

lation should be given. There is a well defined area, external to the olfactory tract, and in front of the uncinate gyrus, stimulation of which causes arrest of breathing. This area rests directly against the base of the skull and is therefore liable to injury by either direct or indirect violence. In one case, dying of respiratory failure after a fall, autopsy revealed a marked laceration of this part of the brain.

JELLIFFE.

DE LA GENERALISATION DES CRISES EPILEPTIQUES CONSECUTIVES AUX TRAUMATISMES LOCALISES DU CRANE CHEZ L'ENFANT ET DE LEUR TRAITEMENT. (Generalization of Epileptiform Crises Due to Localized Traumatism on the Skull in Childhood.) Chipault (*Travaux de Neurologie Chirurgicale*, April-July, 1900).

Chipault states that while in the adult, injury to the cortex only causes Jacksonian epilepsy, as a rule, in the child we usually find that without the slightest predisposition, the most limited trauma may cause general convulsions. The author relates ten cases to demonstrate his thesis and several cases are here given as examples.

Case V.—H. F., aged four years; spasmodic hemiplegia with epileptiform crises. Cause probably an intra-uterine trauma, the mother having fallen when she was seven months pregnant. The labor itself was easy, and the child was normal at birth. When seven months old, the spastic paralytic condition was first noted, and at about the age of one year, slight epileptiform crises appeared, which soon degenerated into ordinary epileptic attacks. Chipault first saw the child when it was four years old; it was well developed and bright, but could hardly walk, and had speech disorders and convulsive attacks. A cranial depression was found corresponding to the Rolandic zone. Chipault performed resection of the cranium; beneath the dura a cicatricial area was found in the cortex. During the next six months there was but a single crisis; the patient then passed from observation.

Case VII.—D. F., aged nine years; was hit at age of one year on the vertex of the head by a piece of cornice. Fracture of skull diagnosed, but no surgical treatment. During the eight or nine months no bad results, but gradually periods of "absences" set in, followed by generalized epileptic crises. Spastic hemiplegia then developed on both sides. When Chipault saw the boy he was nine years old. Contractures were marked, but no muscular atrophy. Epileptic seizures at the rate of two or three per week. Chipault proposed an operation, but patient had not presented himself at the time of writing.

These ten cases reported show without doubt that this species of general epilepsy may be due to intra-uterine trauma, obstetrical trauma, and injuries of ordinary character. The injuries varied greatly in character; simple fracture, flattening, depression, perforation; finally, several cases presented no lesion whatever. If the lesion was seated outside the motor zone, the generalized convulsions constitute the dominant symptom. If within the motor area, the convulsions were still prominent, but the hemiplegic phenomena were more in evidence. Briefly put, extra-Rolandic trauma equals epileptic seizures; Rolandic trauma equals the same number of seizures but of a spasmodic hemiplegic form.

CLARK.

INTESTINAL NEUROSES. J. W. Rothwell (*Medicine*, March 1900).

The author proposes the following classifications:

(1) Peristaltic restlessness dependent upon increased irritability of the motor nerves of the small intestine, and causing gurgling,

or squeaking, rumbling, croaking, and brought on by emotional excitement and not accompanied by diarrhea, as the colon is unaffected.

(2) Peristaltic activity extending to the colon and upper part of rectum, and followed by precipitate diarrhea. These conditions are benefited by general treatment with arsenic or methylene blue.

(3) Enterospasm (or concurrent spasm of both round and long muscular fibers), due to increased excitability of the splanchnic nerves, and indicated by colicky pains and a doughy fecal tumor at or near one of the flexures of the colon. This may be relieved by warm abdominal cataplasms, opium or codeine, and soothing enemata. In this condition the administration of opium may be followed by a movement of the bowels.

(4) Ordinary colic, or temporary spasm due to local irritation. The cutting pains are probably due to the pressure of the contracting muscles on the terminal nerve-filaments, and may be overcome as well by antispasmodics as by anodynes.

Of the disturbances of *sensibility*, he describes: (1) anesthesia is normal except in the lower portion of the rectum. When this becomes anesthetic, as in hysteria, involuntary fecal passages may result. (2) Hyperesthesia, a feeling of distension without tympanites, of soreness without discoverable organic cause, of throbbings, flutterings, etc. (3) Neuralgia, a boring, pinching, or cutting pain centering about the umbilicus, sometimes accompanied by vomiting and feeble pulse, and suggesting peritonitis, appendicitis, renal or hepatic colic, or lumbar neuralgia. However there is no fever, the constipation is not obstinate, and the pain is relieved by pressure. Of secretory disturbances; Mucous colic, and excessive secretion of mucinoid, nonfibrinous material, coagulating on the inner coat of the bowel and discharged at intervals with colicky pains. It occurs usually in neurotic females, and is very resistant to treatment. One may use olive or castor oil as a laxative, cannabis indica for pain, sodium phosphate to prevent fermentation, and salol, resorcin, or bismuth salicylate.

JELLIFFE.

EIN FALL VON VASOMOTORISCHER NEUROSE, ZUGLEICH ALS BEITRAG ZUR KENNNTNIS DER NERVÖSEN STÖRUNGEN IM KLIMAKTERIUM (A Case of Vaso-motor Neurosis, as a Contribution to the Knowledge of Nervous Disturbances in the Climacterium). H. Zingerle (Jahrbücher für Psychiatrie und Neurologie, Vol. 19, 1900, p. 343).

Case.—A woman 46 years old. No nervous heredity. Neuralgic symptoms and migraine, which declined in severity during the climacterium. At this time the patient noticed a diffuse swelling of the fingers and hands on both sides, accompanied by vague pains in the arms and shoulders, more pronounced at night. The fingers were reddened, then pale and cyanotic. Subjectively there was a sensation of cold and slight pain in the fingers, stiffness with dulness in the perception of the finer movements. With the approach of warm weather these symptoms grew better. The next winter the condition returned unchanged. Physical examination showed no abnormality either in the internal organs or in the nervous system, except for a slight thickening of the skin of the fingers. No other trophic disturbance was found. The diagnosis in this case must first of all be made between a disease of the blood vessels and an organic disease of the nervous system in the course of which vaso-motor symptoms are prominent factors. A careful examination failed to reveal any