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A Case of Athetosis Bilateralis.

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J. V., aged 43; farmer; married. Admitted to the Illinois Central Hospital for the Insane 1886; said to have been insane then for two years; cause, "brain fever." Mother was insane; father intemperate. Patient was an alcoholic, and had been so for several years. When admitted he was excitable, full of delusions of persecution, very nervous; physical health much impaired. Complained of severe pains in his stomach, which he claimed were aggravated by loud noise; believed he heard voices in his stomach. Had slight staggering gait, frequent nocturnal seminal emissions.

For two years he improved somewhat physically; mentally was much better for some time; he interested himself in light work about the premises. He was subject to sudden attacks of uncontrollable nervousness; muscular spasm appeared in the peripheral ends of extremities, viz, in the fingers and toes, about two years ago, and gradually the hands, arms, neck, face and tongue were involved. The lower extremities were implicated very early in the progress of the disease. The movements from the beginning have been characteristic, being gliding, not quick or jerky, and are regular and continuous. They can be controlled only by placing one leg across the other, folding the arms and compressing the chin on the breast. The opening of the mouth causes facial distortion, spasm of the tongue, and, if under great excitement, inability to swallow.

Aphasia has gradually developed, until now he can only utter one word, "bully," which he says when coming out of the bath. His mind is now very much impaired, although at one time he was quite intelligent. The dementia appeared and increased with the athetosic movements. The gait is peculiar; it is not jerky, as in adult chorea, nor is it staggering, as in locomotor ataxia, but it is straddling, the stride being slowly made, the toes

touching the floor first. He can walk in a straight line. Walking, however, excites the athetosic movements to such a degree that he will not walk very far or very often. Reflexes are present but normal in intensity. Sensation is somewhat inhibited. There is no motor paralysis, no anæsthesia, no pain.

Such is the history of this most interesting case. From a study of the symptoms, his family history and his habits before becoming insane, I am led to diagnose the case as one of athetosis bilateralis. The lesion is no doubt spinal as well as cerebral, for it is frequently the case in double athetosis, that degeneration will be found in both. In this case the spinal symptoms appeared first, followed sometime later, by the cerebral. The degeneracy may then be ascending spinal-cerebral.

No doubt atrophy will be found involving the cerebral cortex, for it is a frequent lesion in alcoholic insanity. This patient has been a hard drinker; his so-called brain fever was, in fact, acute delirium and the sequences of his alcoholic excesses, associated with his hereditary entailment, are shown in the insanity and the athetosis with which he is now afflicted. This case I deem worthy of reporting because of the scarcity of such cases, and further to show that all cases of double athetosis are not associated with congenital imbecility. Hammond's original case of athetosis, was an alcoholic; this case of double athetosis is likewise an alcoholic and I attribute the lesion in both to pathological results of the habit. I have seen hemiathetosis of syphilitic origin, and am now studying a case which I attribute to syphilis.

Frank P. Norbury