wall shares in this movement, becoming more wrinkled than the left. There is a coarse involuntary rhythmical tremor of the right hand accentuated by movement: there is a slight hypotonia in the right arm. There is excessive rebound of the right arm; repetitive movements are clumsy on the right; the left shows normal co-ordination. No marked weakness in either arms or legs is present. The plantar responses are flexor. Light touch is felt accurately but tickle is depressed on the left side: there is also a slight but definite hypalgesia and hypothermia on that side. Vibration and joint sense are normal. Special laryngeal examination shows adduction contractions of the right vocal cord at 160 per minute not clearly synchronized with those of the pharynx. In the diaphragm no myoclonus of any nature is to be determined. His gait is wide-based and uncertain.

Familial Myoclonus and Congenital Morbus Cordis.—FRANK A. ELLIOTT, F.R.C.P.

J. H., aged 44, sought advice for pain in left arm, paræsthesiæ in thumb, stiffness of neck and reduction of left biceps-jerk—a typical case of herniation of fifth cervical disc. Found to have congenital heart disease—Eisenmenger complex, with right ventricular preponderance on E.C.G.

Since early life has suffered from involuntary jerking movements of the legs, sufficient to displace the limb violently and usually taking the form of a contraction of quadriceps. The resultant "kick" is sustained for some seconds by myoclonus. These movements are limited to the legs, are aggravated by warmth and by lying down, are absent during voluntary movement, and are relieved by cold. They start with tingling in the side of the foot. Consciousness not disturbed. No fits. Quite well otherwise.

Father suffered from precisely similar symptoms but he, too, was free from epilepsy. The only abnormality in the nervous system was generalized exaggeration of the tendon-jerks.

There is no myotonia.

The E.E.G. is normal at rest and after overbreathing. The predominant frequency was 10 per second and distribution was normal.

Diagnosis.—The sustained nature of the involuntary movements distinguish this case from the simple "jumping" of the legs seen in many normal persons and also in epileptics. The case appears to be one of familial myoclonus without epilepsy.

Abnormal Ocular Movement.—FRANK A. ELLIOTT, F.R.C.P.

Violet H., aged 17, came under observation in March 1948 as a case of mild acute glomerular nephritis following streptococcal tonsillitis. Was found to have remarkable voluntary control of ocular movements, which she had discovered accidentally six months prior to the present illness. She is able to rotate or roll the eyes synchronously, in an anticlockwise direction, at the rate of from 2–3 per second. It is a continuous rotation, not a nystagmus. She initiates the movement by converging the eyes, and can stop it at will. The upper lids move up and down in time with the rotation, but so far as can be determined by the unaided eye, the pupils remain constant. While carrying out this movement she is aware that outside objects are "dancing". Unlike voluntary nystagmus, the movement is not stopped by placing strong lenses in front of the eyes.

The rest of the C.N.S. is normal.

? Manganese Intoxication.—MACDONALD CRITCHLEY, M.D., F.R.C.P.

Mr. A. D., aged 54. Brassfounder,

Seventeen months ago collapsed at work. He was admitted to hospital, and during the course of twelve hours had 7 typical epileptic attacks. It was discovered at that time that he had splenomegaly.

Twelve months' history of progressive loss of power in left hand and arm and increasing stiffness of the arm and fingers. Three months' history of weakness and dragging of the left leg.

Seven months ago he had suffered from frontal headaches for about three months.

Examination.—Intelligence shows moderate deterioration from an originally low average; the greatest defect being in memory. Expressionless face and monotonous voice.

Skew deviation of the eyes on deviation to the right—the right eye being elevated and the left depressed. Marked left lower facial weakness. Gait is slow. The left arm is held flexed and adducted; the left leg is held stiffly, the toes dragging on the ground and the whole limb is circumducted.

Marked rigidity of the left arm and leg of a plastic type. Gross weakness of finger flexors and rather less weakness of all other movements of the left arm and leg. Left arm-jerks slightly brisker than the right, left knee and ankle jerks similarly increased and the left plantar response is equivocal.

Sensation.—Moderate reduction in cutaneous sensibility and vibration sense down the left half of the body with sparing of the face. Loss of sense of passive movement in the left fingers and toes and some reduction in sense of passive movement at the larger joints. There is tactile and pain extinction on the left side to gross stimuli applied simultaneously to both halves of the body. Gross astereognosis in the left hand and loss of two-point discrimination and localization in the left hand and foot. Greatly enlarged spleen, liver just palpable but soft and smooth. Blood-pressure 130/80.

X-ray of skull normal.

Electro-encephalogram: Shows random low voltage waves at 2 c/s. over the right hemisphere with no accurate localization.

Air encephalogram: Shows moderate dilatation of the right lateral ventricle.

C.S.F.: Normal pressure, cytology, chemistry and serology. Blood W.R. negative.

Blood-count.—R.B.C. 5,550,000; Hb 102%. W.B.C. 8,000 (polys. 74%, lymphos. 19%, monos. 1%, eosinos. 1%, basos. 5%).

Liver function tests all normal.

? Peduncular Hallucinosis.—MACDONALD CRITCHLEY, M.D., F.R.C.P.

Mrs. E. M. S., aged 47. Housewife.

Two years' history of a severe, bursting, vertical and occipital headache associated with vomiting; these headaches usually occurred with her menstrual period. Two attacks of confusion followed by amnesia for the event, each attack lasting three to four hours (one eighteen months ago and the second two months ago).

Two months' history of failing vision, left more than right. Associated with the visual failure but following it she has had visual hallucinations of a highly organized character. They always occurred in the lower left quadrant of her visual field, and have taken the form of various animals, highly coloured, correctly proportioned, but always miniature.

In addition they frequently take the form of distortion or of perseveration of an existing pattern across her field of vision. Railings on her left side appear to be projected across the street and curtain patterns across the walls.

Examination.—V.A.R. 1/36. V.A.L. less than 1/60. The right field shows a relative nasal defect to small objects on the left side. There is almost a horizontal upper defect with greater sparing of vision in the lower temporal quadrant. Fundi: Moderate bilateral papilloedema. The left pupil reacts poorly to direct light but reacts briskly consensually. All the tendon reflexes are exaggerated and the plantar responses are flexor.

E.E.G.: In all areas there is low voltage, random, irregular, slow activity. On the left side spreading somewhat to the right, and more frontal than occipital, there is an 8 c/sec. rhythm, fairly continuously present, and tending to occur in outbursts of increased amplitude associated with 4–5 c/sec. waves.

Overbreathing increases this 4–5 c/sec. activity, and makes it more markedly left sided.

X-ray of skull: Sella shows complete destruction of clinoid processes and dorsum and some erosion of the anterior wall of the sella and of the right lesser wing sphenoid; the right optic foramen could not be clearly defined.

Generalized Neurofibromatosis with Intracranial Mass and Pulsating Enophthalmos.—R. E. KELLY, M.D., M.R.C.P. (for S. P. MEADOWS, M.D., F.R.C.P.).

W. H., aged 24. Soldier.

Mother had neurofibromatosis and died of cerebral astrocytoma at age of 54,