Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, February 3rd, 1888.

JAS. PERRIGO, M.D., PRESIDENT, IN THE CHAIR.

Drs. Spenclove and Laberge were elected members.

Amyotrophic Lateral Spinal Sclerosis.—Dr. STEWART showed a case of amyotrophic lateral sclerosis. The patient, a man aged 34, always enjoyed a good health until his present trouble began, which was about a year ago. The first symptom complained of was a feeling of pricking, coupled with a cold sensation in the ball of the left thumb. Shortly afterwards, wasting of the thenar eminence was noticed, and this was quickly followed by wasting of the interossei of the same hand. At the present time there is very marked atrophy of the left thenar and hypothenar eminences, and of all the interossei of the same side. There is slight wasting of the flexors on the anterior surface of the forearm and of the biceps and deltoid of the same side. The spinati, as well as the rhomboids and pectorals, are also the seat of marked atrophy. There is slight wasting of the corresponding muscles of the right hand, arm and shoulder. The atrophic muscles are subject to fibrillary twitchings; many apparently normal muscles are also subject to these twitchings. He complains of "waves of twitchings" passing through his head (scalp). The muscles of the lower extremities are very frequently the seat of these troublesome twitchings. The left hand and shoulder atrophic muscles exhibit a modified reaction of degeneration, the contractions being very slow while the A S Z < K S Z. During the past ten days there has been a gradually increasing loss of power in the left lower limb. This has now attained a degree almost sufficient to prevent the patient going about. The degree of paralysis varies considerably from day to day. The paralyzed muscles are neither atrophied nor hypertrophied. They are, however, in a constant hypertonic state. There is marked exaggeration of the knee-jerks. Ankle clonus is present. The biceps and triceps reflexes of the upper extremities are marked also.

The integument over the wasted districts is constantly covered with a profuse, clammy perspiration, and at times a papular rash appears, but usually only lasts a few hours. There is no atrophy of any of the facial muscles. There is no history of heredity. The case is evidently myelopathic in origin. It is a well-marked example of Charcot's "Amyotrophic Lateral Sclerosis."

Pathological Specimens.—(1) *Potts' Curvature.*—Dr. JOHNSTON exhibited for Dr. Roddick a case of very extensive caries of the vertebræ with psoas abscesses. The caries involved the bodies of all the dorsal vertebræ and a large retro-thoracic abscess had formed in consequence, but without giving rise to any symptoms. The bodies of the last dorsal and first and second lumbar vertebræ were completely destroyed, causing a marked angular curvature. The psoas abscesses were perfectly symmetrical; passing in front of the psoas tendon below Poupart's ligament, they had in each case passed backward and inward, reaching to the fold of the buttock near the lesser trochanters. On the left side the abscess had passed down to the popliteal space when it was opened by Dr. Roddick; Dr. Bell had subsequently opened it above in the left gluteal region. There was no tuberculosis anywhere, and the walls of the abscess showed no tubercles. The pus contained no tubercle bacilli.

(2) *General Tuberculosis.*—Dr. JOHNSTON showed another case of vertebral disease, where the bodies of the second and third lumbar vertebræ were infiltrated with extensive caseous areas. A small tuberculous abscess had formed in the right side, at the level of the third lumbar body. This had involved a small vein opening into the vena cava inferior. There was acute miliary tuberculosis of both lungs, which had caused his death. The patient had been under Dr. Ross with symptoms of deep-seated pain referred to the right sacroiliac articulations.

Nephrotomy.—Dr. SHEPHERD related a case of nephrotomy for hydro-nephrosis which was followed by death in two days. The following is the history of the case: C. W., aged 66, a tall, thin man, who had always been healthy, though there was a tuberculous family history, was suddenly seized some two years before with acute pain in the left renal region, which passed down towards the bladder. It was relieved by opiates, and afterwards for a time he felt fairly well. He had a second similar attack of severe pain a month or two afterwards. After this he began to urinate more frequently, and occasionally the urine was