

fact that the calcification tended to take place at the junction of the grey and white matter about a cortical fissure. In the only case in which the calcification was localized, operative excision resulted in great improvement. Microscopic examination showed the process to be vascular. The glia changes were focused about the smallest blood-vessels, and the deposit of calcium had taken place in and about the walls of these small vessels. There were no areas of softening. The authors think that the calcification was undoubtedly secondary to the localized chronic destruction of tissue due to closure of the small vessels. Periarterial sympathectomy of the carotid and vertebral arteries of one side resulted in the conversion of bilateral into unilateral convulsions. The disease might be named "cerebral calcification epilepsy," and the actual pathological process is an endarteritis calcificans cerebri.

G. W. T. H. FLEMING.

*Tumours of the Brain with Acute Onset and Rapidly Progressive Course.* (*Arch. of Neur. and Psychiat.*, May, 1929.) *Elsberg, C. A., and Globus, J. H.*

The authors describe a group of cases with acute onset and rapid clinical course in patients, mostly men, between the ages of 40 and 60. The tumours were usually large spongioblastomas and were most often located in or near the temporal lobe. The differential diagnosis from acute encephalitis or a vascular lesion was often difficult at first. Some of the cases presented a clinical picture like that of metastatic malignant disease. Treatment, surgical or otherwise, gave poor results, but life was most prolonged by partial or complete removal of the tumour.

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*Tumours in the Region of the Third Ventricle; Their Diagnosis and Relation to Pathological Sleep.* (*Journ. of Nerv. and Ment. Dis.*, January, February and March, 1929.) *Fulton, J. F., and Bailey, P.*

The authors describe five cases of tumours in the region of the third ventricle and then proceed to analyse the symptomatology. Hypersomnia of periodic type the authors consider is due to a lesion near the anterior extremity of the aqueduct of Sylvius. Polyuria they consider is due to a circumscribed lesion in the tuber cinereum. Acromegaly they think is due to lesions of the hypophysis, not of the hypothalamus. Patients with tumours of the third ventricle often exhibit a curious emotional negativism. After some discussion of the views of various writers the authors conclude that there is no syndrome of the third ventricle *per se*, but tumours immediately affecting this cavity may cause characteristic symptoms by pressure upon its walls and their contained nuclei and tracts. Among the well-recognized syndromes due to lesions of these structures the authors mention (1) the infundibular syndrome (polyuria and adiposity), (2) the syndrome of the central grey matter, around the

posterior end of the third ventricle and aqueduct of Sylvius (hyper-somnia), (3) the thalamic syndrome (central pain, hyperæsthesia), (4) the extra-pyramidal syndrome (bradykinesia, rigidity), (5) the decerebrate syndrome (hypertonicity, Magnus-de-Kleijn reflexes), (6) the syndrome of Parinaud (paralysis of conjugate vertical movements of the eyeballs), (7) the syndrome of the body of Luys (hemichorea), (8) the hypopituitary syndrome (infantilism, hypotrichosis, lowered metabolism), (9) the uncinata syndrome (olfactory and gustatory symptoms), etc.

These syndromes are of localizing value more particularly when they occur prior to the onset of pressure symptoms.

G. W. T. H. FLEMING.

*Dangers of Diagnostic Lumbar Puncture in Increased Intracranial Pressure due to Tumour of the Brain. (Arch. of Neur. and Psychiat., May, 1929.) Masson, C. B.*

In 94 cases of verified intracranial tumours, in all of which well-marked signs of increased intracranial pressure were noted, and in 62 of which the growths were supratentorial, the removal of a small amount of fluid by lumbar puncture did not give rise to any serious symptoms. Of the patients who had verified or suspected infratentorial new growths, and in whom lumbar puncture was performed before the diagnosis of expanding disease in the posterior cranial fossa had been made or suspected, not one developed any untoward symptoms after the puncture. The author concludes that in cases of increased intracranial pressure there is no danger from diagnostic lumbar puncture if it is carried out with the patient in a horizontal position and with a needle of small calibre, and if no more than 5 c.c. of fluid is removed.

G. W. T. H. FLEMING.

*Disorders of Sensation produced by Cortical Lesions. (Brain, October, 1927.) Holmes, G.*

The author records the results of his examination of sensation in large numbers of men with gunshot wounds of the head both during and after the war and in other instances. The qualities of cortical sensation are: (1) The appreciation of relationships in space, (2) the faculty of reacting appropriately to tactile stimuli of different intensity, and (3) the recognition of similarity and difference of test objects of various weights and sizes. Pain and thermal sensibility and the vibration sense are not affected by disease of the cortex. The distribution of cortical sensory disturbance is always limited to the opposite side of the body. It is, as a rule, more pronounced in the distal than in the proximal parts of the limbs. The disturbance of sensation is often apparently confined to or at least more pronounced on one side of a limb. Numerous observations indicate a topographical representation of the fingers in the sensory cortex, similar to the motor representation in the precentral gyrus. The sensory sphere of the cerebral cortex,