Encephalitis Lethargica

Under this heading a very interesting article appears in the New Zealand "Medical Journal" of June, by Dr. Charles Rossiter, M.R.C.S.E., Honorary Visiting Physician, Auckland Hospital. A brief extract will be of interest to our readers.

A definition of lethargica encephalitis is quoted as—

"A general infective disease, characterised by manifestations originating in the central nervous system, of which the most frequent characteristics are progressive lethargica or stupor, and a lesion in or about the nuclei of the third pair of cranial nerves.

It is apparently caused by a specific virus, which probably finds entrance through the nasopharynx, like that in acute anterial poliomyelitis, and which, like it, has a special affinity for th nervous system.

McNalty recognises seven types :—(a) A clinical affection of the third pair of nerves ; (b) affection of the brain stem and bulb ; (c) affection of the cerebral cortex ; (f) cases with evidence of spinal cord involvement ; (g) polyneuritic type, in which affection of the peripheral nerves is suspected.

The prognosis is better than the alarming state of the patient would lead one to believe. One hundred and sixty-eight cases have thirty-seven deaths recorded.

Symptoms.

The onset is relatively acute, the condition being usually established in a few days. Occasionally it opens in a fulminating fashion. Of the general symptoms, apathy, lethargy or stupor, pathological sleepiness, absence of spontaneity, or initiative, is, in one form or another, prominent from the outset, and throughout the earlier stages of the disease, at least. Occasionally, however, it is not a noticeable feature. A degree of restlessness or restless delirium, with a reduction of mental activity to the level of automatism, is common enough. The automatic reproductions of familiar movements in a purposeless fashion is often most pronounced. This feature was most marked in the case "O.B." herein recorded. Pseudo-hysterical manifestations, alternating with profound hebetude, have been noted, and were present in several of my cases. Catatonia was seen in one case (Mrs. L.), and is also referred to by other observers. Wilson draws attention also to another condition which was present in nearly all my cases, viz., that often, in the height of the illness and most profound lethargy, the patient's response to request would, in act and word, be surprisingly accurate and rational, although relapse into stupor is almost immediate.

Headache, giddiness and vomiting are also frequently present, but in my experience, beyond the eye pain, the former is not very pronounced. Temperature is more or less normal throughout, except perhaps for a moderate initial rise. In fatal cases, as in two of mine, it rises progressively until death, to 105 or 106 degrees. In others meningeal symptoms may be present, as Kernig's sign, pains and stiffness in neck, but as a rule, they are not well marked, and in any case the picture is never a replica of that of a typical acute meningitis.

Ocular Symptoms.

Ptosis and partial or complete ocular-motor paralysis was noticed in all my cases, and seems to appear in at least seventy-five per cent. of cases. Blurred vision, due to imperfect fusion, or accommodation, is generally first noticed, shortly followed by diplopia. To again quote Wilson, "Paralysis of accommodation, and the corresponding indistinctness of vision or diplopia, is a very early symptom, and any degree of ophthalmoplegia, externa and interna, with ptosis, symmetrical or otherwisc, complete or incomplete, may be found. The pupils may be contracted, dilated or fixed or normal, or ectopia pupillae may exist. It should be noticed that the patient may have the appearance of ptosis or mere drowsiness where there is no paralysis. Inability to sustain ocular movements may be the only defect."

This precisely describes the ocular conditions in my cases.

Involvement of the lower cranial nerves is the next common type of the nuclear invasion, resulting in facial immobility, palate, tongue, larnyx and pharnyx being involved in both motor and sensory paralysis.

So far as treatment is concerned, if there are marked indications or increased cerebral spinal pressure, as indicated by a lumbar puncture, possibly the latter procedure may prove beneficial, but in the absence of severe headache, choked disc, or very extensive ophthalmoplegia, I am doubtful as to its value except as a diagnostic procedure, and as such, I think it should never be omitted. I am inclined to think that the same danger attends this procedure as in tumor to the brain, where the sudden pressure upon the medulla, owing to the sudden escape of the fiuid, might cause sudden death. Otherwise, beyond general nursing, there are no definite curative measures known, so far as I am aware.

Medical Superintendent, Wellington Hospital

Major Randell Woodhouse, D.S.O., M.C., has been appointed to the above position recently resigned by Dr. Barclay. He has just returned to the Dominion from active service, when he served with distinction and obtained the above honours. As Dr. Woodhouse he was acting superintendent during Dr. Hardwicke-Smith's absence on leave, and is therefore well known at Wellington Hospital.