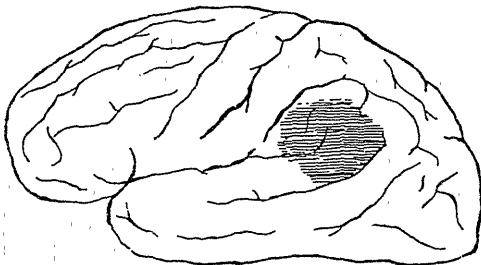


passed off, and now he is quite bright and intelligent.

By measurement the centre of the wound was midway between the tip of the mastoid process and the sagittal suture, three and a half inches from each point. It was one and three-quarter inches behind a line drawn vertically through the external auditory meatus, and three inches above a line drawn through the same point. The lines suggested by Dr. Reid afford perhaps the most accurate method of localizing cerebral areas. By this means the superficial wound was judged to be situated over the posterior portion of the inferior parietal lobule, just around the posterior extremity of the horizontal limb of the fissure of Sylvius. The area would in all probability be over the junction of the angular gyrus with the supra marginal convolution, and would involve the posterior extremity of the first temporo-sphenoidal convolution. The accompanying tracing represents the probable areas of the brain upon which pressure was exerted.



Remarks on the case: An interesting point in the case is the peculiar form of aphasia which was developed. Clearly the motor centre for speech was not affected. The boy understood perfectly all that was said to him, and was able to count fingers when asked to do so; there was no defect in articulation at all. The injury was some distance from the motor speech centre (*viz.*, the posterior part of the left lowest frontal convolution and the adjacent part of the ascending frontal convolution), and we would have been surprised had it been involved. The idea of sensory aphasia may be suggested; the region of the hinder part of the parietal lobe is probably, according to Gowers, the seat of the higher visual centre, and transient "mind blindness" may be caused by its disease, *i.e.*, an inability to recognize not only words but objects also. Although the injury was apparently in the position

which would lead us to expect mind blindness, yet the condition was not present; this was evidenced by the fact that the boy was well able to recognize all objects shown him; he could not voluntarily name them, but invariably assented when the proper name was suggested to him, *e.g.*, a knife or a key; further, as already stated, he could count fingers when extended before him. Another form of sensory aphasia is that known as word deafness, due probably to involvement of the first left temporo-sphenoidal convolution. The position of the injury might again suggest this form. There was not complete word deafness, he could answer questions intelligently by "yes" or "no," and was perfectly conscious as to whether an article was named rightly or wrongly by another. Gowers, however, states that in partial word deafness a condition exists in which there is great difficulty in the voluntary revival of words, especially of the more special words, such as nouns, and this sometimes constitutes the sole defect from the beginning. This describes the condition existing in our patient: he could not voluntarily use special words. This has been ascribed to interruption of the conducting path between the auditory and motor centres, and has been referred to cases of disease of the Island of Reil; it has been called "conduction aphasia." It is possible that the prong of the rake penetrated somewhat deeply into the brain substance, and either inflicted direct injury upon the parts through which the conducting fibres run, or by injury to vessels the blood supply to these parts may have been seriously interfered with and their function thus impaired.

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## Correspondence.

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*Editor of CANADIAN PRACTITIONER.*

SIR,—No doubt very many of your subscribers have had their attention drawn recently to a lecture, by John Marshall, F.R.C.S., of King's College, etc., London, on Cancer, etc., which appeared in the *British Med. Jour.* of Nov. 23, 1889. The principal point of interest in that lecture to me at least, is the suggestion made as to the etiology of cancer—namely, that the new growth is the result of escape of the epithelial