it is presumed, would be best formed wit's caustic and kept open with any proper substance.

Until we are better informed respecting the nature of this disease, the employment of internal medicines is scarcely warranteable; unless analogy should point out some remedy the trial of which rational hope might authorize. Particular circumstances indeed must arise in different cases, in which the aid of medicine may be demanded: and the intelligent will never fail to avail themselves of any opportunity of making trial of the influence of mercury, which has in so many instances, manifested its power in correcting derangement of structure.

The weakened powers of the muscles in the affected parts is so prominent a symptom, as to be very liable to mislead the inattentive, who may regard the disease as a mere consequence of constitutional debility. If this notion be pursued, and tonic medicines, and highly nutritious diet be directed, no benefit is likely to be thus obtained since the disease depends not on general weakness, but merely on the interruption of the flow of the nervous influence to the affected parts.

It is indeed much to be regretted that this malady is generally regarded by the sufferers in this point of view, so discouraging to the employment of remedial means. Seldom occurring before the age of fifty, and frequently yielding but little inconvenience for several months, it is generally considered as the irremediable diminution of the nervous influence, naturally resulting from declining life; and remedies therefore are seldom sought for.

Before concluding these pages, it may be proper to observe once more, that an important object proposed to be obtained by them is the leading of the attention of those who humanely employ anatomical examination in detecting the causes and nature of disease, particularly to this malady. By their benevolent labours its real nature may be ascertained, and appropriate modes of relief, or even of cure, pointed out.

To such researches the healing art is already much indebted for the enlargement of its powers of lessening the evils of suffering humanity. Little is the public aware of the obligations it owes to those who, led by professional ardour, and the dictates of duty, have devoted themselves to these pursuits, under circumstances most unpleasant and forbidding. Every person of consideration and feeling, may judge of the advantages yielded by the philanthropic exertions of a Howard; but how few can estimate the benefits bestowed on mankind by the labours of a Morgagni, Hunter, or Baillie.

Finis

XVIII
The Thalamic Syndrome

Few physicians have been more honored by eponymy than Jules Dejerine (1849 to 1917), the French neurologist. Among the diseases that bear his name are facioscapulohumeral muscular dystrophy (Landouzy-Dejerine), hypertrophic interstitial neuritis (Dejerine-Sottas), olivopontocerebellar atrophy (Dejerine-Thomas), and the thalamic syndrome (Dejerine-Roussy). His American wife, Augusta Klumpke, was also a talented neurologist whose name is now associated with lower brachial plexus palsy.

Beginning in 1902, Dejerine and his associates discovered and studied the clinical and pathological features of the thalamic syndrome. Little has been added to their thorough presentations. Twenty years after Dejerine's initial paper on the subject, Foix, Mason, and Hillemand demonstrated the most common cause of the syndrome—occlusion of the thalamogeniculate branches of the posterior cerebral artery.

The most distressing feature of the thalamic syndrome is the intense pain, which may be related to release of the thalamus from cortical inhibition. As Dejerine and Roussy noted, the pain is resistant to analgesic medications. However, recent experiences with stereotactic thalamotomy and mesencephalotomy give hope that this pain may eventually be controlled.

References
The Thalamic Syndrome

by J. Dejerine and G. Roussy

XVIII THE THALAMIC SYNDROME

The sensory phenomena of the thalamic lesions in its three modalities: touch, pain, and temperature. We will not enumerate them rapidly. The anesthesis is never absolute as in hysterical hemianesthesia, it predominates in the distal portion of the limb and diminishes from the periphery proximally; and finally, on the trunk and the face this anesthesis goes slightly over the midline of the body, 1 to 2 cm. on the healthy side.

Deep sensation is affected much more, and in its various components: articular, muscular, tendinous, osseous. In fact, one notices in many cases the diminution or reduction of osseous sensitivity, tested with the tuning fork, and the complete loss of muscle sense.

In our patients, the awareness of active or passive movements is diminished, and sometimes lost; likewise, the awareness of resistance and strength. The sensation of weight is completely lost on the injured side. Finally, position sense, or the awareness of the position of body parts, is strongly affected (akinesia).

There is no more or less complete loss of "sensorgnosis," which is always affected, but to different degrees.

b. Subjective sensation.

The presence of pain on the hemiplegic side is important to note. These pains should be grouped with the pains thought to be "of crural origin" by Anton, Edinger, Golscheider, etc. They appear early, dating from the onset of the hemiplegia, or a few months later. They reside not only in the paralyzed limbs, but also in the face and trunk.

It is very hard to obtain from the patients an exact idea of the localization of these pains concerning whether they are superficial or deep. Most of the patients, though, insist that they are rather superficial and that it is the skin and the subjacent adipose tissue which are painful.

In any case, these pains are continuous with paroxysmal exacerbations, sometimes bringing cries from the patients and keeping them from sleep or awakening them rudely.

One of our patients kept telling us that what prevented her from moving her left hand, or walking, are the intense pains in her arm and leg. Here is a true painful impotence.

Moreover, the pain is not exclusively spasmatic. In some cases it may be provoked by merely touching the skin with the finger. Pinprick, contact with cold and heat, and pressure are very painful. The patients are sometimes very hyperventilating.

The patients sometimes compare their pains to superficial or deep burns, sometime to twinges, to violence and painful pressure placed on the skin, sometimes to the stinging of a dagger. These phenomena have a paroxysmal character. Between crises, there are formication, numbness in the tips of the limbs and sometimes around the face.

Finally we note another important characteristic. These pains are not suppressed by any internal or external analgesic treatment. Nothing gives relief to the patient, whose suffering is sometimes intolerable...

Pathologic Anatomy

The anatomical ideas we offer today are the result of the study of three specimens examined in rigorously serialized microscopic sections.
In the first case (Joss...), the original lesion occupies the posterior part of the optic thalamus through almost its entire height. In the superior part of the thalamus the focus of destruction involves, in its posterior third, a large part of the external and internal nuclei (Fig. 1). Lower, the lesion diminishes in extent but still involves mostly the external nucleus, continuing medially through the internal nucleus and the median nucleus, and, posteriorly, through the pulvinar. In the inferior part of the optic thalamus, the lesion is represented only by a line crossing directly through the external nucleus. At its highest point the lesion laterally cuts the posterior part of the posterior limb of the internal capsule. Finally, there exists, as a small secondary focus, a lacuna of cerebral disintegration in the posterior part of the putamen.

In the second case (Hud...), there is an equally large focus of destruction occupying principally the optic thalamus in its two inferior layers (Fig. 2). It terminates at the upper limit of the subthalamic region. This focus is located in the external nucleus, which it largely destroys. Furthermore, it injures the internal, median and pulvinar nuclei. From the thalamus the lesion passes through the posterior and posterolenticular segments of the internal capsule, which it destroys, and divides the posterior part of the putamen.

Finally, in the third case (Thal...), study of the series of sections reveals a lesion much less extensive than in the previous cases, but involving exactly the same regions. It should be noted that the clinical signs, although evident, were much less prominent than in the first two cases. The lesion occupies the middle part of the optic thalamus and involves principally the posterior part of the external nucleus. (See Fig. 3.) From there, it passes medially to damage the internal and median nuclei (in relation to the pulvinar), and laterally to cut the posterior segment of the internal capsule and also a very small portion of the posterior part of the lentiform nucleus. The capsular lesion is only visible in the superior sections. Below, the thalamic lesion does not go beyond the optic thalamus.

The cases we studied and present here allow us to add that when the lesion occupies the external nucleus (external and posterior part) extending through the internal and median nuclei of the thalamus, involving only a part of the fibers of the posterior limb of the internal capsule, the clinical picture of the thalamic syndrome results.

**References**