leprosy, and beri-beri. In the typical cases there is a symmetrical localization of motor, sensory and vasomotor symptoms. In earlier stages the symptoms are the result of irritation of the nerve, in the later of destruction. Different cases vary in developing one set of these symptoms, lead paralysis, Landry's paralysis and tetany being distinctly motor; pseudo-tabes and leprosy being sensory; and erythromelalgia and Raynaud's disease being vasomotor in clinical type. The commonest form of multiple neuritis arises from alcoholism, and ordinarily presents a mixed type. Its diagnosis is based upon such evidences of chronic alcoholism as indicated by digestive, circulatory and nervous systems. The onset is insidious; the earlier symptoms are numbness and tingling, cramps and tremors, with painful symptoms and cutaneous anesthesia a little later, and sometimes a muscular hyperesthesia. The paralysis soon results in quadriplegia, with toe and wrist-drop, sometimes there is at first an exaggeration of the knee-jerk, followed by a loss of knee-jerk. Progressive atrophy occurs. Marked psychical disturbance sometimes occurs, due to the alcoholism.

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CLINICAL DIFFERENTIATION OF BRAIN SYPHILIS AND GENERAL PARESIS.

W. A. M'CORN (Brooklyn Medical Journal, February, 1902).

The writer reports a case with the following symptoms: A capable business man, after a week of general apathy, headache, and insomnia, becomes incoherent, irrational and appears greatly confused and stupid. The muscular coordination becomes so marked that it is nearly impossible for him to walk, talk or care for himself in any way. He had had syphilis three years before. Examination of pupils was negative, the knee-jerks exaggerated, no fibrillary tremor of the tongue or face; facial expression dull and apathetic. Romberg symptom extreme. No grandiose ideas, memory poor for recent events. Owing to his unsteadiness on his feet he was put to bed and treated antisypilitically. The patient improved for a short time. Three months after admission a divergent strabismus of the right eye, with ptosis, developed. Almost simultaneously the patient became somewhat filthy, mentally dull, and stupid. The diagnosis of paresis was made by eminent specialists, but is disputed by the writer, for the following reasons: Brain syphilis follows infection closely, from one year to ten. Paresis has a remoter syphilitic origin, and seems to be more the result of a parasypilitic toxin. Mental stress is as essential a factor in paresis as heredity is insignificant. The course of the two affections shows a marked difference. In paresis it is slowly, but regularly progressive, the course of brain syphilis is extremely erratic. A degree of dementia out of all proportion to the duration of the disease is often followed by sudden and rapid improvement, to again lapse into a stupid, apathetic state similar to that found in the last stage of paresis. There is a wide difference in the mental symptoms, other than the intellectual defect. Paretics, as a rule, have a marked euphoria from the onset of the disease, accompanied by absurdly extravagant delusions, while the syphilitic is more depressed, and has hypochondriacal, melancholic delusions.

The physical symptoms of syphilis point almost invariably to focal and more or less limited lesions, while in paresis, to a diffuse involvement. General, tremulous and ataxic movements are not common to syphilis; the speech disturbances are not pronounced, and the headache in syphilis is persistent, diffuse, worse at night; while in paresis it is usually paroxysmal and localized. Optic neuritis is common in syphilis.

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