A CASE OF PSEUDO-HYPERTROPHIC PARALYSIS WITH PECULIAR MOVEMENTS OF THE UPPER EXTREMITIES.¹

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HE patient, L. S., whose photograph taken shortly after the time I examined him, was seen by me in a small city on the Rhode Island frontier of Massachusetts in 1881. It is unnecessary to state that his attitude and appearance is characteristic of that form of pseudo-hypertrophic paralysis in which the atrophy of the arms markedly antedates wasting in the lower extremities. It was this patient whose actions first called my attention to the peculiar movement (class of movements rather) which I have since been able to collate. Whether dressed or undressed, under examination and observation or not, he had a habit with his right hand—thumb and fingers flexed, the index finger but slightly so—of making a sudden motion toward the nose, such as certain persons in the lower walks of life are apt to indulge in when sniffing; at the same time there was a straightening out in his attitude as if all the muscles involved in maintaining the erect posture were associated in the act. A peculiar expression, which at this remote date I find it difficult to describe, crossed his face, his head and eyes being turned toward the approaching finger.

The family, one of culture, refinement, and wealth, were averse, as we often find it, to the unearthing of any family history. I had completed my examination of the child, as far as the physical signs were concerned, before this symptom had been sufficiently evidenced to attract my attention; when I remarked it, the discovery was associated with the fact that the child had certain imper-

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ative conceptions and fear of going under a certain tree, a terror of a Newfoundland dog, at the later hours of the day whom at others he showed a great affection for; he also had a terror of the stairs, and even on the ground-floor of the house, expressed in his childish way an impression as of a yawning precipice.

On discussing these symptoms, the father having left the room to order the conveyance which was to take me to my railroad station, the mother informed me that there were three members of her husband's family in insane asylums in the immediate neighborhood: a brother, sister, and first cousin; and that the grandfather of the patient had died in a well-known institution in the neighboring State. The form of mental disorder, as far as the lay statement, hurriedly made, permits me to judge, was paranoia, tinctured with primary deterioration. In the case of
the uncle of the patient, as in that of the first cousin of his father, it had been remarked that exactly the same motion had been habitual, and became constant and marked during the asylum sojourn. It should be added that the father showed a slight ataxia in the hands sufficiently marked to be recognized by himself; up to 1889, the date at which my knowledge of this case ends; the father had showed no further symptoms. The child progressed, as these cases usually do, developed a more marked grade of imperative conceptions and morbid fears, and a slight grade of imbecility. Like most patients suffering from what was at that period called "spinal disorder," the child had been circumcised, I need not add: without the slightest benefit.

Since then I have seen four other patients, whose histories I shall not read in detail, in whom similar strange
automatic movements were noticeable; in two cases they were bilateral, limited to the arms; in the third, associated with salaam movements of the head and neck; in the fourth there was a predominant effort to make a “hop-skip-and-jump” action, if I might so designate so clumsily performed a motion. As the patient walked, there was a long step on the right side followed by two on the other. This fourth case is the only one in which I might have been in doubt as to the interpretation of the symptoms, were it not for the fact of the family history, which, as in the entire series, is a bad one.

In a case not included in the above series, I had the good fortune to observe the patient at a period at which we seldom have an opportunity of seeing such patients, viz., adult life. He had studied theology and had become an ordained minister, but, becoming paranoiac, was seen by me in an institution for the treatment of mental disorders. He had a motion strongly resembling that of the first patient, greater, however, as regards the turning of the head and neck. The index finger alone was raised and slightly curved, and the patient would suddenly start at the rate of two or three times a minute, imitating a motion which one would make in saying, “I hear a noise there.” He had a fixed hallucination of sound, and located it exactly six inches in an accurately defined direction from the right parietal boss. This had no relation, which I could elicit,² with his paranoia as far as could be ascertained. He was an intelligent patient, and himself realized in his relatively lucid moments that it was unreal; he never associated it with his delusional ideas, but claimed that he had this condition from childhood. He died of diarrhoea.

In this case we obtained an autopsy. In 1879 the methods of examining the central nerve structures were not as advanced as now, and to my great surprise I found no signs of any structural disease whatever, either in

² It may be conceived that every means at my disposal was resorted to, in order to establish a connection of so suggestive a character.
the cord or brain. I found a heterotopia parallel to the claustrum at the region corresponding to the posterior slope of the Island of Riel on the left side, also some peculiarities of the gyri, which I then regarded as abnormal. They were asymmetrical and atypical.

THE BODY WEIGHT IN MENTAL DISEASES.

Fürstner, of Strassburg, bases his conclusions upon observations running through several years. He divides his patients into three classes.

1. Individuals with fully developed brains which were normal up to the appearance of the psychosis. In these there sets in, with the initial period, a reduction of the body weight. This is independent of faulty ingestion of food and the motor excitement. When the disease is progressing toward recovery, the weight increases, even if the patients are still in a state of motor excitement. This relation is especially true in acute mania, and rarer in melancholia.

2. In patients who are hereditarily disposed, or who have been through several attacks, their weight first sinks and then oscillates, until it finally becomes constant.

3. In patients suffering from diseases having an organic base, the body weight undergoes great variations. This is especially true of paralysis and periodic psychoses. For example, a patient suffering from a periodic psychosis, lost, before the period of excitement had set in and while the appetite was good, six pounds in the course of twenty-four hours, and sixteen pounds in the subsequent seven days. A loss of four pounds a day and ten to twelve pounds in four to five days is quite usual. This indicates the important influence of the central nervous system upon metabolism. The writer states that he has observed, in patients with brain tumors, a continuous and sinking of the body weight.—Deutsches Archiv f. klinische Medizin, Bd. 46.

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\(^3\) I have preserved the drawings of both hemispheres and the left occipital lobe itself. The details are more properly related in connection with another publication now in preparation.