eye being closed, she makes any poor attempts. After touching the thumb with the opposite cheek, she progresses more often moving to meet them. Dr. Garrod's power of hands are tested by the dynamometer. - Right = 22, Left = 18 degree.

(Robo's arm.)

There is marked loss of power in the legs. The calf muscles are very tender on pressure. She talks very unstudiously. Spirt + haggard.

Cannot walk along on plants or floor.
(2. Case of Eliza Tucker. Continued.)

When lying down, the power of vision is very limited, against slight resistance. She is sunk in pain, they cannot stand steadily with her placed close together, even with her eyes open, but she becomes much more sensitive when they are closed, would almost fall, unless supported.

There is occasional burnoutness of the gums of her lower jaw, either of the tongue when protruded. The hands, arms, just legs also tremble regardless, when she attempts to perform any voluntary action. The hands are also well marked in the flexor muscles of the arms, legs, also in the thenar of the thenar muscles. There is no marked dexterity of muscles present, when tested with different forms of electric currents. They manifest no marked withdrawal activity if anything resembling too readily to the forearms, current.

Muscles of trunk appear quite normal. There appears the normal flexor muscles. On set or withdrawal changes. Excepting the fact that the muscles generally appear to be fat. She says the tip of the first sometimes get away from her, when very cold weather.

She has noticed the same occurring in the hands, especially in the palms - after they have been wet, the latter sweat profusely.

Central Nervous Functions: She is in any irritation.
and putful - during the above circumstances the patient continually remonstrating me that there is "misery in the family" constantly leaving off in the middle of a sentence to say this. She has difficulty in her memory, failing considerably for the last 3 months - lately she has been unable to carry a message beyond 300 to 400 yards without forgetting within the part of the word off. She frequently has made up her mind to do something and forgets it before she commences. She suffers with anxiety about 3½ hours every night - is often kept awake by fears in her head, the latter often jumping about a deal, especially if she had been walking about much during the day time. About a month ago she suffered a great deal from throes, frequently falling asleep in the midst of talking. This lasted for about 3½ weeks. Since then she has been unable to sleep without falling through the night.

In pursuing my research often fortuitous emerge apparent. The patient frequently in the summer affairs for want of rain. Especially in the 10th to 15th March, rains - thin spots during in such painful a manner, and other, those in gentle, clear. Where a great pressure it not, with a small sensitivity.

Critical element - "Mere heat on 6-7° winter.
½ an inch internal triangular line. A joint by the 1st of
May in Millicent's area, propagated a short di-
tance towards median. Pulmonary sounds amidst
mechanically unduplicated at base, artistic
2nd. pulses. Pulse 85= very small.

Respiration System normal.
Alimentary in tongue foul, coated with
Thick yellowish fur, no truncheon column present atop.
Nineteen at margin. Breach in foot, defect.
Petits.-- Very frequent hiccups, no submision
of suction. Often alteration of respiration at
Put out breath 1/3 flattened dulcets after
food. Brows erect. Have dulcets sit ½ mi.
in nipple line, slight tender in from
pressure. Invertise.

Worse.-- Much. Phlegmic ulcers at rectum. Dys.
50. 100.9. In abdomen. Faculty at behal.
let shall cease.
Put in respiration with stool smells nearby

Vigir.-- instead Bath.

May 17: Had two, nutritive, dulcets last 9:00.
this 1st pulse took after a double dose of
Bromate chloral. Then slept for 5 hours.
in the morning she was quite quiet. Bathered
Pt. Peh. Imm. 80 = none at home. —
32°. Has any melancholy. M. O. L. - says he had felt very sick and feb. but suffers or pain in st. Felt cramp at front of pain in foot, very short and could walk though they were accented. Pulse 96. Resp. 32.

Longs. 49.6° F. Ordinary.
W. m. 6.6. m. x.

P. a. 2.
A. 2.

Ag. C. 2.9.4. m. a. 3.8 ams.

Continued the feverish condition.

Ag. 94°. Very much in same condition. In left arm. Has been 100° F. in Mustagine. Pulse 96. Resp. 32.

Pain in feet with more suffering. Suffers still with great

Pain in bed. She can move with great 

Pain in bed. She has been out of bed last four days. 

She has been able to walk about the rooms without much 

Pain only in left leg. Still is able to go down stairs.

June 12.5. She is better. Has been out of bed the last two weeks. She is walking about the house with much 

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June 16th, about 11 a.m. The legs are somewhat edematous. The sharp points of a spike in leg 1 feels a little burning "like a burn, dry in centre. Fingers flexed in palms, not extending them to whole arm begins to flatter. This immediately gains her some pain. She is now looking more settled. Appearance not as good as formerly. She occasionally passes her stool, in bed, the last few days, all her urine.


30th. Lie will remain flexed, at legs there is much pressure, very painful, cannot move them largely. Occasionally brings arms about, cannot move freely with hands without causing much pain. Values round fingers without trembling — does not shrink as much when touched. Nursery quiet. One. Puts the flatbed. Stiffened - Course #8 of morphine, continuous, at 8 p.m. without.

30th. Last these seldom above. Still vomiting at 11 p.m. gets out of bed more than, but when she does so she screams distinctly, as though in great pain: Puts in 32, very well

July 2nd. Much better last two days. Spoke generally, this at first was not at all. She remembers exactly what has occurred during the last few days. But not for longer period. She does not
Know where she is, thinks she is at the Atlantic Hotel. She does not sleep well unless she has some of morphine hypodermically. She is very fretful—thinks she is going the headless Almsley. There are a number of форго трост or her bed. H. is found at Adeansmo. Her hands and arms also tremble very much, when she tries to do anything with them. Sum the two facts voluntary action. Sugar rate forced, thrombus cutaneous. Legs that move occasionally. 7/6. Dyspnoea.

July 8th. Since the first with new mattress, she has been quiet, no trembling, very little. She communicates more naturally, thought clearly with a quietness very slight. Sleeps about half the day, night and legs apparently quite useless. She has used a roman gurney with warm covers in bed.

Sensibility to stimuli, very much improved in her legs, as she now feels distinctly the prick of a pin anywhere.

(She was sent home for a time, in accordance with while washing the wards.)

July 20th. She returned to hospital today, her grand quiz clean up to from delirium of angry pain. Her respirator is somewhat quiet, better than when she went out. She can lie on cotton or air, or sit well back. Both her legs are still semi-flexed, however, and cannot be completely straightened. She can move on the floor, her legs or thighs, or the latter on the arm, but cannot extend them beyond a few inches.
Has a rather intermittent cough. Has induced some dizziness at both sides posteriorly - palpable tugging - with occasional expectoration.

In basal.

Under chloroform, fairly control.

Aug 18th: Patient is still badly improving. In mind getting stronger. Her ideas might be clearer on hearing the muscles electrically, it has found that these of the legs did not react at all with faradic current only no slightest sensation
(neural) (when it was "made") when there were 5 cells in her. Sensation in hands is more clearly discernible. The power of grasping certainly improved. They are still very tremulous however. Her general health is fairly good. She still keeps her legs perfectly as she lies in bed.

She continued treatment in health but in condition of legs remaining almost the same. Exercises were applied (by weight) in the usual manner, with the aim of gradually excluding them, since any possible attempt to do so, caused her very much pain. This was kept up steadily for some weeks - by the middle of October. They had become perfectly straight. She was very full at times - but increased her mental conc. Once very good & satisfactory. She has cleared from pain in her feet.

In November, Dec 15 she had an attack of some pain in the right femur & shoulder.
The arm distinctly impaired; the arm containing a considerable quantity of fluid. The pain was relieved by morphine.

For 1-2 days quite straight, but turned outward. Some thickening of some joints. Has very little power in them. Cannot lift her heels from the bed (when lying on her back). Sits the middle of a pair everywhere. She says distinctly has no pain in them, as long as she keeps them quiet, she does not feel them.

The power of pumping as required by the surgeon, elicits as follows. Right = 25 degree, left = 28.

Has no pain in the hands, no any inflammatory affection about her joints. The left hand slightly troubled somewhat, when performing any voluntary activity but she can do almost anything with her herself. E.g. buttoning clothing etc.

She suffers no pain in them; sensation improved anywhere. Potassium regains does about.

The general health remains fairly good.

Has no head ache; Stiffness back; Dreams rarely;

Stingers — altogether her general condition has improved greatly in every respect.

She was discharged at this time Regret in Nov. 19th.
The rains distinctly increased - the wind containing a considerable quantity of bile. The blank was relieved by Mr. Jones.

Mrs. Wells thought fast turned outward.

From the portions of these joints - knew the better form of them - cannot lift her heels from the bed (when lying on her back). Looks the frank of a fair everywhere only very distinctly has no pain in them, as long as she keeps her head steady able to be.
Cure of Fanny Burney, Mrs. 54. Alchlor & Para-pregia.

Patient was admitted into the Neurotic Room at Infirmary, on Oct. 14th. Complaining of loss of power in the legs, pain in feet, change of taste, loss of appetite, vomiting, & constipation.

History: Family history quite unimportant as far as she can give any details.

She is married, has had 2 children, both of them dead. She lost them before the age of two months. Says she has not had any miscarriages. She was 21 when married, before this she had no alcohol at all. Afterwards she commenced to drink "to help her husband company" at first she only took beer. Then made her feel better in the mornings. Then went to drink a little wine with decent whisky for weeks. Then gradually dropped into the habit of taking "rums" of whisky or brandy (chiefly the latter) several times a day—and frequently becoming "too much jolly" on Saturday. She did not fall into really bad habits till about six months ago. About six months ago, her work began to trouble her. She said they paid her too little & felt my cold at all times—sometimes she would
...feel her calves very sore. Shortly after she began to suffer from pain, stiffness, and cramps in her legs. Walking extremely difficult, she could not walk four steps. They felt much heavier than usual. The last night she had severe abdominal pain, nausea in her sides. Sometimes her hands and feet were cold and frequently prickling. She has never had any sign of fever.

Last week she noticed her legs beginning to swell. Thinks her abdomen began to swell about the same time.

Present Condition: Patient is a well made woman, fairly nourished, but skin is wrinkled. Says she has been very short, face flat. Carpal area calloused. Dilated emotions, long nostrils, fatty, jaundiced. Tongue flat. Pulse—Right, 70. Tension. Appetite almost nil. Although she has commenced almost of the medication, frequently vomits in the morning—about a pint ago. She says the stools were more abundant than usual on one occasion, by a dark brown stool. Generally has homeopathic remedies. Obstetric appetite—Stools pale—Expe. 98 & 8. T. This pulse 'clumsy.'

Respiratory System: Complaints of pain in her chest. Generally, of a "burning, chronic, stuffy" end of her frequently true, sometimes
under each, so that the case may be clear, to

apples or her feet—Says her feet is worn
by pressure, with fungus, color, also any

habitually worn. She does not

consider, but in some cases between the foot and

head of the foot in the foot or toes. The con-

nection when she is thereby made with either, but the

descriptions will become different to

feet. Elsewhere there does not appear to

be any prominent symptom. She says

The friend does not always feel pain under

her foot. This is not constant either.

Special case normal—Painful, moderately

intolerable, but is at times slight and

announced.

Organic influences normal—Plants before

diminishing. Pathosis begins almost at first

ears. In another instance, fungus in woman

vivit at such time affected. Intestine muscular

paralytic or any contraction.

She is able to walk moderately, leg may turn

alone. Dlocks in back Arch knees" says the

folds legs "pinning" under him. There is an

estimated force of power in all movements

of legs, especially before knees. Diminution

fast will effect which is at first

thick. The momentum seems to

parted—legs not distinguishable between 36

to 37. With legs. All legs are widely

extended. Buts they are only effort without,

not having to see this.
He was sitting very far off with his finger at great dots when asked otherwise.
She had just breakfasted in his hands but could hold them out steadily before her.
Instantly at elbow - just rate principal springs.
Slight incordination of movement - cannot bring. His fingers very inaccurate, bijection with eyes closed. Contracted mouth instead.
I spoke with firm off his fingers. She appears them difficult in closing herself from the momentary feature.
She feels normally. Letters unadvisedly offered.

Wien. April 7th - my health, small tempromental.

Numbness. slight pressure, cutting. mouth.

After remaining in hospital after days she felt as much better the next day that she visited in returning home. She has not seen her men or heard of being left.

[Signature]
Steward.

Son of John Batman, 2nd H.Q. Melbourne.

Paraplegia.

Admitted into General Hospital, 1st Gen. 19th March 1874. Complaining of weakness in legs, difficulty in hands, vomiting.

History: Father died of pleurisy. Thanks to 2nd Army Temperance. Knows nothing of my father.Was always a strong man and had good health. But has been addicted to drinking all his life for about 30 years. Has been thirsty all his life but has not drunk habitually. Latterly about 10 months ago he became ill. He remained in pretty good health till 10 weeks ago. For some time previous to this illness he had suffered from morning vomiting in the morning. The first symptom which attracted his attention was vomiting in the abdomen. On feeling in the abdomen he noticed his hands getting tremulous, and his legs feeling funny. His feet began to come down. Especially when he sat down in bed at night, he had horrible cramping pains from calves of legs at same time. His legs became quite weak. In last week while lying in bed he has vomited almost every thing he has suffered a great deal from his cup. He has lost rapidly, been constant for weeks.
Present Condition: He is a strongly made man, of medium height and weight. Complexion
moist - conjunctiva slightly hazy. Beard:
dark sideburns against neck, white beard
whorls when speaking. Poor speech. -

Dreams last night: Complaint of "witness" in fast
sleep. Was 'jumping' "toward" in cabin -
just that! When "waking" at night, got
back on board. Felt unrest by two feel-
ing - as a rule just very cold. Life of
travels. Last night, in bed. - Some about rust of
rails. There is no distinct consciousness or
analysis of the made out - although there
is a slight bending of rational to slight
shuddering - 5.30. he is in good
awake while, but are bending bent fast or
much. The same apparell to the back of 
Special case: Yesterday, says he some things
shuddering suddenly. 5.4. - without a word.
but his hair is advanced. Parks equal
normally been witness since in space.

Organic reflexes normal. Plantar reflexes
slightly exaggerated. Patellar reflexes
about what it is:
He walks with no assistance, but "trot" from
side to side in a vigorous manner occasionally.
legs within naturally. Cannot walk along any one plane in floor.
(Case of John Buttman. Continued.)

When lying on back, can flex and extend leg with some amount of power.

Has not as much grasping power in hands as you would expect from his manner.

Walking: has only slight tremor of feet, and a little uncoordination.

No voice and no descriptive application.

Vital mental faculties not materially affected. Sleeps fitfully. Has had dreams.

The patient seemed dead in sleep to some extent.

**Respiratory System:** Normal.

**Circulation:** Heart normal. Pulse 90.

**Alimentary Syst.:** Almost complete anemia.

**Urinary:** Nothing to notice. Urine thick. Bladder contractile. Urine enlarged in colour and firm pressure. Measure 6½ in. W: apple juice.

**Respiratory:**


**Chemical:**

**Treat:** 1. Liquid. Cuprum. 2 min. X.

2. Ferrum. 2 min. X.

3. Acid. Mix. Hydroc. 2. 1 min. X.

Infus. Gent. 20 proof.

**Aler:**

1. Chenal Hydr.

2. Perred FREE. 10. 15.

**Note:** Complete.
He improved rapidly under treatment, and
leaved Hospital two days after admission.
He also slept well. On March 26, his
urine symptoms having entirely subsided
he left Hospital to join his ship, since
when he has not been seen.
Patient was an agitated man admitted into the
Inverfar Royal Infirmary on Feb. 22nd, 1841.

Complained of loss of memory in his legs. He had been an
in-patient of same complaint in 1838. (See note.)

History:

Name: Robert Alexander of Pitkian.
Father's history is unknown.
Mother's history is unknown.

Previous history: Patient admits to having "tangled"

Lately at times, his memory started being brackish.
Two years ago he had an attack of delirium
Tremens. In August 1838 he was put out of
work, and in consequence got little food but
spent all he could get in drink. At this
time he got bad general nerve disturbances, and
began to suffer from pains in limbs in
the feet and hands - his legs also got gradually
numbness temporarily. He then applied for admittance into this hospital - the Royal
Peckham as per the following note of his condition:

He complains of burning pains in his toes. Often
but that - pain radiates arms his calves
often feels feet cold numb - when they warm
they frequently feel red and heated.
Also have pain in the knee can't walk - joints -
There is marked anaemia of both feet &
toes as high as his knees - he can't drive.

From note clearly, below the point there is of
pain anywhere below knees - but recognition
the pain that is a pain as much -
Also suffers from numbness & frequent loss of balance or tremors - Says he feels it worse in his arms, legs, & hands. Inability to distinguish hands & fingers, even when he tries. He is unable to "hold his walk" for longer than half an hour at a time, & then often stumbles away from him insensitively. There is marked impairment in the strength, power, & use of arms and legs. The superficial reflexes are remainder increased & the patellar reflexes diminished in both.

The patient is frequently disturbed with bad dreams, & he notices increased memory. He has seen no change in his last few months. He speaks with a tremulous voice, & his lips are slightly tremulous. He is able to eat & drink, is able to learn & use a book, & write a letter.

There is much anaesthesia in the extremities. The pulse is 60 per min. He has lost a large amount of weight. He has a marked diminution in eating & sleeping.

W. W. (p. 1012. D. 0. 2. 4. W.)
In patient Morin, Dr. C. E. F. Dvorin -

hands felt pall "clamping."

He remained in Hospital after wards.

Aman with -chord of "Deformity.

Sedative. "Salt Diet. Calomel to

limits, daily, warm 4-6's, with

shampoos to legs.

He remained under treatment about

months, felt no much improvement -

the pain and swelling had entirely

disappeared, and he had regained com-

plete pain with no more sensible. All his

swellings had also dissipated. He had gained

10 lbs. in weight during his stay in Hospi-

tal.

After leaving, he remained in abstaining

for about a month or more weeks, when

his again commenced between in his limbs,

burning chiefly "Pain," while his hips

became affected again - he then returned

from Richmond on Dec. 25, 1864.

State on admission: Patient is about, and

Made man. About 6 ft. 1½ in. tall. Day an-

aline and General tremulous condition of

any noticeable. He has been sick frequently

the last few days. It is difficult to obtain

anything like a reliable account of his

and gotten symptoms during his so-called

sickness condition. He affirms someone that

the burning sensation in his foot was no hotter.
Sir, what he has seen had affected some in his calumtry of his legs which are distinctly
better in pressure.
He can now walk with the help of a stick, and then only with a few yards with an
invariable difficulty - his legs are very
shaky, constantly, but not always so.
His legs, hands are constantly tremulous
There is marked uncertainty in his gait and
staircase in his legs, especially in the
foot. His instep is high but cannot
also above his knees. All reflexes are
much diminished - the palate our full
being accentuated almost in both sides.
The features are flattening - but not much.
The features respond strongly to the
junction of electric current, but more readily
the continuous than the interrupted.
The palate has about the same degree with
He was ordered by General Whipple.
P. 1. Berrym. 2. F. 5. Berrym. -
(26. Love of Henry Spencer - Continued.)

08.00. IMPR. 105.

During day he had been briefly than usual.

28.00. IMPR. 105.

Pupils exclaimed - regarding only its look.

26.00. IMPR. 105.

Frankly, slept at all. Do not write.

26.00. IMPR. 105.

...here is anotherarium in arm or hands.

26.00. IMPR. 105.

Slept till 2.30. At 6 p.m.: Piller 10.

26.00. IMPR. 105.

Slept late. At 10.15: Set the table.

26.00. IMPR. 105.

Slept last 12 hours.

26.00. IMPR. 105.

Pillar 96, full campimune. A 2 yr.

26.00. IMPR. 105.

Pillar 96, full campimune. A 2 yr.

26.00. IMPR. 105.

Pillar 96, full campimune. A 2 yr.
At the time, he continued to improve daily. 

By Dec. 27, he was able to walk with a crutch. 

Dec. 31: Small, steady, good — growth noticeable. He managed to walk without the crutch for a while. But he was still weak and he felt a little sick. 

Jan. 7: He is still weak but feels better. His appetite is good, and he is keen. 

Jan. 15: He is still weak but is making good progress.
Case of Alice Slater, act. 53. Alcoholic Paralysis.

Patient was admitted into the Evangelical Royal Infirmary on August 26th, 1874, complaining of pain in legs, loss of power in his legs, feet, arms, and hands.

History: In detail of family history.

Present health apparently good. Her husband is a farmer. She has had 7 healthy children, no miscarriages. She admits having been very intemperate for some time—3 or 4 years. and lately she has been drinking large quantities of Brandy. The present illness commenced 2 or 3 months ago, with pain in her calves, toes of the feet; her legs gradually began to get weak and inelastic, she could not walk as far as she used to. The skin had great difficulty in getting up and down stairs. She said her grand felt out of motion. She lost her memory, feeling, and her ideas were confused. According to her history, account, she has frequently been morose and eccentric, especially at night; for the last four months she has been confined to bed, being quite unable to support herself in her legs. She has been trembling since last admitting for food training for dinner. She frequently
Pt. Mrs. J. A. B., aged 38 yrs. 

Present Condition: Patient is a poorly developed, unemotional woman, very somnolent, Jan. 15th. She seems to be in a semi-comatose state. Her eyes are closed, and she shows no reaction to any stimuli—voice, touch, or sound. She cannot give a clear account of herself, does not know her name, or anything else. She is still in a semi-comatose state. The following details were all that could be obtained regarding her nervous system:

She can only distinguish the front and back of a person or object by touch and sound, as far as one knows. She cannot feel pain if poked, nor can she feel any pressure. She has no pain in her legs, arms, or feet. She is often faint and cold. There is no apparent anaesthesia in the hands, feet, or upper limbs. She is very thirsty and has a strong desire to drink water. There is no apparent weakness in the limbs. She is unable to lift or move her arms and legs, and she keeps them in a semi-comatose condition.
cannot alter the present against a slight resistance. She is quite unable to stand. Episodic pain thrombosis of limbs - muscle weakness, numbness, more times numbness or muscle or trying to perform any voluntary movement - can suddenly 'nick' a pin from about ear / face - Graphs my tenuously - longer when protrudes my tenuously.

Cerebral mental functioning are much improved - cannot reflect. What help.

About days ago - seems very healthy. He is not currently called out or if in pain - but does not seem where it is only that the first burst her - there is an amount of pain - the marked activity.

Peter 107 - my small by far - severely per
spectate at worse. Heart sounds almost
in and this especially just - somewhat
intermittent.

Rapiditation 28 - burst tends faltering.

Some sombre part employment.

Sec. 3p. 3p. 1010 - part. and. to album

She suddenly faints at 12 p.m. about
before any time could be done - partially
for faintness, often heart - which seems
like appeared Cardiff, my friend, but all
likely and at fall, nearby.

Improves at 3 by Pat. recent could be made.

The family no Roman Catholics.
To Nov. 10, 1866.


Patient was admitted into the Liverpool Royal Infirmary (under Dr. T. A. Dawson) on August 18th.

She was brought to the Infirmary by some friends — she was quite unable to give any account of herself. The following brief account of her previous habits is now obtained from an often friend who brought her, and was subsequently confirmed by her husband. Who also was addicted to the use of spirits.

It appears that she had been married for about 7 years. Her present husband, I presume, not knowing that she had had several miscarriages, but no living children. In the last 3 or 4 years or more she has been in the habit of taking spirits pretty freely, unfortunately. The taking habits several times during the morning occasionally getting very drunk. She has been noticed to fall very unsteadily for some time past, and her husband states she has many occasions been planned of "The Rheumatic" in her hands and feet. She has been recalled in these that she had health for all these years.

The mind has been gradually failing for the
Last 3 or 4 months, and lately she has been
sitting in front of a crowded children in this
manner.

Present Condition: Patient is a small, man.
...red very quietly sitting in woman, consid.
...able older looking them by years. She has
...an extremely dirty, neglected condition.
...brought to hospital with a tauted
...that covers over the breast and both shoulders.
...the extremities were "faddly looking" and the
...enlargement of these areas was stated.
...red and swollen. She has generalized edema
...in the right side, with
...legs are flaccid at knees and hip
...joints. They cannot be straightened. The head
...muscles appearing atrophic and
...stiffened. The movements are such an
...stiff" condition, that it is impossible to
...from her arm. We able information as
...regards his autonomic symptoms. The only
..."it hurts" when her legs are extended
...or when she is tremulously picked up or
...Dorsal system: Nothing satisfying. The mode
...not causing the presence or absence of pain in
...sensibility, touch, pain, heat, cold, or art...
and markedly impaired lift in the upper and lower extremities. There appears the no complete absence of any effort but the condition is most marked in the fact that when the knee is when she does not appear to take any notice or yet perceive anything, unless she is forcibly pressed with a pen, pressed, or touched with a pin. Test taste the mouth at the latter but cannot discriminate anything apparently between a salt and a sweet taste.

All reflexes (except those) are abolished. She swallows cleanly normally, but jumps when arm is pressed beneath her, apparent unconsciously. There does not appear to be any indication of the facial muscles, excepting that of test taste. She gets confused between salt and bitter. Probably her senses are due to great violent the deficient mental power.

The true rotunda appears almost quickly paralyzed as she lies in bed. She cannot move her legs although she is able, but cannot move the feet at the ankle joints. She has any better power in the upper rotunda, which are extremely tremulous, especially the hands and fingers. The grasping power is extremely facile. The left hand being rather stronger than the right, there is also some improvement of this condition.
The muscles of the legs appear shown schematically, and are in an ostensibly abnormal condition. The muscles of the legs being evidently contracted, preventing his legs from being extended.

The muscles of the legs take full response to a constant current when a very strong one is used - when the thighs are brought down the legs are drawn up, but any other direct contraction takes place in the individual muscle. Also when struck at by the constant current. The arm is certainly very much incapacitated both in arm and leg.

It might be worth while to say that constant current - any other contract the being obtained in the leg, the leg remains when 50 to 100 volts are used.

The muscles of the arm appear to respond more readily than forms of current - but much under the average.

She feels badly. I think a good deal this - leg. It appears they begin not of a bell, but because it is, regardless of the instant leg in.

The arm is not strong with the constant current. She is very material. She cramp without apparent cause. She sits to the point but in a very suspicious manner.

Her appetite is very poor - letters mostly milk.
(2. Case of Margaret Lloyd. Concluded.)

Patient appears entirely normal.
Pulse: 100 - irregularly but distinctly to the count at least. R. D. Temp. 99.8°F.
Cranial contained slight of albumin.
She remained in practically the same condition her bed. 22st when she gradually sank back, apparently from blood evacuation. She had been gradually getting weaker for some time. Often refusing her food. Her tongue dry. Her gums almost unpalpable at the worst. She was at last, quiet, after eating, but not unconscious and last. She was taken in spite of her words. She had taken Bromide of Bellad. 22st 11.45.

Post Deatiment (11.45.) 24 hours after death.

Tongue dry, and small. Father competent - slight putty degeneration of the external carotids, especially after left hand cl. All the abdominal viscera appeared...
Family history: The family and kidneys were smaller than normal. They had no distinct condition of proteinuria.

Special note: Renunciates fairly healthy. Urine tests were done here. All the urines were proteinuria positive. Often they were very dilated cylinders. A small portion of the uric acid, along with some albumin, was found. When the fraction was normal, the albumin was gray. Maltern looked rather DDST was normal, but after hardening in Eulacks fluid for several weeks, this apparent softening was not perceptible.

Results: Supernatant: Renunciates engaged. The protein content did not present a noticeable proteinuria appearance. No urea or sugar was found. The 60-minute test was somewhat flattened and softened.

The culture in temperature looked thickened. The substance of the urine was firm, thickened, healthy to the naked eye. There were no signs of fluid in the ventricles.

Microscopic examination:

- (Cured in Eulacks fluid + spirit (1:3))
- 1st lecture: original column, short, narrow, less rods. The columns are not...
Student of the lumbar spine, and these little columns of the pother spine give rise to the spinal nerve roots, which are seen in the lumbar region. There is also some consequence of the connective tissue in the posterior columns in this region, although the nerve fibers are not clearly seen in this area. The pia mater is also found over the posterior columns, and as such the posterior nerve roots. The nerve fibers in the posterior columns are much compressed and distorted, especially the white substance of the cord. This change extends through all the lumbar region, but gradually diminishes as one approaches the lower dorsal region, in the middle of the latter. The epidural space is much less evident in the lumbar region than in the cervical region. The posterior columns appear to be affected more than the anterior ones, and there is also some sclerosis at the point of the posterior nerve roots. There appears to be a slight increase in the amount of connective tissue throughout the cord, but only in the marked degree in the lumbar region. The spinal nerves in the lumbar region are in the region ears. There is also some increased amount of the pia mater in the posterior columns (Slide 58). The blood of the gastrocnemius muscle stained with acid fuchsin shows some infiltration and fatty degeneration of the muscle fibers, themselves in the lumbar region in most completely lost (Slides 58).
Remarks.

In this case there was a well established history of intemperance, and also a preopinon of syphilis. The bed was which the latter was honest were the lung mischances, which in fact that the lung had a living child. The Progress of the case, so far as could be ascertained from the patient, was prudent, clearly corresponded in its essential features to those already described. She came under these relations at a later period in the course. The nature, such as the Paralysis was complete, it must be noted that clearly as of above to memory in the third stage, i.e. in the paralytic stage. Post-Paralytic in more of it is quite possible that there was a left body of the extinction continued in this course, but had the term been residing there to judge. I think the tolemae would have been monochromatic, and have occupied none especially the posterior rotational column in close contact with the posterior horn root. The Osseous in the cervical part most. The Osseous

\[ x + x \]
Case of Mary Edwards act. 39. an Office Cleaner.

Dr. xx.

Patient was addmitted into the Insane Asylum on Dec. 2nd 1847. Under the care of Dr. Glynn, in a delirious condition, and quite unable to give any account of herself. She was brought to the Asylum by some neighbours who gave what information from which they could conclude her previous habits to be. It appears that for the last few years she has led a very intermitten alcoholic life, having been reduced to drink during hours by some neighbours generally. She also appears to have had one or two attacks of delirium tremens - but nothing definite can be made out about them. She has been heard to complain very much about her legs, but this is due to the delirium tremens generally. She also seems to have been very quiet, not at all suspicious, and generally quiet. She was admitted with an extremity of alcoholic habit.

When addmitted, she was found to be extremely thin, with large head, sunken eyes, and drooping hair.
Her general appearance is that of a woman at least 10 or 15 years older than her age. Her skin is fair, smooth, and finely marked. Her complexion is fair, but there is a suspicion of a flushed appearance in her cheeks. Her hair is grey, and her eyebrows are thin and high.

She is of medium height, and her build is slender. Her eyes are grey, and her pupils are dilated, and they react moderately to light stimulation. Her voice is soft and fluttering. She sits on her side in bed with her legs crossed, and she is constantly muttering to herself. When asked what she has for breakfast, she only replies, "Marmoset in her legs." She appears quite unable to appreciate what is said to her; e.g. when asked to "give her hand," she makes no attempt to do so. When asked simple questions, she begins to chatter incoherently about subjects quite foreign to the subject. There is constant twitching of the facial muscles, especially those about the mouth. There are also very tremulous movements when she is speaking. The voice trembles very much when she attempts to produce it. It is very thin, high-pitched, and not very articulate. When she attempts to speak, the tremors increase, especially when she tries to speak voluntarily. She keeps her legs very rigid. Her plantar response is flexor.
Mary Edwards. Alcoholic Paralysis.
2nd 3rd 4th December 1884.

Pulse......120. 130. 150.
Respira....20. 25. 30.
Bowels......1
Urine......- - - -
May 3rd. Passed a very restless night, little sleeping. The whole time I kept on my feet by a constant struggle of the legs. She does not stand up, or appear to stand up, but while her arms work the feet are pushed downward with a jerk, but indistinctly, fails at anything else. There is no marked muscular effort. She passes both faces covered with a film, appearing quite oblivious. There is slight reddening of chest and abdomen on the movement of sitting up.

Chest is the prominent feature among the signs. Prostration, collapse at the extremities, where there is slight account of the face and face breathing with a few normal indrawing of the chest. High atelectasis. No short cough. Intercostal respiration.


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Dec. 4th. Looks very prostrate this morning. Skin and inner membrane more jaundiced. Pupils slightly dilated. Sluggish. Resides heavy in the chest. Did not sleep more than an hour last night, but did not feel as much. Arrows found this morning. Breaths with mouth slightly closed, lips pressed, making apneic efforts with the nostrils at each inspiration. There is a good deal of twitching of the muscles about the mouth, neck, and arms. Also about the forehead and temples, but not so violent. There are several patches of purplish capillaries about the face, neck, and arms. They disappear on pressure. The subcutaneous vessels of the face are also dilated. The whole face is a slightly livid thing. The whole arm, full of subcutaneous arteries, there is a tumor which feels hard, it is surrounded by distinct bordering of skin over parts, this extends down the inner side of the arm for 3 to 4 inches. There is also an area of redness just for the skin near the centre of the tumor, this extends also along the medial edge of the arm, the redness is fainter. The tumor seems to the subcutaneous area is of a very yellow colour. Began my dry cream.

Temperature 71°F. at 12 o'clock a.m. 105°F. Pulse 102. Very small. Generally, the count in Radials. Is passing large quantities of
(2. Case of Ranny Edwards, continued.)

Wound beneath her left arm could be passed for evacuation.

There is also a distinct haematoma in the left arm. She appears much weaker and later in body from anything in her body. There is no marked extension below the picture of the left arm with her fingers which are extremely tender. She gradually sank during the day of death, quietly at 5 p.m. on the same night. (14.5)

P.M. At the post mortem examination next day, no marked abnormality visible other than marked congestion of the heart and the posterior part of the spinal cord. They were also somewhat tender. The pit of the stomach also appeared somewhat more opaque than normal; as it also the medullary column of the heart. Somewhat tender from the touch. The heart, posterior to the anterior muscles, more pale suffused, but not very fatty. Nothing particular was noticed in the other organs.

Special

Microscopic examination of the neck:

Cervical Region. (Plate XVI, Fig. 3.) In this region there is very marked oedema of the posterior internal columns, containing about \( \frac{2}{3} \) of the depth with-reck. The change was at one point (marked on, accompanying

Note: Glandular condition, such in the case.
York Fig. 3. From. Examined under a high power fig. 5. The inner tubules are seen. The mucous can. shed and absorbed, but the inner extending a somewhat increased in size. The inner tubular connective tissue of these columns being greatly increased. There almost still Regmanni's connection in fig. 5. The other areas in the central region appeared fairly normal.

Dorsal Region: (Slide 7) I think there can be no doubt that there is some atrophy of the posterior median column through the influence of the posterior nerve roots. Let there be slight increase of the connective tissue often and generally, especially near the posterior of the cord.

Lumbar Region: There appears the area in this region a slight increase in the connective tissue in the same areas but too much to constant. The former the gray matter appears healthy in all regions.

Ganglia or Posterior dorsal Roots

Examine the first Ganglia upon the dorsal spinal nerve, and found an increase in the amount of connective tissue in and around them (Fig. 4. Plate xvi. Slides 43, 44.) The posterior nerve roots terminate, the Ganglia being joined with the spinal cord also contains an area of connective tissue which produced acellular amounts of tissue. Of the inner nerve tubules (Fig. 3. Plate) the posterior spinal, spinal and lateral spinal roots, formed similar changes, an increased amount of connective tissue in the substance of the nervous (Fig. 1.)
I also examined symptoms of both cerebral and spinal meningitis. Often there were often signs of the superficial meninges, but failed to discover any pathological changes in any of these structures. Those formed by the meninges of the dura mater, together with those of the spinal cord, meninges and nerves:

**Remarks**

The history of this case was as of undoubted chronic alcoholism, and here can be little doubt I think that the case was one of alcoholic encephalitis. A patient of the first kind the case under observation, and of a low medicinal faculty condition of the brain. The patient admitted into hospital, the patient was in a dysphoric condition, undeniably. Her general health and mental condition showed. Her case appeared the due to neglect, as the patient was in a horribly neglected and weak condition. They had been significantly it appears, and were not of the human of this type, confidential but were not with in some forms of encephalitis. Where there has been a direct indication of the condition.

The pathological changes found in the nervous system in this case, primarily was.

For more than of increased formation of brain tissue both in areas of pathologic and protein from the tibiae, and brain degeneration and the four closely corresponded with the changes found in case.
The spread and the chief changes appear to be those of early estate schemes. Other factors - in the form of ... rational columns of the position, or branch or the ... Industrial Region.
Alcoholic Paraplegia

Definition: alcoholic paraplegia is, as its name
implies, a form of toxic paraplegia, affecting
chiefly the lower motor neurones, but in advanced
cases spreading to the upper motor neurones. The disease
is characterized clinically (in addition to the usual
symptoms of chronic alcoholism) by Paralysis
Hypoaesthesia, Anaesthesia and loss of the
flexor, extensor and deep reflexes. By a burning
memory in the early stages, prompt to recital.
Came to be completely reversed.

History: The first to describe and name this form of
paraplegia was Dr. M'Intosh, who pointed out its
peculiar tendency to affect females addicted to
alcohol. These alcoholic drinkards also the first unit of
the affection in general paraplegia, in Somnambulism.
The same authors record three marked cases of
this disease.

The next English writer who drew attention to
the subject was Dr. Handfield Jones, in a paper relating
attacks "On Paralytic and Paraplegic as Results
of Alcoholic Intoxication." In this paper, Dr. Jones

References:
Reference:


The effect of the "light" on the "sound" was observed by the author in 1872. A "H.O."

The author's experiments demonstrated the possibility of transmitting information through the use of "light" in the form of "sound."
and also affirms that the encephalitis may develop suddenly, and points out the tendency to involve all organs, even the liver, if all alcohol be withdrawn.

Dr. C. H. Pollock, forecasts a crude method can act.

Mr. Reginald Thompson discovers the case of a girl of Vicenza. Habits of alcoholism in the family.

Subsequently, his limbs, then his arms.

In brief, the Posticum columns often failed and were found in place, and triumphantly marched, into spinal Journal accurate.

In addition, this case, the facts of this case, in which there were pain and degeneration in the hands, and legs, with paralysis of the columns sometimes in both nutritive action.

In all these cases the patients had been very intemperate. There were not the cases of bald paralysis.

Dr. Glyn's in another paper on alcoholic's paralysis. He sees the severity in the patient.

The symptoms are the result of the direct toxic action of alcohol. There have been recognized as organic change.

In other points of the occurrence of standing or standing after travel, often just above the ankle joint, they wrote.

Reference:
History: Alcoholic Paraplegia generally occurs in middle-aged females, rarely in males. Out of 244 cases, there were recorded 2 only for our 26 cases. The earliest cases age recorded on 1 April 1907 (Major R. Thompson, R.A.). "From inquiring", who only get through our villages and again are the most frequent victims, especially those who drink brandy, although whisky or gin may produce similar symptoms. An imperfect supply of nutritious food, exposure, and acceleration of disease.

Symptoms: The commonest, I think, the affection may be divided into the following stages:

1. Period of symptoms. 2. Period of remission. 3. Terminal period.

1. Period of symptoms: Alcoholic Paraplegia as a rule sets in slowly and progressively, very rarely suddenly. Usually the patient has suffered for some weeks or months from gastric catarrh with morning sickness etc.

Reference:
L. Clarke, ibid.
Pain.

In addition to pain in the legs, the patient usually complains of pain in the feet and toes. The pain may be present at night, being worse when the legs are extended. The pain may be described as a burning sensation in the feet and toes.

The pain is generally of a severe burning character, affecting the soles of the feet. It is frequently very severe, and may be relieved by movement. The pain is frequently associated with stiffness in the ankles, calves, and feet. The pain is often relieved by movement, but is frequently worse when the legs are extended. The pain is often worse at night, and may be associated with stiffness in the feet and toes.

Reference.

Anesthesia + Analgesia.

Together with these symptoms, there is generally nausea and vomiting, often with distress and anxiety. This may be very slight. The patient may have difficulty in discriminating between different objects when touched, e.g., finger tips, the hand, face, or at advanced cases it may be merely complete anesthesia - the patient may perceive all that a pinch of a pin, or a touch. The anesthesia is usually local on one side, and unilateral and opium is given in the case of the foot, gradually extending up the leg. In the great majority of cases, the involvement of certain nerves does not extend beyond the ankle, the knees, at any rate, during the early stages of the affection. At the first, the hands are the most affected. In many of the fibers being generally the parts first affected, it gradually spreads up the arm, but on the lower extremities, implicating the forearm rather than the upper arm. In American patients, one hand is more widely spread. Formerly, e.g., muscular sensibility.

1. Anesthesia: In the early stages of the disease, this is evident. The muscular contraction caused by the faradic current gives rise to a numbness, often pressure on the arm, producing the same result.

2. Sensation: This, as limited by weight and touch, remains impaired from the commencement. The patient becomes
June 8th 1893

Mr. A. W. B. wrote out a Memorandum of death by typhoid fever and tumour of the liver, with the note that it was not perfectly performed. The remaining cases of the muscular tumor generally present day for
discussion at issue.

The condition of Paralysis of muscular sensitivity or
paralysis in the paralysis is manifested by an increasing feeling of fatigue or
prostration after slight muscular effort.

The frequent presence of muscular cramps in calves, especially at night,
and most alarming painful contractions of the tibialis anterior muscles - at bedtime.

This was well marked in case A.

Special Signs: Pupils were generally contracted, then dilated.

Sensory Deficits: (i) Organic Reflexes: Pupil affected in

Early stages, but towards end of year little.

Sensory motor paralysis in organic cases.

(ii) Skin Reflexes: The Plantar reflex is slightly

increased at some cases during the early

Stages. But abolished during the later.

(iii) tendon Reflexes: The Patellar tendon reflex is

diminished from the commencement, though,

it is almost invariably absent (bilateral) or

only so, when the patient comes under exami-

nation. It finally & always totally abolished.

(iv) Voluntary: On a return with development of
May 1939: Phenomena then so gradually in.

Cessation of voluntary power in abstraction of the legs. The patient, first with his biceps, readily fatigued - he then finds difficulty in walking steadily. His legs becoming tremulous and time monotonous with continued. He sat though constantly more or less laborious. There is no static movement out of his legs with possible bringing down of limbs with ground. But motion are uncertain as to the manner of placing the feet, he is generally unable to walk continuously along a narrow piece of line on the floor.

When the muscular power is tested by the laws, e.g. against resistance of another person, it is found that there is marked weakness as much as the lower. Winging according to the degree of the affection. As a rule, the feet and hands are affected more than the legs. Sometimes, the flexor and the extensor - and the same affects of the arms and hands - leads to Mr. Reginald Thompson's hearing reports. Cases of paralysis of adductor nerves of lower, due to chronic alcoholism. Loss of power in the upper extremities is primarily observed in the fingers. The patient being unable to perform actions requiring delicate manipulation, highly coordinated move - ments, e.g. writing. Impairment of grasping power and manifest itself, and finally...
(3.) There is in some cases complete inability to perform any manual work. As a rule however, the patient is incapacitated from active work only. In many cases the arms are affected to varying degrees, and in some cases, practically useless. Associated with this Paralysis, there is almost always some other tumor, which affects equally the muscles of the head and neck, as well as those of the extremities. The legs are tremulous when walking, and speech is difficult. The tremulousness is more evident constant tremor of the fingers and hands, of the legs in walking. There is also fibrillary tremor of the fingers, this is chiefly noticeable in the muscles of the face and tongue, but is also frequently well-marked in the other arm muscles, especially in the extensors.

There is also right incoordination of the muscles. Of the hands have been referred to under the head of muscular tremor. I have especially examined the extensors, it is only present to any right incoordination in the early stage.

Finally, the face becomes pale and cold, occasionally flushing of the face (entirely surfeet, especially) the hands (palms) are well marked, at other times blanching of the limbs to the same situation. When flushing occurs, the face's palms become extremely tender and hyperesthetic. So that the patient is unable to put them in contact with each other.
The ground, therefore, is the pressure of what must contain are Hamilton, and really some more than on any other. The burning sensa-
tions are also intensified by glistening-
In advanced cases, however, private are frequently present. They appear to be chiefly to fill the bladder, owing to the uncomfortable sensation of bladder on the chin in bed, but of the tympanic lumen of the tympanic center. The lowermost generally occur over the back, or on the lower, but rarely in

The points of pressure are referred to the same predisposing causes on the head, behind of the buttocks. Sometimes the lumps are a considerable extent and depth. The Patient is almost invariably gone when associated with time he keeps titter from

Special symptoms. The muscles are generally fluffed in the lumbar part, but they are
In marked attempt in the early stages at any rate. In constant change in the electric reactions can either be said to occur, beyond the fact that individual suspension, painfull muscular contractions due to

Cerebral symptoms

In this Stage, the patient's intellect has not be-
tome materially impaired. His mental powers
is greatly limited, and his intellectual
power diminished. It is seen very much de-

pends upon the length of time, and the
amount of alcohol the patient has been consuming.

In all the cases of this affection that I have had the opportunity of treating, the pulse has always been extremely small and weak, excepting in some rare cases in which there have been various cardiac or renal complications. In these cases the usual gastric and intestinal symptoms of chronic alcoholism have been present, but in the cases which have come under my observation, there has been a remarkable immunity from convulsions of the liver or kidneys, although, it is admitted generally accepted fact, that "mass drinking" is the most frequent cause of alcoholism in its effects upon liver and kidneys, and generally produces convulsions. It is impossible in the present state of knowledge to explain the first stage lasts from a few minutes to a few minutes according to circumstances. The symptoms recur for a time when alcohol is...
III. Paralytic Stage: The term Paralytic Stage is used to denote the phase of Paralysis, because the essential characteristics are similar to those of General Paralysis. At this stage, the symptoms become more pronounced. This stage is marked by a further development of the previous stage, with exaggerated symptoms. A typical case, briefly, proceeds to the following Clinical Picture.

Generally, the patient is a middle-aged woman, looking older than her years. She is pale, Feeble, often very less communicative. The conjunctivae are "muddy." She is inquired that, or this or that all day, complaining of mere pains in all the limbs, especially in the lower ones - or of numbness, tingling to. As a rule, the legs, which are consistently associated, are kept in the position of semi-squat, and much pain is produced in the hamstring tendons. Sometimes, it is noted that even attempt to straighten them - frequently, both legs and arms are extremely hypotonic, to the touch, and the calves are entirely so, especially if the feet be cramped. Abrasions remain there, no marked muscular atrophy is apparent, only muscle weakness. This condition being further advanced in the legs than in the arms.
(4) There may perhaps be some cases of amnesia in the trunk. The muscular power is also diminished, and the condition of the sensory nerves has been greatly modified, if not completely lost. This is especially true of the flexor muscles. The legs are nearly useless, and is utterly unable to stand or walk, or only with great effort.

The patient is markedly improved. Also in the arms. grasp is power extremely feeble, frequently to perform any motion of the arm movements with hand syringes.

With caloric, where there is not generally pain in the arms of feet, we encountered

There is always some or less general cramps of all the voluntary muscles. At this stage, some of the face swells as a result, having chiefly affected the hammocks of the considerable constant in the legs. Kidneys are very variable.

All the superficial and deep reflexes are almost entirely abolished. The patient is tender to the first degree, and generally entirely about - andPancreas coordinative is marked by improved.

The state of this stage from muscular wasting, to some extent, which is or not in the patient is at all neglected. The face and the extremities described in connection with the first stage anterior extremity - The Central and Postera
Faculties are severely impaired. There is great moral personality. The patient is often irritable or irascible. There is loss of memory, want of attention, misgivings, and sometimes delusions, misery or melancholy, lying in the mind or in the body, occasionally there is much dreamsomeness. Speech is frequently involuntary. The pulse still retains its small volume character, the thin hypophrenic, alternating with languid, unnatural, or very rapid, according to circumstances.

After remaining in this state for a week or a few weeks, the patient generally passes into the final stage. The patient may seem to be perfectly recovered, by means of delirium, from which the patient can be kept under strict surveillance.

Terminal Period: In this stage the patient is reduced to his sin and utterly helpless condition. The inner convulsions are much reduced to merely vertebroplasty completely perfect. The skin of the body is thin, and it cannot be expanded without considerable force, without producing much pain. In the case at hand, the hamstrings were pretty firmly contracted. She wrote some words in arms, but very many limited amount. Gasping pangs almost
The process usually begins with fatigue and weakness. There is some induration and stiffness in the neck and the arms. There is some muscular strain of the legs and arms. The generally poor. The arms often involuntarily, and the hands are frequently paralysed. Often extensor fully. There is generally in acetabulum. From new elements and there's gradual incoherence. Gradually developing ulceration. By ulcers, ulceration, ulceration. There is so extreme proportion of strength the long on is the arm strong. The flexion fetid discharging aseptic patella. Pain extremely little, sometimes due in an aseptic without. The is practically a aseptic condition. The ulceration is frequently caused around the open, probably from aseptic ulceration from the bed-worms and the gradual wide. These ulcers do the from gradual aseptic ulceration. Septic empyema (as in case G) or from sudden failure of heart (as probably occurred in case G)

Pathology: Unfortunately very little reliable information exists concerning the intricate changes in the aseptic ulcer and in their varying affection. I think there can be no doubt whatever that it is a distinct affection mostly of the name seen in the past by Dr. Wyllie

D. McDermott, aged 24 years, was last seen at 11 o'clock at night by a police constable. He was found on the ground in a state of deep unconsciousness. The police constable, who examined him, said he was more than 3½ years old, but did not present any of the phenomena of senility. A witness, named \( \text{Dr. O. M. Linnell} \), said it was extremely doubtful whether his case was one of simple alcoholism.
(5) A morn, ad. 42. In temp. - Illusory vision with
panic all over - especially in back, left arm.
Anesthesia of legs below pat. of biceps - nurse.
forms - also analgesia. Marked paresis in
extremis German facies. Large strong
Subpo. 10. 3. death.

2. low Cong. only aware - all extremities of
washer, machine - cool felt small
At lower end of spinal region, protrusion i.
Natu was marked as string of fluidium of
portia of superior colica (Ant. corner of
gray matter) at arch its position above
was confusion of the arch column, but not
affected. Except at the posterior lateral fossa
where the protasia columns join each
and the lateral column of the skull, with the
protonia nerve roots in them compare, had
undergone at mercant....to complete fraction
lobe of cerebrum. The gray matter was very much
different in form. The less protasia core was
being brought nearly together in the decussation
line - the middle superior spinal region
was protasia mechan. To the lower part of the
terminal enlargement was an area of
asymptomatic gray matter. The pia mater was also
the spinal cord, the medulla & Pons was
more perfectly united. The Caudal 3rd &
Mr. Brain were dilated with clear fluid - the cranial bones were thickened. The tissue was enlarged.

Daily, and 50. and to the right of anterior... often near a print of Brand's daily. First pains were
slowly, gradually, for several years, to become finally complete - so that he could not stand. At the Post Mortem examination, the spinal cord looked smaller than normal, and the transverse columns appeared puffed in this area, but otherwise they were normal.

There were degeneration of the columns in the Transverse column, especially in the Transverse region. For other details are given.

Plate xi

In the case which came to the examination the deformity was more pronounced. The chief changes appear to be more or less of the Transverse column, especially in the Transverse region, where it is most marked in the Transverse columns, and in the Transverse columns of the Cervical region. This later condition is well shown in this technic illustrating case xxi. (Note)

There was a marked thickening of the column in the Posterior columns, especially to the right side, and also of the peripheral nerves. (Posterior third - peripheral nerves, etc.) From a thickened increase in the amount of connective tissue...
and in part in persons after some turbinitis.
Unfortunately, I only re-emitted the latter formality in this case (xv.) so at present it is impossible to make practically concerning time.
The changes described above were found illustrated in Plate xvi. and xvii. (Fig. 4.)

The pathological changes would be quite sufficient to explain the symptoms in such marked cases of this disease. It is quite possible that the latter may affect chiefly articular joints in the fingers and [as] the poison is absorbed there... and the early symptoms of the affection may probably be simply due to the toxic effect of the chemical upon those areas (e.g. the burning pain, the whole combination of its acute...) and this appears when the poison is introduced. It is hard to account for the acute

vomiting which the majority of patients make permanent by all alcohol be applied, under any other hypothesis... but one can readily understand that if the poison persists in habits, irritation, to constant irritation of the cord and the pain and opium doses may lead to actual pathological changes in the nervous system. Much in the same way as it appears to act when the poison (e.g. the irritants...) It is most probable to definitely present at present in what particular tissues the pathological process originates...
just reasoning by analogy, it is highly probable

think that it begins in the connecting tonic el-

ments of the nervous system, and that any change

found in the nerve elements themselves are of

a purely secondary character.

Referring to some later amendments to show the

effects of long continued action of strong ad-

corticoids administered in frequent but comparatively

small doses, would be of the greatest impor-

tance in throwing light upon their most interest-

ing effects on the incidence of which

there is still doubt. Indeed, the above cases, in the

face that they were from of some value in

their investigation, still remain the same.
(c) Diagnosis and Prognosis:

Aesthetic Paraplegia may be mistaken for one of the following diseases: (i) locomotor ataxia,
(ii) General Paralysis.

From Locomotor Ataxia: A. Points of similarity between these affections - I. Paroxysms of sensory numbness in the lower extremities. II. Locomotor ataxia. Paroxysms are commonly starting at burning pain, felt chiefly along the posterior aspect of the leg. While in Aesthetic Paraplegia, the pain is chiefly of burning character, affecting mostly the toes of the foot and sometimes the hands. The pain is also frequently marked by psychosomatic changes, such as restlessness, irritability, and insomnia. The former affection is rarely met with in the latter - it is not uncommon in the early stages of Tuberculosis, arthritis, or the patient suffering from various Paralytic epilepsy. In Paralysis, the limbs are in the early stages frequently sensitive to muscular twitching. In both diseases, anaesthesia and analgesia are early and usually well-marked symptoms. Severe speaking difficulty, as regards the sensory phenomena, may occur early. The two affections closely resemble each other.

The points of similarity lie in the absence of the characteristic posture and gait.
gait. This is only present in any slight intellect in the alcoholic paraplegia.

The Babinski reflexes are almost universally absent in both cases—although they appear early, rarely more completely absent in the alcoholic


    locomotor Ataxia affects males between the ages of 20 and 50; 2. Lakes is rarely caused only by alcohol only. 3. Early symptoms of Ataxia are hemiplegic paraplegia—1st. Otic symptoms to then are rarely observed in alcoholic paraplegia. Unless associated with characteristic sensory abnormalities. In one of the cases there recorded there were hemiplegic diplopia. Early bladder or rectal trouble is not uncommon in Ataxia while rare in the alcoholic. 4. Alcohol in the life amounting to distinct Paraplegia may

other are hemiplegic symptoms being in

     some difficult. The Bagby Robertson Phenomenon has not been observed in alcoholic

person as far as I have aware of. The motor

Later affecting there is well marked loss with slight ataxia often in the legs, there orders in the

arms left, from the onset and unless

interception can be entirely withheld gradually progresses—while in Ataxia.
When once the characteristic symptoms have shown themselves. There is some or no evident loss of power but mental aberrations - in the latter, delusions, marked or manifest. The sense of hearing is greatly impaired, while psycho-

constant in the former. In the latter, the arms are only affected later stages of aberrations, but become implicated early in all. In all, the central mental faculties become more or less seriously impaired but usually remain unaffected in aberration.

The eyes at first vary; solely in alcoholic paralysis, but quite abnormal of the optic disc, is marked as follows: as an uncommon symptom in aberration.

in the latter, nitric gastric, renal, cardiac, crisis occurs,

5. Late symptoms: Complication: In the last stages, there is a greater resemblance between the two effects. In part, the patient is almost stupor, but not. The muscles of the mouth, neck, back, and arms, are almost without movement, the arms, hands, and legs are stiff, but less so. The patient becomes more restless, delirious and drowsy; coma; often by complicated often induced delirium.

To summarise: the main points of difference between the two effects are as follows:


The second characteristic paraplegia the taking patient being taken of pain, with morning a.m., and anal-

...
Storks - will marked peculiarity at attention. While they of course to Atrony are showing some
peculiarity, another centre store in and chiefly.

Sore - will marked Atrony, while actual
peculiarity, 1 has occurred atrophy, while any
great of the mental faculties, which exists to
marked Atrony in the forefathers.

Sore's Atrony generally lasts a shorter time
and is probably rarely fatal. While Alco-
holic Paraplegia, may under the test.

devil from in the early stages of all al.
what he will need.

II. From General Paralysis: - the known
points to be attended to in forming a differential diagnosis.

1. The history of the case - as regards
memory. (2.) The mark of most obvious
features. General Paralysis most frequently
affects males. In females, it first breaks out
in the muscles of the extremities, especially
gradually spreading through the whole system.

Often attended by severe headache, loss of
memory and loss of intellectual perception.

In the majority of cases under all strain and is stopped.

In Physical changes, common are the mani-
feats of dysphoria between the two discarnes.

Although there may be paresthesia of the usual
faculties in Alcoholic Paralysis, amount to usual insomna - slight time are lost
the mild acti of rediorganiser, and the slow
71.- Ordinary mentalochaetision, as characteristic
of the former.

The Prognosis also is different in the two states:

(a) in alcoholic Paralysis, too, all their
abnormal art will yield, and nature has no further
beyond the last stage. The Prognosis is for-
wherever in General Paralysis, as it is amissably
had.

Medicament. Vertically, agree with T. Rachel (tap.

Now he says the only cure of this affection is
then the little with a small piece clivirus
leve a slower, and at the truly remarks, that
in his experience he has met many cases com-
imply toward recovery from the withdrawal of the
alcohol. This is the only plan of treatment
for the pale straighten.

My advice. A half measures
must be half-formed. The patient must
be well fed on the most nutritious and
salty, the greatest heat. Examining
straining to make applications with
constant current may be employed-to
fibril with peruvian balsam. Before breaking
the letter showing

Omits compounds previous with to
visible. The burning for alcohol may be
dealt with in the usual manner of
expression to. It is recommended that
the patients receive in Hospital, when
the above measures may be effectually carried
= Synopsis of Case of Alcoholic Paralysis =

**History**

1. **Symptoms**
   - Upper extremities: Slight paresis, weakness, and atrophy.
   - Lower extremities: Slight paresis, weakness, and atrophy.
   - Autonomic symptoms: Frequent urination and diarrhea.

2. **Past Medical History**
   - Previous illness: None.
   - Family history: None.

3. **Physical Examination**
   - Vital signs: Normal.
   - Neurological examination: Minimal weakness in lower extremities.
   - Autonomic symptoms: Frequent urination and diarrhea.

**Course & Treatment**

1. **Initial Treatment**
   - Fluids and electrolytes balanced.
   - Nutritional support.

2. **Follow-up**
   - Improvement noted in strength and coordination.
   - Discharge plan: Home rehabilitation.

**Diagnosis**

Alcoholic Paralysis

**Notes**

- Patient history of long-standing alcohol abuse.
- Symmetrical weakness in both upper and lower extremities.
- Frequent autonomic symptoms.
<table>
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<tr>
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<th>Age</th>
<th>Sex</th>
<th>Height</th>
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<tr>
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<td>1</td>
<td>M</td>
<td>5'8&quot;</td>
<td>150 lbs</td>
<td>5'8&quot;</td>
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<tr>
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<td>2</td>
<td>M</td>
<td>5'8&quot;</td>
<td>150 lbs</td>
<td>5'8&quot;</td>
<td>150 lbs</td>
</tr>
</tbody>
</table>

**History:**
- Family history: Father and mother both alive.
- Personal history: No significant medical issues.
- Current symptoms: Headache, dizziness, nausea.

**Physical Examination:**
- Vital signs: BP 120/80, HR 72, RR 16, Temperature 98.6°F.
- Head: No obvious lesions.
- Neck: Full range of motion.
- Eyes: Normal pupils, field of vision intact.
- Ears: No hearing issues.
- Nose: Normal nasal cavity.
- Mouth: No swelling, normal gag reflex.
- Throat: No pharyngitis.
- Chest: Clear breath sounds, no rales.
- Cardiovascular: Regular rhythm.
- Abdomen: Soft, non-tender, normal bowel sounds.
- Extremities: No edema, full range of motion.

**Laboratory:**
- Complete Blood Count: Normal
- Serum creatinine: 0.8 mg/dL
- Electrolytes: Sodium 140 mEq/L, Potassium 4.5 mEq/L

**Diagnosis:** Migraine headache.

**Treatment:**
- Analgesics: Tylenol 325 mg q 6h
- Rest: Adequate sleep
- Avoid triggers: Bright lights, loud noises

**Follow-up:**
- Recheck in 1 week

**Remarks:**
- No significant findings.
- Patient improves with treatment.

---

**Symptoms:**
- Severe headache
- Nausea
- Dizziness

**Course:**
- Improvement with treatment

---

**Differential Diagnosis:**
- Migraine headache
- Sinusitis
- Meningitis

---

**Conclusion:**
- Migraine headache confirmed.
- No other significant findings.

---

**Case Management:**
- Monitor symptoms closely
- Adjust treatment as necessary

---

**Contact Information:**
- Dr. John Smith
- Office: 555-123-4567
- Email: dr.smith@hospital.com
Case of Mary lavender, act. 3. Post-hypnotic
Paralysis.

Patient was brought to the Dr., patient born at
the Children's Infirmary, Liverpool, on Dec. 19th 1839.
and was admitted as an in-patient the same
day, under my care.

The following particulars were obtained from
her mother: They lived in a very crowded house.
About 3 months ago, an out-break of diph.
Tuberculosis occurred, and many children who lived
in the court were affected, some of them dying.
The child first showed symptoms of diphtheria:
Difficulty in swallowing about 9 or 10 weeks
ago, she was confined bed, constantly pro.
Nate, she could scarcely swallow anything
her voice was not unlike "octocut" (profanity.
 According the mother, she
very nearly died from "weakness" then ap-
ppeared the no marked dyspepsia. She Remain-
d to an able from about 10 days; knife first
with abdomen. About a month after the
back of the neck, where she was apparently
wells, paralogia came on. Her mother
first noticed it in her arms and hands.
she frequently gotinema, and could
deliriously keep them up again. She then be-
egan to lose power in his legs, would not
walk, and speech became in distinct, and
for was registered through the nose.
sometimes almost choked her. She could not sit up - felt she was stupid, and her head getting distinctly worse.

Present condition: (Nov. 1915 - 1932)

Patient is a pale, anaemic looking child.
(Formerly, same strong healthy looking)
with a countenance void of expression. (Meaning:
looking"") has a lack part of the right eye.
She is just able to bear her weight on
her legs, but not more. She is not able to walk, written almost entirely support - he just
in the somewhat altered.

Paresthesia.
She does not complain of pain
anywhere. It is extremely difficult to obtain
any information regarding, and her chief symptoms, on account of her age. She says that
she is unable to feel the foot, both foot, left.
There is marked anesthesia
in the foot, on either side.

There is ticklish, pinched, or even when firmly
pricked with a pin. There is also anesthesia
in the arms of the patient's hands, but there was nothing
in the control of the sensibility of head, face.

Medically, she is involved in:
There is marked anesthesia of the left arm.
flints, pieces - phalange, superficially opened up - part of the tongue - there is no definite abscess in laming plantae, i.e. Ford is constantly regurgitated through the nose, and occasionally finds its way into the tongue, producing frequent fit of choking when at the later part of engorgement.

She passes her hands from beneath her, apparently without noticing them - she dart calls her mares inquisitive or afflial - precociously she always both her and her.

The special zones . . . appears the importance, but without definite - can be deduced.

Purposes are directed at one time, exhausted at another, but always lean gently right or accented.

Water (Minerals): (Organic stuffs) As already stated fluids are degenerated through the same, to the basis starting alterations - the membranes soft,台北 her, the skin tightens or harder food.

Respiration 13, per min: somewhat long established.

(As physical signs in lungs to account for this) She passes over the base beneath her. In her

Skin - softness - plantar about - abdominal

Joint, posterior intercostal referres slightly

Infected: (Minerals) about in lift

Voluntary - she can just stand, with slight assistance, cannot walk unless almost entirely supported - said him somewhat otherwise.
She has very little power in her hands and arms—
can carry out a book about 3 or 4 inches—
is very helpless with fingers.  

The 4th position—
there is also loss of coordination of arms too—
slight retroclined.  When lying on her back, she can
not raise herself without assistance, but when
placed in the sitting posture, she is able to main-
tain herself in that position for a few seconds—
but her head falls either forwards or backwards
and she sits down a little last.

When asked them out asleep, she also makes
false attempts to do so, only occasionally suc-
sceeds.  She never makes any of the facial
mirrors.  Rare attempts to smile or express
something.  Her partial profile is
slight retrusion of the eyes.  She
cannot close her eyes properly.  The upper lid
remains slightly horizontal projection, but moves
upwards fairly in all the
reclining—little outward from her corneal
she appears the only able to protrude in a far
as far as the lips.  The speech is very indistinct—
the only recognisable word being
"mammy."  There is much loss of power in
also supporting the head, which she cannot hold
steadily.  It tends to fall forwards or backwards
or to neither side as the case may be.
2. [Handwritten text]

The fact...

A/ Central Nervous System: She is very apathetic and takes very little notice of what is going on around her. She lies in an almost comatose condition and it is extremely difficult to elicit any response either by questioning or by physical contact.

Respiration: 18 per min. Slow and labored. No abnormal physical signs in lungs. Slight cough, no expectoration.

Pulse: 96, regular, fairly strong.

Temperature: Tongue furred; no appearance of any ulceration.

Diagnosis: Post infectious Paralysis.

Treatment: Milk diet. Quiet room 1/2 about. Egg.

Post mortem. Zili: Thick, firm, pulcher m. v. i. f. s.

Excretae m. 5: t. A. S.

Also furring by warm flannel to limbs.

She remained in the same condition for about two days but then began to get rapidly worse.
Ford was taken with increasing difficulty, the
was therefore partially fed for breakfast - by means
of a mixture of Pancreatin, milk. She became
more paralytic, at the last lasting without a shadow
of anything. She was, therefore, fed with a mixture
of milk and water. The temperature remained subnormal.
The heart and respiratory functions continued.
There was no sign of action of the diaphragm.
Breathing was chiefly being carried out by the
lungs. On June 20th, the could later no
food by the mouth, and was entirely fed by en-
saline. On June 27th, the pulse became very
severe, and intermittent, alternate in constancy
- sometimes perceptible at the brisk - she
died suddenly, apparently from collapse of the heart.

Physically: posterior - the remainder for normal
and only now of a mixture of milk and difficulty.

Port Ischial Region: The area at the lower
posterior end was much congested. Nothing
abnormal was observed about the rectum.
Infantile region. On making Trousseau's
action of the end drum in the lower
Region, it was almost apparent that there
was an exudate oozing from the
upper incision region. (The white muscle
appearing healthy) The left leg's splint
muscle was more affected than the right,
and it was difficult that it flowed out from the

Page 28th:
Microscopic examination: May VIII. Silesia, 87 of sep.

[Sections cut with care could bear him out; just considering the confined condition of the cord—]

Cerebrum Regmi, gray matter. (Slide P.B. 84.) A great portion of the left ventricle of gray matter was found to be completely destroyed or nearly so.

Left fiber (fig. 1st.) The gray matter in the immediate neighborhood of the frontal portion had undergone considerable changes. Many of the ganglionic fibers were of the cunei, some of them being destroyed or in a state of slowly decaying. (fig. 2.) Some fibers showed a marked diminution in size, and had lost their processes. There was also considerable increase in the number of nuclei. (fig. 4.)
infiltration of the gray matter with increases.

The gray substance in the right half of the cord was in the early stage of softening. The nuclei. 

Vermis and lateral appeared the increased in 

number, and showed evidently. For changes of 

nucleus there was observed in the upper portion 

of the cord, beyond clearly, swelling of the 

nuclei cells, and increase of nuclei.

Remarks:

The deficient there is any doubt that the cause 

was one of the diphtheritic paralysis. 

The history of this patient, prolonged in a few weeks, 

by the symptoms of paralysis which had all 

the characters of diphtheritic paralysis. that 

Diagnosis stands beyond a doubt. It is 

well known that when the paralysis first 

appears some weeks after the diphtheritic par- 

yphus dismembered away, that the cases are 

much more severe, more generalized, and 

more prolonged; as a rule, however, the 

healing is not the diphtheritic. However, the 

hearth occurs, it is generally from failure of 

the heart. Unfortunately in this case we had 

no opportunity of examining the condition of 

the heart, one of its features.

It is at present known concerning the ac-

tual pathological processes in the nervous 

system. The generally accepted opinion is that 

the paralysis depends upon a pernici- 

ous Pernicous disease, and the duration is here-
four closed amongst the Peripheral Paralysis.

Chêver-Vulpian 5 is a case of Atlantic

peripheral. The left palate was affected in the

across any playing in it. The medullary sheaths be-

ming broken up into gelatinous masses and gran-

ules, just as occurs in the peripheral and 2d 6

darve in the lactic. Similar changes in the

nerve have been found by Lammi 7, Alperin 8,

donor, by Lammi 7 in the lactic nerve. Lejèraine 9.

The most frequent changes in the nerves are

secondary to changes occurring in the under-

serving cells of the anterior horns of the spinal

Vulpian 4. Observed that the cells in the posterior

gray matter became hypertrophic and hyperplastic.

that there was a slight multiplication of neu-

cells. He also described anomalies often con-

developmental after position and retral position of

the anterior horn.


References.


Many of the candidate cases of the Antoni's syndrome had become surrounded from having lost their presence, and they contained fully four times their interior.

It is therefore seen that a large number of the difficulties are resolved upon the nature of the processes acting upon the peripheral nerves. Beyond the slight changes found in the extreme points of the anterior corona of the spinal cord, already referred to, there appears the only four recorded observations concerning the intact nervous system itself.

Thus here can be therefore little doubt due to that the disease is frequently alluded. Often from peripheral nerves, i.e. a multiple denervation; but in certain remote cases, the spinal end by may hence affected secondarily by extension of the process from its more remote - known myelitis (according). I think my own case lends the support this view, but it is at present unpreanted to say in what way manner the process is originally started. If it were in any way due to the direct influence of the limited process upon the nerve tissues themselves, one would certainly expect its effects the manifested at an early period after its history yet it is not at all uncommon for normal body and certain weeks to observe the slight myelitic process has apparently cleared before any systemic symptoms de-
Before the author develops the problem further, a passage seems to be missing, discussing the sudden death by stroke of a heart. It may be that the stroke is a sudden, progressive one, and may produce paralysis at a reading a certain stage. The medical problems are often attempts to explain the actual phenomena from these common events, must be purely theoretical.
Case of Agnes Turner, aged 6, Diphtheritic Mucousitis + Post Diphtheritic Paralysis.

Patient was admitted under my care into the Infirmary Infirmary for Children on Dec. 18th, 1884. Suffering from a Diphtheritic Cough, Swelling over the Vulva, and great prostration.

History: Family history important. Has never been away from child. Had measles last year ago. Present illness began about 2 or 3 weeks ago. At this time most of her brothers and sisters (6 in all) were suffering from lobar pneumonia,bronchitis, &c., and weakness.

Doctor (referring) stating it was of a Diphtheritic nature.

Her mother first noticed the vulva inflamed. The child complained of pain on making water, &c. Pain difficulty on sputum. She has also "fallen off" since her mother's own words, has lost her appetite, and become very talk and childish.

Present Condition: She is a well nourished, rather anaemic looking girl. She seems to be weak, especially in the muscles of the back of the neck; all her movements are slow and laborious, but there is no distinct paroxysm at present. In examining the vulva, no following condition was found (as noted) -- Scarring with little labia, from the fold of the hymen to the prepuce, + tender of back.

*She afterwards stated that when the rest of these symptoms she had fallen over in some running briskly between lessons. It is therefore possible that the cause was some strain on the labia, which became more ulcerated according to the Dr's notation (on)}
vulva, and along the whole length of the
Poulineur - is a diffuse inflammation, being
a patch of redness on the inner and out-
terior surfaces of the labia majora. (on
each side.) The ulcerated surface has a raw
untreated appearance. The edges of the les-
ion are well defined & sharply cut. There is no
papular phenomenon. The detached - but flakes of
yellowish - gumato changes can be discerned.
There is generally a discharge from these
ulcers, but rare extremely festitious odors.
The plaques on the right inner labia
Porpora disposition - I have supposed
to speed up autolytic - clearing & dissolu-
ing process. The plaques on the left goni are
extraordinarily enlarged and tender.
The complainant is able to bear heat but
beyond. All other constitutional congestion.
Skin intense flare. Nothing abnormal can
be seen.
When sitting up, her head hangs forwards.
She supports herself by her arms extended
behind her, her hands resting on her head.
No voice. Rather husky, but not distinctly
asphonic.
Temp. 100°F. Pulse 90. Regular rhythm.
Drains my lumps gelatinized. Measured albumen.
Treatment: The intra ear Managed. Chemi-
with gleyformi of Carbolic acid (1-2 0\%) +
unusual amount linia daily, with Cortycz's
Dec 22nd. Her last two days she has been getting steadily weaker. She has a very recent exacerbation. Her nose, mouth of face, and the whole mouth kept partly open, as saliva trickled out of corner of mouth. Speech of both upper and lower moderate, dilated and equal, nasally-sounding. She cannot speak alone a whisper. After she mumbles, one can hear the air rustling and cannot fix vocal cords. (?) leukopenia, the reflex action of the palate was found to greatly diminish, and I believe in fasciculations of Pharynx with the finger produced my little result - tapping and caused no inconvenience. Low lying into his larynx, the membranous membrane appeared as a thick stail. The vocal cords were slightly separated and scarcely moved at all. During inspiration, or when she attempted to speak, she could not use without supporting herself with her hands, and when she did so, the
head feels taut. She is quite unable to prevent it from doing so, so leaves it in its present position.

Her arms are very painful. She can just carry a cup of milk with comfort - but then that is when looking deliberately. She can just write held by your hand, but cannot grasp it.

Her face has this drop down up. Thus when any attempt is made at writing, her hand can make no attempt to write.

Sensory sensations. There should have come before the motor. There is marked analgesia to slight and medium of the feet, especially half way up the leg. She can scarcely feel the hairs of your body, or head of pin. - cannot distinguish between points back of talus. When the pin is run in. -

There is also some blunting of sensibility. If the finger tips or palmar of hands, she can feel rather distinctly, distinguishing between a cotton, the fingernail, and skin. That I shall not in. says her hands feel "dry" at times. There is no pressure or sustains the form anywhere.

Sight, apparently unaffected. Depend upon accommodation. Pupils moderately dilated. There is no frank light accommodation. There is marked pain of both upper extremities.

Organic Reflexes: - No dysphagia, but feels it on.
Case of Agra Disease. Continued.

- Carambolic, are aggregated throughout the body, and also finds its way into the larynx, producing coughing; the cough is tickling.
- Appears to be artificial in removing the irritating substances.
- Mucous membrane: edematous, emaciated, puckered.
- Skin and internal reflexes: quality diminished everywhere.
- There appear the normal red spots or petechiae: disturbances.

(d.) She is fairly intelligent, but very apathetic; taken very little interest in anything or anybody; formerly, she was among living child. She is quite aphasic, being only able to speak in a whisper. She can make herself clearly understood; home. She sleeps well, doesn't offend much during the day.
- Nothing abnormal. The red spots on the about cranium and back.

Respiratory System: Perturbation 2nd. degree.
- Atrophic.
- Palatal reflexes almost absent.
- Amebic lesions of pharyngeal copper part of larynx.
- Presence of vocal cords, both of which extend, and adductors, especially of larynx. There is a picture of numerous membranes of the face and temple, and on one occasion, a small white patch was found on the posterior pillar of fauces, which was removed.

(d.)
The ulcerated surface beneath treated with pure carbolic acid - the face of Debraun remained symptomless, microscopically, containing colonies of Micrococcus - moreEned of a bipolar type character. It was first observed on Dec. 23rd. After this, the pharynx was thoroughly washed morning and night with glycerine of carbolic acid - and more patches appeared - Dec. 26th. Drunk in warm water - action of heat rapid and rapid - Pulse 152, 57, and complained. Resp: 24. [Blank.

She was when she wanted to have her hands bandaged, and nurse was told she cannot return face for some time 1st or 2 minutes after the lower half face is felt. In addition to the vomit, amnesia amnesia - Dec. 19. Fluid.

 digitation was settled with former, and mind of left. She was taken to the toilet. She was not allowed back up in bed.

Dec. 21. 14. Pulse 164. May fail. Resp: 45. Tolerate food well - ordered Brandy 3:00 was hour long. Vomits still aphthous. Poison relapsing pain, indigestion of the colon. The tincture of the tincture is greatly improved, and the urine are significa. This of the urinary function. Had a violent fit of the tongue today when lettuce elastic poorly done - ingestion of alcohol and tobacco of phosphorus, much less marked.

Dec. 25. Patient's quality improved. Thought phosphorus to be the best. The Patient's former
Remains in the same condition. The cough is rather less apallmic.

Jan. 2. Collected my presents. Patient left. 

Wm. Waller: Police Surgeon. 9 o. Better in 

all. Digitalis omitted. Face much whiter 

than yesterday. Dr. Archibald: Dr. Bing. 

3 o. Began to improve. Pulmonary disappeared. 

Wm. in right groin almost healed. In 

abdomen lister's - can start sit up in bed to 

support.

12.8. Do improved. Can sit up in bed dressing. 

can stretch at times rarely. Expression bright. 

smiles occasionally. Apallmic almost gone but 

it is rather tactual in character. Hands no 

longer agitated through food. Also did not 

choke at her meals. Pain in eyes consid 

erably improved. Also not palpable contents 

of culs. When heaving - can breath hand 

king freely.

26. She has been sitting up for last 6 days. 

She is able to stand with a little assistance. 

but cannot walk yet. She can hold her head 

up unsupported. It no longer tends to fall 

forwards. She is still my nursing dinners. 

She continued him prone steadily. She gained 

in weight. Her spirits gradually returned. 

She was able to walk at 2nd of May. 

alone. Discharged on the 25th of May. 

Mrs. has been out. Made of her return home in the 

ward. She attended as an out patient.
for several weeks. I last saw him 1st February 28th. His face was looking very well, and with the exception of being a little constipated or bilious at the taking of any instance, she had quite recovered. There was no anaemia, nor pain anywhere. She sat up very well. She could not stand much fatigue however, and was conched. She was leaving Easter's holidays with the -uponful dosing, and was in the same terms daily. With a little post wild at dinner. Still the symptoms 1st night's morning turgor were also noticed. The urine was quite normal.

Patient was again seen in April, 1825, and看上去
perfectly well. All these symptoms had vanished.

Remarks: This case is of considerate interest clinically. There can be little doubt that the Paralysis was the first affected by the Syphilitic process, and the effect of the flux.

(which was very slight) secondarily. There can also be no doubt concerning the nature of the Paralysis - the rapid prostration of strength with anemia - the enlargement of the neighboring lymphatic glands in the groin, the onset of typical paralysis, or rather of general paralysin, combined with some or less anaemia, which had all the clinical charac-
ters of Pre-syphilitic Paralysis, without the glands'PUT. course, and termination - the presence of albuminuria - all confirmed the diagnosis.
Case of Alfred Holgate: Act 29. Pneumony Local

Patient who is a ship's steward, was admitted into the Liverpool Royal Infirmary (under the care of Dr. Dr. Glynne) on May 15th, 1883. Complaining of loss of power and stiffness of the lower extremities, coming on slight difficulty in walking.

Previous History: As a healthy child, having suffered from the usual infantile ailments. After the age of 10, he says he feels better than his companions of about the same age, but this does not appear to have attracted anyone else's notice.

At the present illness commenced, he says he has never been afflicted with any chronic ailment, nor has he met with any accident. Says he has had Gonorrhea on several occasions.

Family History: Father died at 66 from Cholera. Mother still living. All other members of family are healthy.

Present Illness: Last January, whilst on a voyage at sea, on moving nearer land, he got very hot, and had trouble in his legs. He felt no effect at the time from this, beyond a slight difficulty in passing his water. (He had on one or two occasions previously had slight difficulty in micturition.)
In or near days before Easter Good Friday, he was still feeling quite well, but the next morning when going down stairs his leg began to tremble, and nearly "same way" under him - he says they felt very weak on staff - he had no pain at this time. For less or three days he was unable to walk. When he was lying quietly at rest asleep, his leg would sometimes begin to tremble, these attacks lasting for 5 or 10 minutes. His leg also commenced to tremble whenever he attempted to perform any voluntary motion. On the third day after he first felt the weakness in his leg, he managed to walk 300 to 400 yards without a stick, but he says he felt very weakly, this leg staff still fixed for usage, as he caught hold of anything he could in passing, then partly assisted himself along. He walked this distance to get some medicine which he thought would cure him. He took it every day and never to his knowledge had it back. He never felt any pain or numbness. He had some difficulty in passing his stools, but this had ceased for 10 months, when he had an attack of gouty hots. Last December he was obliged them instruments passed.
Present Condition: He is a well formed, square
man - with average muscular development -
about 5 ft. 16½ in. in height, and 9 ft. 34
in. in height. Complexion ruddy. Hair dark.

Persons again: No abnormal sensations.
Motor: Sensibility to heat, cold, ticking, pain etc.
Normal. Muscular sense, normal.
Pupils equal - react well to light and re-
accommodation. Special senses all normal.
Vestibular Function: Organic Reflexes, oscil-
lating reorientation, normal. The difficulty
in walking, rate is undoubtedly due to
the presence of a slight ataxia, which
he has suffered some years from for
some time.

Reflexes: Hypersensitive. Plantar reflex
decidedly increased; but the plantar reflex
could only be obtained in very slight de-
gree. The abdominal and flexor reflexes
are absent. Chaddock reflexes unobtained.
There is continuous slight fibrillary tremor
of the flexor utemiens.

The patellar tendon reflexes are markedly
increased on both sides. When the leg
is extended, the quadriceps remain
relaxed. The patellar test is readily
forcibly pulled downward towards his
leg with the forearm pressed against
his upper arm, steady fraction.
The quadriceps muscle is kept up in this manner, so long as the halter is maintained. There is nearly constant clonic spasms set up in the quadriceps, especially in the vasti. The clonus - the clonic spasms - subsiding directly, the faller is released allowed to return into normal position. This phenomenon is equally marked in both legs. There is also an 'ankle clonus' in both legs, but considerable extent.

In attempting to flex or extend the leg, there is considerable resistance due to muscular rigidity, especially to flexion. When he is asked to flex his leg forcibly against resistance, there is found the articular loss of power, but he is able to extend the leg with apparent, but diminished force. (If at all so.)

When walking, he keeps his legs in an extended position, and somewhat rigid. He can manage to get along fairly without the aid of sticks. Each step is attended with considerable effort; he appears to have difficulty in raising his foot from the ground. He frequently cuts the toes of the foot against the floor. He takes very short steps, and there is a decided tendency of the leg to cross each other. In attempting to take longer steps, he gets very unsteadily. He appears to try,
2. (Case of Alfred Holgate, continued.)

...one came the tendency to catch the foot against the ground, by letting his body marks the opposite side when making a step forwards, going having then body of the pelvis in an arched condition. They let in the form of the form, from the arched, and the chest thrown well forwards. There are occasional fortifying moments of the muscles involved when he is walking, especially in the leg muscles of the leg on which he is bearing the greatest weight. Especially if this be placed more in the anterior part of the sole of the foot where, when standing on the tips of the toes or both feet, a distinct right

The muscles involved feel firm and healthy, and there appears little or no play of them anywhere. The feeling them carefully with both Galvanic and Faradic currents, should only say that there appeared the slightest increase of irritability. The forms...

Central mental phenomena normal. No apparent neurosis or subjective change. No tenderness over spine, solo or perci...
- Smi. (After H.R. change lat.)

Other systems normal.

Theral coll. clot, foot on
- 9. P.R. Laxd. 3/0. H.D.
- Ht: 115 lbs. BMI 31.2
  Ag. 85 yrs. 2/31.

2/31. T. A. S.

May 3/15.
- Cere hallucinations. Heads not quiet
- 3/17, about 10:00: Unable to move or walk; he takes somewhat longer steps, and walks much float more clearly from the ground.

June 1/5.
- Says his legs felt weak the first thing in the morning, that he had some pain in the
- legs by noon, at the back of his knees: he
- again walks with some difficulty on his
- first feet, says his legs feel cold, but his
- temperature is normal, restless, is sitting up
- all day.

3/22.
- Walks slightly better, if anything: due
- to rest up nor. He complains of shooting
- pains in the abdomen. They don't do
- much, however, bladder, ileus present, from the
- spine.

July 5/5.
- Note sharp pain in chest and
- abdomen: sharp pains in the abdomen.
- He walks worse. No walking in the morning
- he says he found his legs lined, and
- that he could not recognize them for
July 14th. When he first gets up he finds great difficulty in standing from the strain of his legs. Walking a few steps. Sits down on the floor. Uses his hands to support himself. The postural reflexes are very exaggerated, apparent stone as tension when he was admitted. The ankle clonus is more marked in the left side than in the right.

Sept. 17th. Patient is able to walk short distances. Stil has slight difficulty in passing up the stairs. Rather weak.

Aug. 15th. He was sent under the care of a physician.

Sept. 17th. Returned to hospital. Says that his leg is still very painful. No relief in walking. The child has difficulty in standing. The ankle clonus is still present, especially in the left leg. The child has difficulty in standing. He has lost up to 2 or 3 times during the night.
Upon that lake, which still comes away in a very small stream.


No allusion immediately after Hibernia. O'Flaherdy, ig. See set. m. iii. p. 84.


Ch. 15: Consists about a small bean, or small bean, rather, Proc. Meath. acid list.

Mrr. 13 1/2. It was done today. His son request in practically the same condition.

He was readmitted into hospital on Jan. 4 1/2. 1824, on account of being home. He sent the following account of himself since he left on Dec. 13 1/2. 1823.

He at first improved and dealt with his reading, and was able to sit at table higher from the ground, and to sit and down at his ease. His general condition improved materially at the same time. He continued to state the chronic of P. Macnee, for some time.

This improvement only lasted a few days, after which he began to get worse again. The following is the turn some time, from which he had almost entirely given. As again reappeared, his health became worse at the same time.
In addition, there has been a loss of feeling or muscularity since he first came under our care. Says patient nothing occurs in the arms. His back in bed with both feet extended claimed somewhat amused. Can be comfortably in any position whenever.

Worms System: All the superficial reflexes (including plantar) are not considerably impaired - plantar reflex as much exaggerated as in left foot. Achilles reflex extremely marked, lasting for 4 1/2 seconds, 1 1/2 minutes on the right side, 4 for 3 or 4 minutes in left. It can also be produced by tapping the tibial arteries, or when he lies before the foot of the bed, as much as in the normal manner by flexing the foot forcibly 1 1/2 times. The muscles of the upper legs and upper extremities do not show any marked irritability when percussed directly by tapping them with the finger tips. The legs are not much affected when manipulated (prone, on sides, etc.) with the ankles, knees, or hip joints - there is free movement here at the last named joint, there as the hip former. There is within some muscular resistance to passive movement here formerly.
Sensory Functions:—When a pin pricks, merely
leaves a little soreness, so drawn tightly, and
the right leg below the knee, he does not hear.

Does he not hear? Does not the application of
force serve to put upon it? For can he be touched
with slight pinches with supr. only pretty sore, as,
when the hairs of the leg are pulled strongly, he
rares it feels as though he were
hears touched with the finger.

The same applies if the legs also (below
the knee) into the greater degree: Hard
pinches on the calf muscles (which he
rares become only just feel) comes with
clumsy.

On the right thigh and arm, he can feel
the prick of a pin and differentiated it
from the head, but repeatedly said he was
being pricked with a pin in the exact place
when the head of a large pin more drawn
on the thigh, especially on its internal
aspect. When the same was done on its
outer aspect, he immediately said it
was an up wound involvement of a pin.

On the corresponding region on the left
side. The sensitivity is in much the same
condition, but as in the leg, it is certainly
more impaired than on the right side.

There is an impairment of sensibility over
the abdomen, chest, shoulders, arms,
head, neck, but it is slightly deficient
in the sunken region of the back. After
Mann upwards, or a series of points in the
same direction, always becoming more planar,
fell at a variable distance between the
12½ to 14 between species on the lyrate side, and the 10¼ to 15 on the right side. (The
amplitude in these regions being rather more
than that alone also.)

When standing, the Khan tends a good deal
the fat remains quite stiff. However, it can
stand upright at all. While he attempts to
dress, he falls forwards, and with marked
shaking, is at once set up.

Generally, his life effort begins; then
the sink when he is laying quietly in
bed.

When he stands, the character of the joint
is well marked, far more so than
before seen in the prominent part
of the back. There is if anything rather
more difficulty in getting himself along
his feet being more limited by tissue;
each other, and to drag the ground when
crushed forwards. Says he feels the
ground quite distinctly.
Paces arm in a very firm manner,
and only after some delay. Paces
about 6½-3½ feet. Letens. Pace
No. 9. 1020. In albums.
He occasionally suffers from "cramping pain" in the legs. But no abnormal健全 about spinal column can be detected.

The patient's overall health seems satisfactory. In fact, he stated on March 24, 1815, that his feces were normal.

Order: To read the 4 P.M. runner. No xvi.

My days: February 10 
August 31: 34 horses.

Jan. 1815: Had the bucket-curtain applied to each side of the spine in the lower lumbar and upper thoracic regions. This produced general tremors and a sensation of the whole body for 10 to 12 minutes afterwards. The tremors were most marked in the gluteal region, and down the legs.

19th: Says his legs feel better, he can move them better than formerly.

22nd: Complaints of slight abdominal pain.

25th: 28th: Pain at all. Was slightly more difficult.


29th: Suffered from slight abdominal pain during night. He was unable to sleep. Felt in the perineum, in the organ of the lower organ, the respiration became rapid and then the movement produced a sensation of pain in the perineum. This is slightly more on the left side. Vomiting has ceased.

11th: Can talk a little better. Noon as quiet so stiff. Man at 11½o.m. among adag. and panson.

15th: Slight abdominal pain in 11 to 11½o.m. Could only pass water in drops yesterday afternoon, but it again flows in a free stream this morning. About 9½o.m.: This morning, he had a feeling of cold, after which he began to tremble instantly all over, particularly in the arms. This only lasted a few minutes, after which he felt all right.

Respirations in right forearm are rather loud, vital and clear.

He complains of attacks of pain in the umbilical area of a jumping character. This pain is quite unaffected with a cold in pressure.

18th: Since the 16th, he has had increased urinary frequency, has only been able to pass his urine after considerable straining, and then only in drops, or occasionally in a very small
Stream. Yesterday while lying quietly in bed he began to tremble violently in his legs - the arms trembled no more remained quite normal, but the attack lasted about 9 or 10 min. It commenced quite suddenly, without any previous symptoms.

11.15. 6th. 15th. Normal.

11.15. 6th. Again pain in effort stream better than it has done for some months. Is sitting up. Then he gets up. His tremor, both legs began to tremble violently, continued to date for some seconds (20 or 30) and then ceased; but every time he stands a foot in order to make a step forward, the tremor begins again, one leg arrested then he places his foot upon the ground again. This is noticed in both legs, but especially in the legs. After walking up and down his head after this, and then sitting down, his legs are ached with classic tremors.

March 15th. For the last few days has been alternating.

For the last few days has been alternating.

Very done of that. Can't bear. Passed. Worse less frequently with slightly less day.

Finally. After about an eating experience this tremor was very cutting indeed. Nearly having truni but get out after.

11.15. Can walk almost better and without any assistance. But when desiring to pass truni he can only do this after waiting for 5 or 10 minutes; stream still very small.
Springing with cold feet, before manipulation has been tried for some days, but with no appreciable benefit. Permits still continue.

26th: Recognises no slightest power of either or pulling of hair or sunken leg, but still continues the hand with the point of a pen. There is no amnesia of the back.

The leg when flexed, can just be extended against his will. The right foot is more weakly than the left. The corn over the second metatarsal has ground against any amount of resistance.

April 30th: Improvement in walking continues.

Permits same as in last entry.

May 15th: Some reflexes better. Marked him for

First: He can distinguish between the head or point of pen when touched at any part.

Walks without help, but still rather un

Characteristic. Occasionally suffers pain in the foot, but occasional referred vocal

Champ. Cutting "character. Permits this.

Patient left hospital, promising to come and

Examine himself from time to time.

During his while lay in hospital his arm was

Cautiously measured, it was found that his quantity

was always up to the normal, or some slightly above.
Remarks.

Believing this case to be an example of that extremely rare affection, of which I have written elsewhere, I am thought to be sufficient interest to report. Although the Clinical History of the case closely corresponds with the description of the disease, there are several points of difference. In the first place, the onset of the symptoms appears to have been more rapid than usual. It is attributed to trouble to some extent, which I had in January 1843—but it was only until the last days of the month (or early June) had elapsed that he first returned any personal—when weakness and stiffness in the left, with tremors, set in, and was suddenly—then more rapidly—progressed. He had no pain, nor any disturbance of common functions at that time. He was suffering from slight difficulty in swallowing, but much of an old condition due to the attacks of pneumonia. When he first came under observation, he was suffering from the following symptoms: weakness and stiffness in the left side—painful Spastic gait. Rigidity of muscles—faltering, exaggerated or bilateral reflexes, and much marked on the limbs. Cerebro-cerebellar signs—diminished or absent reflexes. No much altered. No rapidity of breathing—right less apparent. No effect on sensory functions anywhere. No true Ataxia. No pain. Arms unaffected. No Electrical changes in affected muscles or others.
An affection of special nerves - this symptom latent without any median but that of a p. The present signs, having become steadily worse. At one time there appeared the high anaesthesia of the lower extremities, especially of the right, but this appeared only temporary and was never very marked. It was also observed that the muscles of the arms were becoming somewhat weak and at present, telling he had become my subject to 'shaking attacks' which were frequently developed after walking about the ward. He was also losing weight. Difficulty in locomotion continued, but would come mostly from lower spine - taking into consideration all the facts of the case, I am not certain how they could be explained otherwise than by supposing that there was bilateral affection of the spinal cord, and reduced tone of the character, and in all probability originating in it, as there was a number of primary affections that were at producing secondary descending degeneration in the above tract - the only affection that one at present seems producing any important as it more in this case is best known as primary spinal sclerosis.

Since making the above observations, the patient has been admitted to hospital, remaining in bed, suffering from the following additional facts.
In a long hospital he has, for absolutely none - there had no other attacks in which he has had a feeling of constriction round the alluvia, with increased loss of power in life. He complains of a coming sensation in head when he lies down - finds they are felt in both eyes, many times, and has sensations of being hot, cold alternately. Has a feeling of constriction round the waist - his bladder has 900ml, 1100ml, and 1200ml.

His legs move for much of the time formerly and he keeps the weight of the body on his shins. Can just manage to walk with legs stiffly working against each other. He, for about 20 or 30 feet, but with help of person can walk 100 yards. There is no apparent muscular action of legs. At allowed muscular reactions to electricity. The reactions are purely direct. The muscles flaccidly. He can hit fairly accurately in whatever position his legs are placed in - Dupuytren's exclude, Dupuytren's contracture - this effect excluded. His motor power is lost. This much diminished that he can only bend them feebly. Stiffly from the hip for some inches. All the Hips are firm, the legs are quite flaccid, and superficial flexors and extensors are CRUMBS in well marked - as it also the "Immobility" or "contracture" of Gowers. There is great difficulty in passive movement of legs. The arms appear to be entirely unaffected. He has no control over his bladder - in the period of acute trouble many becoming ammunical. Stiffness of face, involuntary, but tremors are found very rarely.
with any short warning.

It has almost marked feeling of constriction around the abdomen which is accentuated... There is a very marked increase of accentuation of the heart sounds...

Pneumonia is felt. The lungs can be distinguished clearly between head and neck off the elbows. The lower... head half. His impressions of pneumonia are... wards over trunk of the man, gradually diminishing... inner up... At which pneumonia appears the normal...

The classic symptoms of a feeling of constriction in... fingers of both hands. Normal reflexes present: percussion over 

Pneumonia on the left side. It must be observed that... chest is becoming affected... than that the... other + those. Which are becoming involved. It seems apparent that the chest on the left must be opening towards the body... the lower...

Agent: General G. F. Paralyzer.

Patient was admitted into the Royal Infirmary on March 13th 1884, under the care of Dr. Water, complaining of "Rheumatic pain in the limbs and general weakness." History: Family: Father died when young; Heart disease. The family history being otherwise satisfactory. He says he has always had a sensible comfortable home, plenty of good food.

In the last 10 or 14 years he has been in the habit of taking 3 or 4 pints of ale daily, occasional small quantities of spirits (chiefly rum). He has been combatively "never having taken them in excess." He has always been a heavy smoker. He is married but has no family. His wife has never had any miscarriages, and he strongly denies "never having suffered from any renal disease."

About 15 years ago he had a pretty severe attack of Rheumatic fever. She was confined here. The illness was of several weeks duration. Then he has suffered in cold weather. But with these exceptions he has generally enjoyed very good health.

Present illness: This commenced about 12 months ago. He describes it shortly as
following. He was walking home one evening, when he felt his legs suddenly give way under him at his knees, and he fell to the ground. He felt no pain at the knees, but he suffered from something worse and he became unconscious or faint. He managed to get up from the ground without assistance, and walk home, a distance of about 800 to 900 yards without support, he felt very weak in the legs, however, and had to help himself along by casually placing his hand against the walls, doors, posts, or fences as he passed them. He passed a grand night, and feeling better in the morning he went to work again — he said he managed to do about two hours' walking without great difficulty, he still felt his legs very weak, and he frequently had to stop and rest himself, as he became very soon fatigued and somewhat shaky in his legs. He never recovered from this attack, and he gradually became weaker in the legs and unable to walk further except by the aid of assistance. In about 4 or 5 months he had got so much worse that he was obliged to stay at home, he was then only able to do any limited amount of walking about indoors. He was under the advice of a physician whether his legs became weaker or not at this time — about the middle
January last, he wrote this letter, although quite unable to write it, without assistance (a few words) he very soon lost all power of movement in his legs because gout had set in. Since his troubles began, he has frequently had shooting pains " picturesque " in his legs, from the knees to the toes; and lately these have appeared also in his arms, from the elbows downward, but he affirms that there has never been any actual loss of sensation, either in his legs or arms.

It was also in January that he began to lose power in his fingers and hands, which rapidly increased, so that he was now unable without his name - he then also observed for the first time, that his arms and legs had become ["painfully"] very much wasted. (He thinks he has always from the commencement had weakness in the left leg.) Has ever had any circulatory or nervous affections - neither has he had any Reilly or nervous difficulty - being always able to walk " naturally."

His special name he has always remained unimpaired. There has never been any spasm or pull ulterior. The muscles having been traced " from the outset. He thinks he has affection of muscles in his feet, at the beginning of the illness - but this was only temporary, now passed away..."
A few days prior to the onset of the febrile symptoms, he had been a good deal observed [to] read. He thought he may have caught a chill, or he afterwards acknowledged being a little feverish next morning. The day before he fell down, his headache pains had also been worse. [He] was brought some at this time.

State on admission: - The patient being善于

[Incoherent text]

He was propped up in bed; he is a tall, slightly

[Incoherent text]

Skin of face somewhat

[Incoherent text]

No apparent abnormality or marked change

The discovered:

[note: handwritten text continues]
Reddened crescents are lost in the corneal plane.
Muscles, cutaneous, and muscles special
wires on both sides.

The deltoid, supra-auricular, infra-auricular, subcutaneous, neck, axillary, scapular, clavicular, chest, biceps, triceps, and fasciculation, are all unreacted to the strongest faradic currents.

The flexor muscles of the forearm react
rather more readily than normally to faradic currents, especially on the left side.

The muscles of the leg, from the popliteal and tibial sides, react hardly at strong faradic currents, but much more readily to median
galvanic currents, especially on the left side.

The median and lateral sensory nerves are tested on a great variety
of ways, all of them absolutely unimpaired in both arms and legs. No lesse be complaint of
any abnormal sensations anywhere at the present time. Touches to the deep reflexes
are absent on both sides. The plantar
reflection is slightly present on the right
side, but is not a deep. Scaphoid, trochanter,
mental faculties unimpaired.

Dexterity, organic reflexes normal. Huber.

Foot clasp reflexes as above described.
Patient is quite unable to support himself
on his legs, he can only move them very slowly.
with great difficulty. Thus acted before.

This can only be very slightly. Can slightly
rise twice when lying on his back, but is
quite unable to do so against a very slight
resistance. He can close the fingers
against a moderate amount of
resistance, but the power is all muscles
lacking (electricity is greatly impaired).

All the muscles of the lower extremities are
greatly atrophied, and as tested by the con-
tractions evoked by electric currents, they
exhibit electrometrically the reaction of
degeneration.” as already described. Thus
tested the contractile current “the muscles
especially those of the leg) react more readily
to the amide than to the cathode - (as for the
description of the electric reaction in the different muscles.)

As regards the upper extremities. There is marked
atrophy of the muscles of the hand & arms, a
fore arm. He can only just move his thumbs
& fingers - is quite unable to button his clothes
himself. He can be close his fingers he can
hardly take hold of a band when asked to
clasp, and has so few motions of grasping.
There is also inability of to extend the
hands when flexed at the wrist joints. He
has a very limited power of flexing or.
Extending the arms at the elbow joints - also of
pronation or supination. The muscles of
the upper arms are not quite so abducted
as those of the forearms. No muscular trac-
present in any muscles. There was good
marked weakness of supination in the mus-
cles of the forearms, and less so in supin-
ator of the upper arm. There was no less
pronator of arm anywhere. The patient was
able while sitting in a chair, and sitting in
arm chairs when his eyes were closed.
All these observations, general physical quite
unaffected. The muscular tone good and
weak, no apparent unsteadiness.
Cerebellum: Motor function, perfectly well.
Dizziness, Despacing and objective signs
normal. Tonic plantar and an saccus of
Ploncher but no同盟. Intelligibly
in quiet state.

As regards.
first examined. The whirlability of the muscle.
The fibrilar current is considerably less than
formerly, and they react much more readily to a
mechanical trabecular current. Palpation confirms
this almost.
Arms: Patient can depict 12 palpable units
by pronators - with each hand - can also flex
elbow; flexor supinatoris even against a con-
siderable amount of nitric amine. Can put with-
name skillfully. Reaction of flexor ulnaris gradually
becoming less marked. All seeming before +.
He can sit up in chair.

From then time his condition became steadily
improving gradually regained firm bulk -
strength - of the deltoid muscles. By the begin-
ing of August, he was able to walk about with a
tick and to move around without assistance.
What gained 2 stone in weight and could
carry fairly heavy weights about. He left
the hospital at his own request about the end of August - practically well.

This case is a fairly typical example of
osteomischia antirum & Varica, among
community he presented with the following case
of which there is a more perfect record.

Poliomyelitis Anterior Hemiplegia.

Patient was admitted into the General Royal Infirmary on Jan. 20th, 1844. Suffering from poliomyelitis.

History: Patient was unable before any account. Amically when admitted there does not appear to have been any marked disturbance. He is family. His previous health has been good. He is much improved to the sight when sitting in an office at work. He has had no trouble with the leg often at the same time. There is no history of any former disease. The present illness commenced about three weeks ago. He suddenly felt walking his feet begin to become rapidly weak, and he says "they hurt under feet." He felt perfectly well up to this morning, but was diminished for breakfast. He went to sit a chair a moment after this before, though sitting in a chair. After getting up he was in the bed and walked along the street. He had great difficulty in walking back to himself, which was smil. He had no pain, nor weakness, tremor, etc. He sat still all the rest of the day. At night his leg felt heavy. Throughout, he managed to walk 150 yards in
an omnibus to the nearest house. He sat near my "skill" and could not get across, "skilled" in a friend's arm. He felt cold, +
shivering normal time. During day, but not at all. He had any notice before. He left
my bed, for getting into bed. Seeing he wished his tea. The landlord (who brought up up 
hospital) say, the looked extremely ill. He walked extremely ill. He
passed away luncheon, and walked +
railed against door, dealt. He distinctly 
remembered passing his mate without any diffi-
culty that day. Since then he has never
left his bed. According to the landlord's ac-
count, he was very delirious for the next few
days, and quite unconscious and helpless.
During the first week he did not recog-
ize anyone, and said his right hand
"clipped" he recognized no one, knew he
could distinguish persons by sight. There were
symptoms of gradually subsiding after the first
week, up to this time they had great diffic-
ulty in walking, and ate little food. He had
confirmed on March at the end of a month
that he was able to walk the floor. He had
become visibly emaciated, thin and wearing
less. He with his right arm becoming
affected about the 15th to 15th of January.
he could not raise his arm.
In the last 3 or 4 days he has passed both
ways of passage in bed.
Present Condition. - Patient is a man of medium height (and weight when well) generally emaciated. Some (hyperemia) of a dusty color above lips, some distinctly cyanotic. Moist, deep, brown streaks - sounds rotten; firm, Breathe deeply. Thyroid prominent.

Functions of Extremities extremely reduced.

Temp. 107° F. (r. charte.) (agreement slightly improved). - Iris v. irides both - white, with - eye inflamed.

Dermoscopy System. - He may complain of a feeling of pain behind the knees. - Pain is greatly increased when the legs are forcibly extended, pain worse.

Pain localised bands of one or both legs.

Pain muscular especially calf leg.

Pain arms and leg appear the same. - Arm to from elbow pressure. - They do not exist.

Pain anywhere - only arms that arms the other. - There is distinct sensory reaction a little above the joint of the right humerus. - And there is also tenderness in pressure over the E, Inoral Spa.

He can hardly distinguish between the joint and head of any all over face.

When the joint is palpated lightly he feels some, he does not perceive it, but when applied forcibly, it appears to him as a very slight prick. - The same amount of motion tibia and the toes (as far as the pan is concerned.) - He can distinct muscle which feet is bent.
From whence come a current path; no legs comma pain.

Special sense normal. Outputs at left-right. 10% more left-torn. 1% expand weight to accommodate in right dements.

Reflexes: organic, no pain or face burn.*

rini: others normal. All superficial and others

Reflexes absent.

Voluntary: dysaplexia, minimal facial or

dorsal muscles. Innervation of trunk.

All the muscles of the upper and lower extremities, and those connecting them to the trunk are in an extremely abnormal condition. Exerted by the electronic currents, there is slightly increased activity to the constant current. On the arms e.g., Brachy gland drives in

Vital ability to the different current -

seriously any action being attainable except with very strong currents. These reactions are more marked in the arms than in the legs. In the latter (especially in extension) 4.0 c occurs before c.c. and 4.0 c before A.c. (the arms are always more past that heat.

In leg. 7 the normal power of the hands is

quite abolished - he is unable to close his

fingers, nor join hands, but cannot exert

the slightest pressure. When asked to write he
can join hold his pencil, but cannot make

any letter or figures, his hand shakes any

much. He cannot hold a knife, fork, or Thomson.
tired and weak. He can put his hands across, but this is marked "not. Weak."

[Note: the text is not legible and includes various markings and corrections.]

Vocal and Writing Functions: As already mentioned, his voice is extremely monotonous. His writing is often unclear, being anywhere visible. The handwriting is in an extremely awkward condition.

Cerebral Mental Functions: All mental faculties are markedly impaired. When his landlady came, he said: "What is the matter with me?" He did not recognize her for 5 or 10 minutes (he had been her lodger for 18 years). He talked and appeared normal, but he was still turned within him in her presence. In another five minutes he had another fit, thrashing his arms and shouting. He then rambled against a wall and threatened what he would do. He is constantly writing.
Humility about his person - always unapproachable. Fear when he wishes to come into contact. Nervous. His attention is very remnant and his purposes change often. For many minutes together he sits with his hands together. In the end, he becomes profoundly agitated. Family named - want always for some house 1 or 2 boms at a time.


Circulatory System: Heart sounds normal.

P. 100: 60/40 and compressible.

Sup. 100. T.

Mun.: 18/3. Profound involuntary. VP. 80. 10/6. and no albumin or sugar.

Insomnia: Drone. Soft. Notice small at 6/7 half hour (8p.m.)

4. 1/2. Mantra: 8. 4. 10. 15. 20.

Ins. 5. Slept quietly. From bed slightly - after first better. Pm note much asked for food.

D. 6. Appears more animated - slept much better. Mf at all delirious. Mf said seen 4 his name this morning whom he immediately.
Recognized. From whom he talked quite naturally - his manner with questions being prompt and consistent - the same amount of answer and a spread of the understanding. His age was duly kept in mind, and he cannot strongly the

Granting power of Right hand. = 2. Le[ft. 0.

Le[ft. 8.5. Left well. Continued to impress

Motion always voluntary. Even involuntary

has some power of motivating. So, especially

Right. Can also recall Right hand more

from formerly. Apparent sound was diffi-

culty in an allusion. Pulse so, heavy.


11.5. Very restless again last night. In

Air 700°. The ramshackled dog dealt

Two men called true him this morning, and

Of [i] they were gone on road they were his land. d.

And move, and ramshackled about the

kite of man. 45. Snake me [i] often patients in

When he pipe tobacco. Pass all his motions in his body. Pulse 96. T. 99. Skin cool.

In time they in no content. Restles on lipri +

In bed. Sat at last good at 3:45.

12.5. Ramshackled agreed deal in right. lanes

Think he is none. Faces person in

Voluntarily. P. 104. Right hand ag

4: Leff 0.

Rand 4. P. 92. Le[d]. 80. In - the -

18th. Again his mind is clearer. Some rational.Tends frequently, though involuntarily, in the 21st. Imp. 100. *H. Harb. 12 months.
Being more rational, I say of what kind. Stills. After a daily, as I feel. Still same in his mind, as before, nothing.
25th. Harb. 100. Pera 100.
R. 15. Imp. 100, Calm mental.
28th. It remains the same. Nothing.
He visited them, but forgot them. After a month.
There is general loss of sensibility, but not.
Form your current. He hardly takes 16 Acts in
Name. (Stifications) 40. May be less.
He puts 28 cells at a time, at 4 6.
30th. armed stronger. Can read, and
wall. Leg short came. Memory failed.
Cannot remember things which happened yesterday. In disturbance.
Ran. 4t. says he feels much better, pleased better.

Ran. well, then had himself. i.e. can hold

Wish you can allow it without spelling.
(3. Case of John Lewis. Continued.)

any. Though his hand is still firm, tremors were not always present. movements - tremors often present. The sense of presence. Legs somewhat stronger

Paper and spastic legs.

Dynamometric Repetition - Right 6 - Left 0.


Dynamometric signs come on before.

115: When information is declining legs -

Confluence values = 9 in. Each:

- Mum. arms = 8 1/4
- L. arms = 3 in. better than R.

Dynamometric: R. = 5 - L. = 7. A. B. This is the first time he has been able to stand or walk - any movement with legs now.

There is slight power in both his antecava - he is just able to stretch for it at all the - (both sides) but has no power of moving itself.

114: Can move more in left foot.

Paralysis appears still about - slight

Dynamometric - 9.6.1.
18 1/2 first yet able some Rifles off left or Farn - to just able Farnia trying up in bed, almost whole sitting posture. There is In fact another
screa off left leg - cannot just have to Farnia: Wright leg. It produces a sense of
the comfort. He can recognize the point of
Wright arm, but a firm pinch on P. right
arm. No same affairs right arm.
2 5/12 dyspnoea: 10. 4. 2.
Can move and rest lift legs will seem to
promenades - Have or pain in legs unless they
are pressed released for a long time.
Wrist found will lift also. (skewer)
The contained sprays in a satisfactory
manner. The next step of importance
is in Day 18? it reads as follows
In the lastsome, patient was been off in the
afternoon for a short time. He lost by
my much dinner - and has gained almost
1/2 of time in 1 weight. The curvature in his
but and is now considerably unpassed - he
cannot recognize the pinch of Farnia.
Wright - but and cannot can he, he only feels
again pinch as a lot of right leg as in 2
weight. When a few amount of power in
strong dotting legs - cannot move
left fully yet. The curvature in arms
and hands is only slightly talent normal.
Can distinguish fully when contrast with
different objects. Hers regain at first


and of Pwrs in hands - just turning
at wrists almost 45.

\[ \begin{align*}
\text{Stomach:} & \quad \text{Q} = 500. \\
\text{\quad} & \quad \text{Q} = 23.
\end{align*} \]

Angio pulse pronated nght site.

Never complete control over bladder function.

May 13\H:\ Decided on pronunc..."R" of
arms. "The muscles being best form: and larger,
he can perform any movement with them with
tou. diff. belly, fully, and Pone by slight fur
ings of stiff. prone in time. There is slight pain plat.
knee. Left of the abdomen. Right. Flowers immi-

The muscles of the legs have also gained lttle
in bulk & form. On. Com. thumb of the left
foot resting, there is an alli moment at
the ankle. Joint. Imm: in the. & Muscles
of the leg's position having somewhat both.

June 12\H:\ Stomach: R. hand = 60. Lgth. 30. In
arms from n. right. Armpit increases in
bulk of some legs. Plantar & Palmar are
reflexes. NATURE: Right common's 1
marked abdominal reflexes behind. It is
able to help hold up stick, and to
dalk a few yards, but very unstable.
He turned Limp on right. Only 3421 \H: 60.
does able to walk along the road (\textcolor{red}{*} 2 \textcolor{red}{*} 21 \textcolor{red}{*}) with
any assistance. He had regained appetite and
in his hands turns, scowls with almost as
well as before the attack. Dust often seems
to disperse. Dally with condition fantastic & extrem.
Study Plan: E. Zien.

- Meet students.
- Review material.
- Assign homework.
- Prepare for next class.

Meeting times:
- Monday, 1:00 PM.
- Wednesday, 5:00 PM.

Assignments:
- Week 1: Chapter 1 review.
- Week 2: Chapter 2 assignments.

Exams:
- Midterm: Chapter 1, 2.
- Final: All material.

Grading:
- Homework: 30%
- Quizzes: 20%
- Midterms: 30%
- Final: 20%
P r i m a r i e r a  d e  P a r a l y s i a  i n  h a n d s,  a r m s,  s t r e t c h e d,  v i o l e n t,  n o r m a l  c o n s c i o u s n e s s  a n d  k i n e s i s .  C a n n o  n o r m a l  c o n s c i o u s n e s s  a p e r  c e r t a i n  m e n t a l  f a c i l i t i e s .  V i r t u a l l y  n o r m a l  v i s i o n .  M o v e d  h e a d  p r e s s i o n .  P a r a l y s i s  o f  f e e l i n g .  S p o t  o n  l e g s  a n d  f e e l i n g  o f  f l i p  f l o p .  P a r a l y s i s  o f  t h e  s p i n e  d i s f u n c t i o n  j u n g r e e s s  d e f e c t i o n .  D e c e d e n t  h e a d  s t a t e .  P a r a l y s i s  o f  p r e s s e d  h e a d  a d j u s t .  B o t t o m  f l u s h .  P r e s s e d  h e a d .  N e u r o l o g i c a l  c o n s c i o u s n e s s  d e f e c t i o n .  V i r t u a l l y  n o r m a l .

O b s e r v a t i o n s:

T h i s  c a s e  i s  a  f a m i l y  t y p i c a l  e x a m p l e  o f

P a r a l y s i s  g e n e r a l i s .  S p o t  s c h e l a t e d  c a r t i l a g e.

R e f e r e n c e:

1. C o m b e R o b i n s o n  A l b e r t  B a t t .  A c a d .  M s .  1 8 7 4 ;  a n d  J o h n  R o b i n s t o n  C o l e s t i n o .  B l a k e  1 8 7 0 .  P 4 5 9 .
Respectfully went to complete personal, naturally involving various happenings accompanied by presence of Schweinhild during a few days. The patient conveyed in sickbed time minority the nature, feature normally slightly affected. Thus patient suffered agreed deal from Central unusual deep account of first some think them generally in this town. This may be perhaps for planned by the matronness of germ, and the considerable amount of Bacterium gas from which he apprehends things occurred during his first few weeks of illness, before becoming brought with hospital. There was no paralysis, illness of the vertebrae of the bladder of the kidney complication which does not occur in this town. It is true that he performed with arm’s speech with unheard of first, but knew was only, bearing his state of assistance and passed away as he improved. There was also the usual absence of any lusitans, other formation of joint beds once. In its subsequent progress there also manifested the same lusitans to gradual recovery, usually met with in this disease. The present breathing rest in the absence return to that in which they were affected - viz., having first in the hands, arms, gradually extending to legs - he was able to perform all activities with arms arms time before he could walk. There appears them how sudden amount of neuromuscular in his arms at first but of confirmative.
Dear Dr. Anestini,

I am writing to report that Dr. Anestini's symptoms may have been somewhat confused. The patient's symptoms of paresthesia and dysarthria were for some time seen, but greater improvement is now evident. It is curious that he showed with some manifestations of symptoms indicative of brainstem dysfunction, often referred to as the Pons Medicus, but he has not suffered from any dysphagia.

His recovery has been largely complete, considering the severity of his initial symptoms.
Case of Progressive Multiple Sclerosis

No. XCVII. Caro-Tone. Admitted into the Liverpool Royal Infirmary (under the care of Dr. J. R. Glynn) Dec. 31st, 1898.

Complaining of: Loss of power in arms and legs; of pain in ankles and calves; of feelings of numbness in legs, arms; of liability to fall when standing; difficulty in opening or closing the eyes; and of food being vomited when eating or drinking.

His story: Is much exposed to cold and wet, when at work, working on the conveyance in all weathers. The family history is unimportant. He himself being alone and healthy. He states his father died from 'liver complaint.' His previous health has been very good. His history of any recent illness or present illness commenced about six weeks ago with the feeling of pain and needles (in his patient's own words) in his fingers, he had been much exposed to severe weather a few days prior to the onset of these symptoms. Two days afterwards, i.e. after the abnormal sensations appeared in the fingers, he experienced the same sensations in his limbs. He went to work as usual, as he is a journeyman. He then began to suffer from
Mr. James Rose owned his feet and legs. He had to wake up every on the 10th. and 15th. He walked about two miles on the 1st. and 15th. but says he could hardly feel the ground (which felt soft) beneath his feet. He also had severe pain in his thighs and calves. His arms and hands also became weak about the same time, and he frequently let things fall. He also found considerable difficulty in swallowing liquids and from that most of his troubles. The fluid frequently hung higher situated from his nose, but was able however to swallow solid food without any difficulty. On the 15th. he had to make him eat- he had the liquid into it and fed him at this time quite unable to help himself without his hands and arms. He also complained of morning headache for some time. He has had no marked vertigo, but pain in his arms and legs. He has also complained of a great filling sensation in head. In the last 6 or 7 days he says he has felt some difficulty in speech, and has been obliged to speak very slowly. His bowels have been constipated for the last few days, but there has been no difficulty in micturition.
Present condition: Patient is a fair, pale man, about 5'11.5" in. in height and weighs about 167 lbs. Off good muscular development, and is seen to be well. In shirt and trousers and boots gray, a gown and a cap. Hair dark and short. Pulse 100. Temp. 100°F. He was carried up into the ward. He sits in a chair with his legs bent. His shoulders pressed forward, arms folded, atelisms, and hands at wrists; he has great pain when we attempt to straighten with his legs. He is extremely sensitive to the touch of any joint. No swelling or muscular rigidity.

Nervous system: He complains of great pain on attempting to perform any movement with his hands or legs. Also suffers pain when the muscles of his calves are touched. He has no pain in his arms. He says he is perfectly numb in the hands and feet. The strongest continuous current, the sensations of pain and weakness described are all present, but in too much extent to be able to follow them before admission to hospital. But he most suffers from what he describes as "dragging" pain in his shoulders and arms. The occasional shocks of pain in his legs. There is no pain in flexing the fingers. He does not feel when the bed is pulled out of his legs. And describes the touch of a pinprick on his legs as a scratch.
He recognises the prick of a pin at one and a half inches, but cannot distinguish between the needle and point of a pin. In some instances, he did not recognise as separate points those of a pin of compasses even when they were separated 3 inches, firmly pressed against the skin. Can only just recognise the prick of a pin in his hands, and could not distinguish the prick of a finger as such. Sensation is also considerably delayed, especially the term of heat. He can recognise the heat of a warm flame after 5 seconds in the hands, and in his foot after 9 seconds. As before stated, he appears quite insensible to the slightest continuous current. In the solar region of the spine there is great tenderness for about 1½ inches. There are no movements of the legs or feet on tickling the toes, and no deep reflexes are present on both sides. The pupils are moderately dilated, and faint pupillary light. Vision apparently unimpaired. No pathological anatomical condition was made. He is somewhat deaf; he cannot hear the ticking of a watch when it is placed at a great distance, but from 1 inch from the left ear. He affirms that he has always been deaf in the right ear, from which there was a running for several years.
Case of Mr. M. in Ani. (Continued) 2:

His tongue unaffected. He is quite unable to swallow anything with his arms, legs, etc. Constant hiccup present in all muscles. In case only just close his hands. When any attempt is made to move him, he complains of great pain. When forced anything down him, an attack of vomiting occurs immediately. The hand taken frequently, being regurgitated, running his nose. He cannot write, though he brings his lips very near together. On closing his eyes, squeezing his muscles forcibly together, the right hand lateral point is found. The so-called 'fasciculata' is nowhere noticed. There is no pain in the muscles of the legs. Central fasciculata unnoted.


Was put on common diet. and an official receipt medicine (Hospital Pharma Spain). No. 4. P. 10. April. 3 fr.


Pt. Ananita. 3 fr.

Pt. Zvi. to air.
Jan. 19: 1849. Did not sleep well till a sleep.

my thought had been administered. He can

planar of great pain in his left ankle, and

mildly pain in his right. Perspiration freely.

insp. 98 60" Pulsc. 128 Respir. 46.

Can just bend his left leg. Nightly at the knee.

Muscles of his protractor belly tender and sore.

more. Movement causes pain in his joint. Muscles can slightly rotate legs outward and inward. The foot falls sideways. Can drag the right leg up with difficulty, but is able to move the right foot and toe fairly. The left foot feels slightly. Muscles of his still somewhat better, but not so much as in the legs. He can just get his hands as high as his to his head. He can feel his feet

[chart]

64: The movements of the right arm are much improved, and the pain is the limbs are

much better, except at night. The movements

also in his left arm are improved. He is

cable to extend his fingers and wrists of both hands, and can move them in his right

hand above his head. Pains in his eye,

clear, but takes for it well. J. Normal. p. 38.

A: do.

15: Pains in shoulders and right side have disappeared. but he still has pain all over his

left leg, which does not bend or extend as it

did yesterday. Suffer a good deal from
19. Complains of great pain on pressure on the right side of the abdomen. The pressure over the right malleolus and the muscles of the right thigh are still very tender on pressure. He recognizes the pain of a few quicker but he cannot discriminate between the touch of a finger and that of a thumb. He says his abdomen is tense. He is sensitive to variations in pressure. He does not know whether his legs are lifted or not. He can just hold a spoon with his right hand, but frequently lets it fall. His right hand is a little weaker than his left. Has much pain when the fingers are pinched. Has constant feeling of numbness in the fingers and in the hands. Still has the same pain at night. Takes cold iced. 

O. P. Tongue dry. Ordered belladonna.
Jan. 24 Ahas very sad sight tonight. Walter's foot won't hold up well. Siffs quickly in small's fluids. He says his hands feel more numb when they are kept warm under the towel, and that he is unable to use them as well as off. They were kept uncovered. When he stops the tooth paste (29.) it can be taken from him when his eyes are closed without his being aware of it. 92. P.S. normal.

24th. Complaint of achning pain in legs, ankles, often symptoms as before.

A strong transonic current sprints on the muscles at all over his leg except in the extensors of the toes. Another fibrillary movement must only be observed. Very tender areas are everywhere eroded by the current in his legs. The muscles of the arms remain are very sensitive to the current. Transiently:

Feb. 14th. Has improved steadily. Grip of right hand = 5 kg. dynamometer. Grip of left = 7 kg dynamometer.

Feb. 21st. Grip of both hands about the same, each being about 9 kg dynamometers. In the last 3 or 4 days he has been able with assistance to get out of bed, and now he can manage to get from his bed.
The fire place (about 10 yards) by cat. with
fold of his beds and pretty supporting him:
self as he goes along - he lags his feet and
legs and if he stands too walks too much.
He can distinguish between the print and head
of a pen in both arms - knows recognises the
branch of a fungus as such. The sensibility of
the feet legs has diminished in a correspond-
ing degree.

The left foot and leg respond better than
the continuous current from the left.

When sitting, he can extend his legs freely,
and can joint feet, stand up, and adduct
foot slightly cannot abduct it or invert
it forwards. Has much little control of
movement.

March 31st: Returned from Woodfor.

Can walk well. When sitting on, there is only a
slight tremor visible only. Says he feels
ingenious things occasionally. When holding
out a cup of water the arms tremble a
good deal. The fine fingers of the right
hand is 21 1/2 grammes - the left 22 -
Has no sign of any desquamation. The
dorsum of this somewhat wet and
in his hands and arms - he cannot see
and very paroxysmal lesions (e.g. sweat, hotspots)
drew them between his fingers.
When bent ahead of arm is found forming
he then recognises it as such but can-
First recapilll then wear - less pain in backs.

My knee undens both are pressed firmly against them. The sensation in the feet legs is still slightly unpassed, but less much less so.

but than formerly. It is about equal in the arms and hands.

Patient then left Hospital, with in.

sometimesatoes feets incicularly occasionally.

he had been listening extensively赞誉

of your til he cut to Morton - or

alsome ofthe time when there he did

notreturn up again till September 1880, hav-

ing felt no much better, and able go to

his employment. When cane then he

seemed guilt well - was leading an active

life. But 2am in lace of lameness, soon

his previous symptoms had according

the statement "guilt vanished."

1884. He was again admitted on May 24th 1884.

complaining of loss of sensation in his legs -

of moving pains in the back of his legs, his

knees, and shoulder arms.

History: Since last seen he had enjoyed good

health (with the exception of occasional slight

rheumatic pains) till the 19th mil. when

he began to suffer from a "movement" sensation

in his face and tongue. The con.

slirious first began in the tongue, and extended

to cheeks, cheeks, velum, between 8 or 10 o'clock.
of the same day. (It had not lately been agreed to be said to cold and cold.) The day following his fingers became scrambled, he says the feeling was like that produced by a galvanic battery, especially at the tips of his fingers. The following day he took castor oil. Dr. H. E. H. noticed that the sensation of numbness was gradually subsiding in intensity from the foot upwards. On the 22nd he was still able to walk, but he was "sleepy" and "numb" in the arms. On the 23rd he noticed, as did also his fellow patients, that his gait was staggering. The numbness had increased; he says he felt it more, every time he fell up after sitting down. On the 24th he became little hospital. On a admission the numbness had increased slightly. The description of his general appearance to the naked eye was not already recorded.

Postmortem: Complaining of a feeling of numbness in the feet, legs, arms, hands, and head also. The percutaneous to bend, kick, pull, heat, and cold, as well as delayed. From the sensation is more impaired on both legs as well as delayed. From the sensation is more impaired on the other.
44 (Case of Mr. Black, continued.)

The legs, then on the floor:

Dorsal reflexes are also minimal, for when the feet are crossed, and are touched, the right is called the left plantar reflex. When crossed, he is made more often positive, he is able to judge weight about impressions received.

When the legs are separated, and he is asked to point towards his great toe, with his eyes closed, he only does so very unperfectly.

The ankle reflexes (plantar) were absent or quite limited. Plantar reflexes also absent.

Upper pathological reflexes present. When asked to lie and to move, he was able to do so fairly, but with closed eyes, he seemed to pro-

When attempted to make this flight foot was frequently brought down first and the movements of the leg came.

The cremaster reflex was made positive in his legs is also seen in minimal health. When lying on his back, he is unable to raise them from the bed, against an invisible amount of pressure.

As regards the upper extremities, when asked to touch the thumb of one hand, when placed at a distance with the middle finger, often, he, in this fails

originally between, or does not in many attempts. He also fails originally to clasp
his hands under the same circumstances, and when asked to stretch his left arm, with wider fingers of right hand, he makes the wildest attempts - goes very near of the mark, reaching for head, chin, shoulder, chest near etc.

245. Head agitated but steady to reach but slightly, light, but with no rapidity to accommodation.

244 lbs moderately dilated but equal, to reach but slightly, slightly, but with rapidity to accommodation.

243 lbs. required to Bkagrams - right

244 lbs. 25 lbs. 90 lbs. 4 lbs. 26 lbs.

256 lbs. Good power.

256 lbs. 245 lbs. 244 lbs. 243 lbs. 242 lbs. 241 lbs.

26 lbs. Slight will - complains of burning pains in his ankles especially in the left one.

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26 lbs. Slight will - complains of burning pains in his ankles especially in the left one.
He seems afraid that more pressure than
was known admitted. He lies with head-
then ask to turn to side, he only turns
the upper half of his body. When he at-
teports trait are he complains of much pain
in the loins. He is quite unable to raise his
but from off the bed. Hands in some intervals
also right frontal headache, and the
cough is still going on.

[Note: pulse 80 full. Remains at open for 2 days.]

Medical Dr. Adjey again: 80.

When the point or head of pain is reached over
for two years after lift leg, above the knee, the
considerability is found only by the slightly below
the hipline. He can distinguish well at distance
difficulty other between the tip of a finger
from point of pain, when they are drawn
over the surface of right leg.

Muscle of leg somewhat app.\footnote{f. o.}

Pupils react less readily. Temperature:
28\footnote{f. t.} Sept 7th. 11. Tomm: had great pain in his
back which could not lie in any position more
than 10 minutes. He also had pain round
his body. There were much worse severe after
midnight. The felting of sensitiveness state per-
cepts in the same situations. Apparatus
feeling, longer stay behind in centre stop-
formed unrest at sit-in with one: Pulse 84.

full regular.

\footnote{f. w.} - 2: 03. 24 Dec. 87. 1810. 28. adm. o. the.

\footnote{f. c.}

To Mr. Green: 

\footnote{f. c.}
29 1/2. Had a strange of 36 men of P. armi:

30: 5, enlisted Am. 36 men. It was found
that he had difficulty in holding a cup, be
cause he could not get it. This month, put-
ing the contents when attempting to do
so, he being seized it, was unable to hold it to
take hold of it again, except with
difficulty. There has also been gradually
increasing difficulty in swallowing
in the last day or two, about which he
has not always complained. It is
in more marked today, especially
when swallowing liquids, which are
frequently regurgitated through the
nose. There has also been some diffi-
culty in taking solids; he is fed chiefly
on semi-fluid diet. P. 106. Mr. Sullivan: R.P.

24 1/2. F upon 99 F.

30 1/2. Slept for about 8 hours after comp-
ing a night. Complaints of sore pain
in the head, the mouth, too much use and
in his hands which put quite "tuckled"
clearly; some his own words. "The
level part. He had very marked left
arm; very red. I put my hand on
in centre of arm so at margin than
yesterday. Was covered with moles.
Passes warm; naturally. Remits to
open vi. sick of M. arm. Cold, right.

He yawned, jumped fast.
5. Mr. Nelson continued.)

11th: 1/2 grs. oil at 2 A.M. His run failed
6 times, then became so severe a
for about 8 of which was rapidly followed
by copious vomiting.

Mr. 4th & 5th. Amen. Colonel. 
May 9th, 10th.

Daily from 4th. Mr. 7th, 8th, 9th, 10th. Amen.

May 9th: 10th. Amen.

11th: About 10 p.m. last might be asked the
word with, when his breathing became
very quick, laboured, especially during inspira-
tion - the complaint of ascreeation as though he had something in his throat
which prevented him from breathing. The
pulse was 110, small. There was a dull tone
over the lungs, when both were often heard
above, especially on the right side. The breath
sounds being almost absent in that side.

Inspiration was almost accompanied
with small shuddering in the throat and
the chest and sides. The attack of
hypersomatia lasted about 25 minutes, after
which the respirations became slower,
but were still somewhat laboured. The
upper part of the abdomen can be in throes
inspiration, apparently from an action
of the diaphragm - after the attack be
became much exhausted. He had half
an ounce of Dr. and which he swallowed
with very great difficulty, and after
Drugs Attempted-

At 12.15 A.M. (June 15th) having very convulsions. The House Physician called him an injection containing 50 min. 0 Spirit of Nux vomica in 1 oz. which was administered. His breaths being slightly more accelerated time at 12.45. The reaction again became laboured. The pulse now rapid, pulse irregular, he seemed very collapsed. Had a subcutaneous injection of 10 min. of ether. His respiration gradually assumed a gasping character and became slower. His pulse intermittent. There was peristalsis in the rectum. He gradually became unconscious and found himself several times before death, which took place at 1.25 A.M.

P.M. Report—June 16th:

Obstinate: The Pia Mater was seen to be convulsed with blood vessels over the motor area of the cerebral hemispheres (an area that was shown in the figure) indicating the extracerebral space. There was no appearance of any condition in the dura mater by its opacity.

Diagram 1: occipital
There was some excess of cranial-mental fluid. There was nothing pathological in the eyeball except the redness in the temporal end. The veins in the superface of the brain were enlarged and congested. There was a slight ophthalmoscopic light for about an hour along the lower margin.

= Symptoms of Case =


Lagging symptoms in Dec. 1878. Helps comes to bed has great pain when they are extended - caloric tests at pressure - impossible to bring Galvanic current - percussion in limbs etc. Pains in Peroneus Vag. Anesthesia in arms & legs. Sensation plantar reflexes 
- delayed. Help right arm slams on left sides of accessory tenderness in left ear. In sight deafness.

No symptoms can only just close hand with pain.

Great pain in movement - can only crawl.

Great difficulty in opening mouth - cannot swallow solids without difficulty. Central function may
feated. Remarks only of my letter to President - In the
March less officers in Cagi - Received by Letter of
Brevet of P. President: in answer was decided to return - Had panic in joints but no evidence -
Jim last in Snack Bragglet. 8th 36th - Panic
Confidentially described in secrecy - In a fort yet.
Ate cake and wine - Remarks of Colonel W. B. B. Gin.
Anecdote in arms command continued -
In a minute had regained abort and officers
in Cagi - He was made St. up not fixed - walk
a short part since - Above thing heart broken.
peeled from arms it. In three minutes had recovered
remark that only a slight command was
perception in walking - Pains all joint
obliged about being only stiffness that like.
Him came up. 1880 has perfectly
well - Him again admitted in Aug 24th. 1884
with similar symptoms; 8th was examined
perfectly well the 1st of Oct 1st when he felt
permanently in jacks strap - Just may have
been cured of fever. Him left Keg.
23rd in barracks - Him occurred - There
was also in case where observed migration
in legs - especially in extremity surfaces.
in my second recorded name. Planters +
Palaters W. B. B. B. Letters advent - Consider what remains
weight above in legs - He there was much in
in hands in arms - Had hernia panic in
and was, 10th panic in legs - Pains in
covered. Could not walk with difficulty in bed.
(6. 28th. Mr. Baker, continued.) Pains in abdomen —
feeling appetite. Increasing difficulty in
swallowing especially fluids. Tongue dry —
Bouche dry. Rectal prolapse — m. 31/8. day (i.e. almost
munch after admission) had an attack of severe
hypertension — hypoglycaemia appeared paralysed,
permanent hypoglycaemia ensued, without some
mgt. apparently from organic paralysis.

Microscopical Examination.

I could find no definite changes in the
Spinal cord (v. Slides 105 to 109; Dag 45. and e. c.)

beyond what appears the same increase
number and apparent activity of the nuclei
of the lower part. (v. Slides 105, 106; 107; Dag 8.)
in these nuclei stained with carmine (for
process) the nuclei stand out with remarkable
brilliance the nucleus, it with particularity
to draw attention to them. beyond it will
be seen that the nuclei around the central
canal are relatively numerous, from a
brilliantly stained mass. Beyond this
nucleus there seems the nothing remarkable
about the spinal cord — I don't
say much whether this is in any way to
be regarded as abnormal, only one impression
being that it is so accidental.

The course of the hardening can unusual
way demer is extremely bitter, as though
it is unusually difficult to pumpstone
Of them - indeed harm was scarcely felt in daily practice, and should not remain any. The only men, indeed, were longitudinal ones - only the main bundles of brain and spinal cord. Those were transected. The drug appears to have some effect on degeneration, probably by a neurtotic action. The blood vessels are filled with blood. The fat connections become apparent increased, and the dead and healthy appear broken up and indistinct.

(Plates 10 & 113. France.) As far as known to judge, the muscular fleshes often sit a - phragm and don't appear changes undergo any change. None of the muscles are examined microscopically.

- Remarks -

I think there can be no doubt that the dose on human just summarized was agreed closely with that of "Progressive Multifocal Leukodystrophy," as seen by Gramijs and Shore. The disease being first described forms by Jannin 2. The main facts in support of this diagnosis being briefly, as follows -

1. The History of sudden onset of the symptoms
   - References -

and, last, in a man of previously sound health, of the following symptoms:-

A loss of power in his limbs, with difficulty in action of his limbs, and weakness of his 

It is important to note that these symptoms are accompanied by loss of power in the arms and legs, and also marked by absence or presence of these symptoms. There are additional symptoms of anemia and loss of muscular force.

The characteristic group of symptoms could only be explained either by a primary affection of the central nervous system, the only two affections likely to be associated with it, being acute ascending paralysis, and the involvement of spinal or peripheral nerves of the person. But a careful consideration of these phenomena often turns the diagnosis.

In this particular case it is important to note that the symptoms are accompanied by an acute denial of sudden weakness, with the face or in dressing his clothes.
2. In many cases the patient comes off the cure very well, sometimes rapidly, sometimes more slowly, but under the care of a physician and in a suitable climate. The symptoms are not severe, and the patient is able to continue with his usual activities.

3. The point of interest in this case is that the patient showed a marked improvement after being treated with a special diet, which was followed by a complete remission of symptoms. This suggests that nutritional factors may play a significant role in the management of this condition.