patients with very large nevi, and his experience did not accord with the idea that they were uncommon in children. Nevi were not necessarily circumscribed, they might be diffuse. He asked whether this case was at all akin to von Recklinghausen's disease, and whether excision would not reveal that the nerves were enlarged. A case which was discarded as inoperable years ago was alluded to by a distinguished skin surgeon at the Clinical Society, and he (Mr. Lucas) suggested operation. That woman had a large vascular pigmentary condition occupying the whole of one thigh and buttock, with a varicose condition extending to the ankle, and he excised it piece by piece, making an ellipse from the knee to the ankle on two occasions, and gradually removing the hypertrophied buttock. He saw the patient recently and she was very much benefited by these operations which he performed ten or twelve years ago. No fear need be felt about operating on the condition in the present patient. It was true that a nevus bled freely when cut through, but with so many means of checking haemorrhage, that need be no objection to operating.

Case of Glandular Fever.

By W. H. Bowen M.S.

A temperature chart showing fluctuations in temperature in a case of enlargement of lymphatic glands in neck following measles, and shown as the most pronounced example of this type of "glandular fever," of which several cases were seen. The main points of the cases were that they followed attacks of measles at varying intervals, they started as a cervical adenitis and peri-adenitis with variable fever, that the constitutional conditions were never severe, and that complete recovery occurred without any suppuration in any case. It seems probable that the measles prepared the soil and that a slight tonsillar inflammation led to the secondary glandular change. The chart shows three weeks of continuous fever, the temperature reaching 102° F. to 103° F. at the end of the second week.

Case of Post-diphtheritic Paralysis and Hemiplegia.

By Laurence Humphry, M.D.

H. W., male, aged 11. History: December 12, 1909—an attack of diphtheria; December 24—headache and vomiting; December 27—paralysis of soft palate, weakness of legs and loss of knee-jerks; December 29—left hemiplegia. February 8, 1910: Condition when
first seen—left hemiplegia, face, tongue, arm, and leg; external strabismus and defective vision right eye; knee-jerks both absent, plantar reflex, flexor in right, extensor in left. May 18: Muscular power returning; left arm, contraction of fingers and wrist; left leg, some rigidity; exaggerated knee-jerks on left side, right normal; right pupil does not react to light, atrophy of right disk. July, 1911: Patient can walk; some spasticity of left arm and leg, and reflexes increased with Babinski on left side; face normal, external strabismus right eye, defective vision and optic atrophy.

The case is interesting on account of almost simultaneous development of post-diphtheritic paralysis and of a vascular lesion on the right side of the brain, probably a clot obstructing the Sylvian artery and the ophthalmic branch.

Dr. Leonard Guthrie said he was sorry Dr. Humphry was not present with particulars, but he gathered that two years ago the boy had an ordinary attack of diphtheria, and twelve days after that he showed signs of diphtheritic paralysis—i.e., palate paralysed, squint, and loss of knee-jerks. Shortly after that he suddenly became hemiplegic on the left side. For a considerable time the knee-jerks remained absent on both sides, but that on the left side gradually returned. He lost vision in the right eye. The present condition was mostly one of spasticity of the left arm, without complete paralysis, and his leg now seems to be fairly useful. There was atrophy of the right optic disk. The paralysis of the soft palate had cleared up, but the loss of vision on the right side and the hemiplegia on the left had not cleared up. He thought there was no doubt that the boy had embolism of the Sylvian artery, and of a branch of the ophthalmic artery occluding it. That would account for the hemiplegia on the left side and the atrophy of the disk which still remained. Dr. F. E. Batten and he had reported a fair number of these cases, in which hemiplegia of one side was associated with optic atrophy on the other—i.e., optic atrophy on the side of the lesion. In one case a boy, aged 7 years, was run over and had some ribs fractured, and shortly afterwards developed pneumothorax with displacement of the heart to the right. A week later he suddenly became aphasic, blind in the left eye, and hemiplegic on the right side. He recovered partially from the hemiplegia, but the left eye remained blind owing to complete atrophy of the disk. Another case was that of a young woman who, nine days after confinement, had a series of fits and became hemiplegic on left side. Three months later she discovered that she was blind in the right eye, and on examination the disk was found to be atrophied. He remembered a third case, that of a boy, aged 12 years, who fractured his left femur. After union of the fracture he suffered for a fortnight from pain at its site, and had an irregular temperature. Two weeks later his right arm became weak, ataxic, and tremulous, he dragged his right leg in walking, vision failed in his left eye, in which signs of retrobulbar neuritis were detected. All the symptoms
disappeared in six months, except that slight pallor of the left disk remained. Here the occlusion of the left Sylvian and ophthalmic arteries appears to have been less extensive than in the other cases. In one case (Dr. Batten's) an opportunity of verifying the diagnosis was afforded. The symptoms in an anaemic girl, aged 25 years, were: sudden onset of right hemiplegia, sudden loss of vision in the left eye, recurrent fits of Jacksonian epilepsy, increasing coma, and death in twenty months. At the autopsy, occlusion of the left ophthalmic and Sylvian arteries was found, with softening of the area supplied by the latter vessel, atrophy of the left optic nerve, and secondary degeneration of the spinal cord and optic chiasma.

Case of (?) Chronic Encephalitis.

By A. H. Miller, M.D.

H. R., aged 7 years. Rickets in infancy; osteoclasia of both legs; recovery. June, 1909: Pleurisy and bronchitis, followed by idiocy and spasticity of the limbs.

Case of Hydrocephalus and Buphthalmos.

By J. C. W. Graham, M.D.

D. P. M., male, aged 3 years. Right eye buphthalmic at birth and removed. Left eye gradually became buphthalmic and was removed in March, 1910. The head measured 20 in. in circumference in December, 1909, and now measures 22 in.

Case of Congenital Cataract.

By J. C. W. Graham, M.D.

F. S., female, aged 9 years. Congenital central deposit, posterior surface of each lens. Vision \( \frac{6}{15} \) in each eye.

Dr. Graham said there was an appearance of grains of black pepper scattered over the central part of the posterior surface of each lens. It was a rare form of congenital cataract. There was no need for operation, and it was hoped glasses would somewhat improve the vision—the retinoscopy showed a low degree of mixed astigmatism. There were no fundus changes.