Comment.—There are several interesting points about this case. She is the subject of congenital heart disease (? patent foramen ovale) and had led a full life up to 1941, when she was in the bombing of Coventry. Since a hysterectomy for menorrhagia in 1947 her existence has been that of an invalid, punctuated by febrile episodes, in one of which scattered but transient petechial hæmorrhages were found in the skin. Searching investigations failed to prove subacute bacterial endocarditis.

Then during recent months there was progressive weakness and numbness of the limbs with rapid advance over four to five days, an advance accelerated by myelography, after which respiration was dependent on the diaphragm.

The finding of a hæmatomyelia at operation naturally called for the exclusion of a blood disease as the cause.

The absence of abnormal neurological signs now, makes it most unlikely that either a tumour or syringomyelia is the underlying pathology.

It seems that we are left with the assumption that the congenital defect of her heart is associated with telangiectasis of the cord.

The spastic nature of the weakness and the lack of interference with the sphincters suggest that the lesion was slowly progressive although there was shortly before operation a fulminant episode causing swelling of the cord, with increase in the motor signs and loss of all forms of sensation below that level.

I believe that it was to this patient's advantage that I failed to correlate her cardiac and spinal conditions, for knowing that a remarkable degree of recovery occurs in hæmatomyelia, I might have denied her relief by surgery and it is almost certain that she would have died without it.

Infantile Hemiplegia Treated by Hemispherectomy.—L. S. WALSH, F.R.C.S. (for WYLIE MCKISSOCK, O.B.E., M.S.).

E. P., female aged 20, a packer. Admitted to National Hospital on 31.3.50. Discharged on 3.7.50.

History.—"Epileptic fits" since she was 7 years old. Paralysis of left side of body since birth; worse for three months. Born with paralysis of left limbs. Did not walk or talk until she was 8 years. Began school at this time and continued until she was 14 years old, having completed the third form. Aged about 7 years she had chickenpox and about three months later a febrile illness which was suspected scarlet fever. She was sent to hospital and while there developed left-sided fits. These have continued and have been more frequent since January 1950. The fits start with a feeling of numbness in the left hand and this spreads to the trunk and leg. The left arm and leg become drawn up and she falls unconscious. There is tongue-biting and occasional urinary incontinence. The whole attack lasts five to eight minutes, and she has been having attacks two or three times a week; usually at night. She has also had numerous attacks of numbness of the left hand which do not progress to involve the rest of the body and which are not associated with unconsciousness.

She has been on anti-convulsive therapy of phenobarbitone and epanutin.

The weakness of the left arm has been increasing since January 1950. She has been quarrelling with her sister and parents, particularly during the past three months.

On examination.—Co-operative but of limited intelligence.

Cranial nerves.—Visual fields: on confrontation some constriction of the left visual field, particularly temporal portion. Right full. Discs normal. Some deafness of the left ear. The left arm and leg were smaller than the right. They showed moderate increase in tone and were weak, most markedly in flexion and extension of the left wrist and the fingers of the left hand, and there was marked inco-ordination.

Touch, temperature and pain normally perceived on the left side. Slight impairment of vibration sense on left, but severe impairment of position and joint sensibility, two-point discrimination and graphæsthesia. There was astereognosis on left side. Reflexes increased on the left side and left plantar response extensor.

General examination normal.

Special investigations.—Straight X-ray: Right side of skull smaller than left. E.E.G.: Alpha rhythm less evident on right with slow waves over both hemispheres. Focus of recurrent single waves which might be attenuated "sharp waves" in right occipito-temporal region. Blood W.R. negative.

12.4.50: *Air encephalogram*: Dilated right lateral ventricle with a large cyst in the right temporal region.

2.5.50: *Right common carotid arteriogram*: Anterior cerebral arteries displaced to the right—confirm the atrophy shown in encephalogram.

11.5.50: *Psychiatric report*: Disorder of behaviour of the epileptic kind.

18.5.50: *Hemispherectomy with stimulation of the cortex*, in collaboration with Dr. J. A. V. Bates who kindly supplied the photograph (Fig. 1).

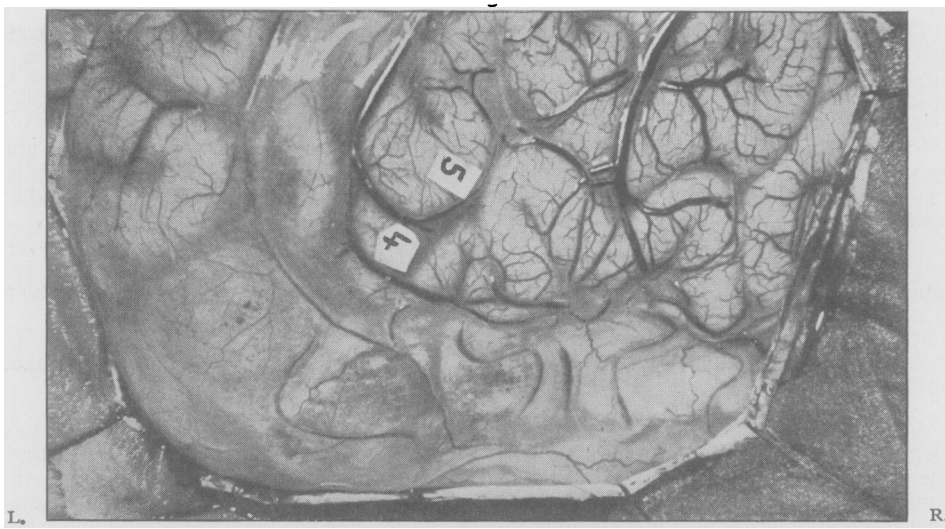

FIG. 1.—Photograph of exposed brain. The mid-line is uppermost and the anterior aspect on the right. The points 5 and 4 produced movement of the left hand on stimulation—*see* text. The cortex below and behind the sylvian fissure was grossly abnormal and in this region no recognizable cerebral tissue was seen.

Point 5: Movement of left wrist and fingers 3, 4, and 5 of left hand. These movements were followed by a generalized fit.

Point 4: Movement of left wrist.

29.5.50: *Post-operative E.E.G.* The left side is not greatly different from the pre-operative state. The right side is not devoid of activity, showing low voltage alpha rhythm and phase and distribution studies suggest that this may be arising from the stub of hemisphere which has been left.

21.6.50: *On examination* she was cheerful and co-operative and said she felt better than before operation. She had had no fits and thought that her left arm was less stiff than before operation and of more use to her.

She had a left homonymous hemianopia.

Apart from some decrease in the spasticity of her left arm and leg there was no other change noted on examination.

A recent report states that she has had no fits and is much more pleasant at home.