

LESZYNSKY (W<sup>m</sup> M.)

Bilateral Neuritis of the Brachial  
Plexus following Acute  
Croupous Pneumonia.

BY

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Post-Graduate Medical School, etc.

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BILATERAL NEURITIS OF THE  
BRACHIAL PLEXUS  
FOLLOWING ACUTE CROUPOUS PNEUMONIA.

By WILLIAM M. LESZYNSKY, M. D.,  
INSTRUCTOR IN MENTAL AND NERVOUS DISEASES  
AT THE NEW YORK POST-GRADUATE MEDICAL SCHOOL, ETC.

ALL practitioners are more or less familiar with the nervous manifestations that frequently arise in the course of acute lobar pneumonia. In former times it was thought that symptoms such as delirium, headache, etc., were due to the continued fever or hyperpyrexia. To day, however, most of these symptoms are attributed to functional disorder resulting from the condition of toxæmia.

Among the more prominent complications affecting the nervous system is purulent cerebral meningitis, which in my experience, and so far as I can ascertain, has invariably proved fatal.

It is well known that acute lobar pneumonia or croupous pneumonia is classified by all recent writers as an acute infectious disease, and is assumed to be caused by the *Micrococcus lanceolatus*, which excites a local inflammation in the lungs, and by its toxins constitutional disturbance of varying intensity (Osler).

Many recent investigations have confirmed this view,

and this conception of the disease is held by the majority of pathologists of the present day. The medical literature of the last few years abounds in reports of peripheral paralyses following measles, scarlet fever, diphtheria, typhoid fever, small-pox, influenza, articular rheumatism, etc.



Anatomical examination has demonstrated in many of these cases either hæmorrhages or exudation into the nerve sheaths, interstitial neuritis, or parenchymatous degeneration involving the axis cylinders. With the foregoing facts in view, the following case is placed on record :

W. E., born in the United States, thirty-six years of age, and a bookkeeper. During the third week of an attack of acute pneumonia affecting the right side, he began to have pain in both shoulders, which rapidly extended to both arms

and hands. The pain was of a sharp, darting, and shooting character, being so severe that it frequently kept him awake at night. It gradually subsided, and two weeks later he first noticed that the left shoulder was weak and there was some difficulty in moving it. The right arm also felt weak.



*Examination: Left Upper Extremity.*—There is typical paralysis of the serratus magnus muscle and paresis of the superior portion of the trapezius, and consequent inability to raise the arm above the horizontal position. There is also some atrophy of these muscles and the supraspinatus and infraspinatus. No disturbance of sensation.

*Right Upper Extremity.*—Supraspinatus and infraspinatus are somewhat atrophied; deltoid markedly atrophied and paretic, with loss of faradaic irritability, but normal galvanic reaction. Absolute anæsthesia in the sensory distribution of the circumflex nerve. Supinator longus slightly paretic.

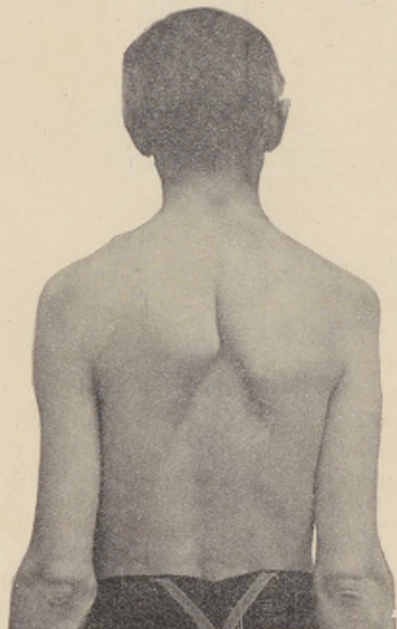
The triceps reflex is active on both sides. All of the other nerves and muscles react normally to the faradaic current.

Both knee-jerks are well marked. No clonus. No involvement of the lower extremities. The pupils are normal in size and reaction. No evidence of lesion in ocular fundi.

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The heart's action is somewhat feeble. The lungs are normal. Examination of urine negative.

There is no history of exposure to cold, traumatism, alcoholism, syphilis, or rheumatism, or other similar toxic condition that could be considered as a constitutional or local cause of his present condition.



This patient was first seen by me on June 27, 1895. The triweekly application of the galvanic current to the paralyzed and atrophied muscles resulted in a moderate degree of improvement in motility after four months' treatment. General tonic measures were also instituted.

The accompanying reproductions of photographs clearly

show the typical deformity of the back resulting from paralysis of the left serratus magnus.

Among three hundred or more cases of peripheral-neuritis observed by the writer, this is the only one into which pneumonia entered as an ætiological factor.

Osler, in the last edition of his work on the *Practice of Medicine* (page 557), states that "among rare complications (of pneumonia) may be mentioned peripheral neuritis, of which several instances have been described."

One of the prominent features in the case under consideration was the paralysis of the serratus magnus. It may therefore be interesting to note that the usual causes of such paralysis are traumatism, pressure from carrying heavy weights on the shoulder, excessive muscular effort, exposure to cold, and the involvement of the muscle in the course of progressive muscular atrophy. The unusual features in this case are: 1. The primary cause of the acute degenerative neuritis affecting the upper branches of the brachial plexus on both sides. 2. The early limitation of the permanent lesion to the *right* circumflex nerve and the *left* posterior thoracic nerve.









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