*Mania with Amaurosis and Paralysis: Suspected Glioma.**

By W. J. Vincent, M.B., Assistant Medical Officer, Borough Asylum, Nottingham.

Eliza Elliott, aged 30, house-wife; married. Admitted into this asylum November 4th, 1896.

History of the Case.—The patient has not been in good health for the past 12 months. During this period she has suffered from menstrual irregularity, with considerable loss at periods varying between two and three months. Two of these "floodings" were probably miscarriages. She suffered much from headache, generally "all over" the head, but frequently referred to the "top of the head and back of the neck," and was sometimes sick, but not frequently, and at no particular time of the day. Three months ago, however, while at work in her home, she lost consciousness and fell, wounding her forehead and eye on the left side. She was convulsed, and this convulsion was followed by two others during that night. The seizures were described as beginning in the arms, which were spasmodically extended, the hands being clenched; the face was drawn to the right side, and the eyes rolled up; twitching of the facial muscles followed. The fits lasted a short time, and the patient did not sleep after the seizures. Vomiting was severe during the night.

Next morning patient was found to be unable to stand or to attend to herself in any way. During the next week headache was continuous and intense at times, the patient throwing herself about in bed in pain; vomiting was frequent, and food retained with difficulty—fluid food being often instantly rejected. Vomiting, however, gradually subsided and headache became less intense and persistent. Subsequently she developed hallucinations of sight, and vision was noticed to be imperfect. She became very restless and sleepless, "wandered in her mind," and faulty in habits. The family history is negative, except that two brothers were said to have been peculiar. Patient has had eight children—all healthy.

On admission to this asylum, a month after the sudden onset, she was absolutely helpless, very restless, chattered continuously and incoherently, and later became decidedly drowsy. If questioned she took but little notice, but sometimes made some irrelevant reply.

When examination was possible she was found to be fairly well nourished and of healthy aspect. There was no cardiac, pulmonary, or renal complication, and the nervous system alone showed signs of abnormality. There was much vacancy of expression, which I thought was due to paresis of the facial muscles, but there was internal strabismus and ptosis of the left eye. On the

* Case shown at the General Meeting, February, 1897.

vision being tested patient could count figures and detect bright objects with the right eye; but in the left eye the amaurosis was absolute. The right pupil reacted sluggishly to light and with accommodation. The left consensually, but the direct reflex to light was lost. The pupils were moderately dilated. By the ophthalmoscope there was well-marked double optic neuritis, more advanced in the left eye. The movement of the left eye was deficient outwardly, the patient being unable to bring the eye well out toward the outer canthus. The tongue was coated, tremulous, protruded normally; there was tremor of the lips when patient was speaking, and speech was slurred and indistinct, and articulation imperfect.

Hearing was normal, but the sense of smell less acute than normal. Taste, as far as I could ascertain, was natural. The patellar reflex was unequal on the two sides, the right being decidedly the more brisk of the two, and this condition obtains to some extent at the present time. The superficial reflexes were normal, and sensation to touch and pain were natural. Patient was unable to stand, but had power over her lower limbs, and they were usually drawn up as she lay in bed. There was no incoordination of the upper extremities.

Progress of the Case.—During the first week the restlessness was extreme. Patient was placed in the padded-room, where she lay curled up, with her knees drawn up, arms flexed and head bent towards the sternum. She was continually throwing herself about, jerking her head, tossing the clothes off her, chattering incoherently the while. If questioned she sometimes made some reply, usually irrelevant. Her habits at this time were faulty. Subsequently she quieted down and gradually regained mental stability. The case was thought to be possibly of specific origin, and mercury and potassium iodide was given. The improvement continued, and patient regained muscular strength. Ptosis less marked, and the movement of the left eye of wider range, in an outward direction, but the squint still persists. She was able to stand and to walk if supported by a nurse on either side.

But while she improved both mentally and physically, her eyesight steadily became worse, and three weeks after admission the amaurosis was absolute, with dilated pupils and loss of light reflex in both eyes. By the ophthalmoscope the fundus showed no further change, well-marked papillitis being present. The mercury and potassium iodide was pushed at first, with the result that the patient was severely salivated after she had taken the drug for a fortnight. This cleared up under atropine in a week. During the time she was salivated she became mentally affected—she became restless and emotional, and developed hallucinations of sight and touch, patient imagining she had a child in bed with her.

From this time she progressed well, and is now pleasant, tidy,

and cleanly in habits. Memory for past events seems to be excellent, but there is much mental confusion as to recent occurrences. The ptosis is scarcely observable. There is still internal strabismus and absolute loss of sight, and the ophthalmoscope shows the papillitis to be clearing up, and the condition seems to be advancing into the atrophic stage.

The diagnosis of the case I have found of considerable difficulty and interest, and I have not been able to come to a definite conclusion. From the history of the case and the symptoms observed at the time of her admission I think there can be no doubt of some coarse lesion of the brain. We may safely eliminate epilepsy, embolism, and hæmorrhage, as optic neuritis seldom obtains in such conditions. The urine is normal, and there is no evidence of renal disease. No history of specific disease is obtainable from her relatives, though most careful enquiry was made.

That the optic neuritis is of anæmic origin may be, I think, excluded, and there is no history of lead poisoning. Neoplasm alone remains, and there are some symptoms in its favour.

Among the general symptoms we have convulsive seizures, vomiting, headache, and optic neuritis; the two latter symptoms persist at the present time. It is not uncommon for the convulsions to be few and infrequent, but one would certainly have expected the vomiting to have persisted, and this introduces one difficulty.

Of the localising symptoms the following may perhaps be of value:—Ptosis of the left eye and paresis of the left external rectus, causing internal strabismus; the more advanced disease of the left optic nerve; and as to the headache, the pain being on the whole most frequently referred to the left temple and left side of the head.

Another point of considerable value is, I think, the very rapid loss of vision—the patient was absolutely blind six weeks after the convulsions, and before the seizures her sight was stated to have been good.

This rapid loss of sight is in favour of a direct implication of the optic chiasma, so that the position of the lesion may be assumed to be at the base of the brain, almost central, but possibly involving the left side more than the right, and partially involving the 3rd and 6th nerves of the left side. The paresis of the lower extremity is not readily explained (especially as a specific history is not obtainable), unless direct pressure on the corpora striata could cause such an effect.

From the history we must exclude gumma, and though a localised meningitis might be seriously considered, the want of a syphilitic history is, I think, against it. If neoplasm the nature of the growth is difficult to determine.

There is another point in the progress of the case that leads to difficulty, inasmuch as the patient has steadily improved and was improving before the exhibition of mercury and iodide—therefore I cannot think the improvement can be ascribed to the drug.

In conclusion, I may venture to offer an opinion, hypothetical certainly, but still within the range of possibility. We know that gliomata are a fairly common variety of brain tumour, and that this variety of growth is liable to hæmorrhage into or around its substance. I think it probable that the case has been one of longer duration than is at first apparent, and that the sudden exacerbation of the symptoms might have been due to hæmorrhage into the tumour, and with partial absorption of the blood the severe symptoms have abated.

Hysterical Hemiplegia and Aphonia with Mental Symptoms.

By S. H. R. Montgomery, M.B., Assistant Medical Officer, Borough Asylum, Nottingham.

S. U., married, aged 42, has led a hard life, was a heavy drinker and a noted boxer. He had always been healthy.

In November, 1895, he had a fit during which he was unconscious and jerked his arms and legs. On recovering consciousness he was found to have lost all power of speech although he was able and ready to make himself understood by signs. His right arm and leg had also become much weakened. For some days after this he had a series of convulsive attacks. These passed off, but left his arm and leg quite paralysed.

He was confined in bed from this time till June, 1896, when he gradually began to recover the use of his arm and leg; his voice, however, being still totally lost.

In October, 1896, he became an in-patient in a hospital, where intralaryngeal faradisation was performed on him. The result of this was complete and immediate recovery of his voice, followed by an attack of acute mania, during which he tried to jump through a window and struggled violently with those who tried to prevent him.

He was removed to this asylum the following day. On admission he was violent and maniacal. Next day he was quiet and sensible.

Range of vision of right eye was slightly decreased. Deaf in right ear. His right arm was wasted and slightly rigid and he