mucous membrane heal with less apparent cicatrices than those upon the true skin.

These cicatrices are so slight that they are only visible on close inspection. No deformity is present, and the non-medical friends may not know of the existence of such lesions. These cicatrices at the commissures of the lips are considered as quite characteristic of inherited syphilis, and I believe correctly, but I am far from saying that similar scars cannot be due to other causes than syphilis. I have seen one case in which scars in that spot were due to another cause. They exist in the person of a lady who, when hardly more than an infant, had scarlet fever at the same time with two older sisters, with a very sore throat which throat was treated by applications of nitrate of silver which she resisted with all her strength, and the applications were undoubtedly applied to all the vicinity. She is described as having had an awful mouth and has carried these scars ever since, and one might be pardoned for thinking them syphilitic. Close examination shows that the scars in this case lack the linear form characteristic of the disease.

Cases in which there is disease of several bones are open to suspicion and should lead to investigation. I am by no means ready to say that necrosis or caries may not exist in several bones in a child or young adult without that child or young adult being a victim of syphilis, but I think the chances are many to one that syphilis would be at the bottom of such a case. That probability is still stronger if the symmetrical bones are attacked. The terminal extremities of the long bones are specially liable to suffer. I am inclined to think that the necessity for treatment in these late cases is not fully appreciated. They need to be treated in the same way and as carefully as the acquired cases, and perhaps even more persistently. Treatment was not universally successful in the cases I have narrated. The young man, Case IV, died, a result almost inevitable from the grave character of the lesions, but in other cases the results of treatment were brilliant, and I think I may say the success depended in great measure upon the faithfulness with which it was carried out. Practically the same plan that is pursued in so-called tertiary disease in the adult is adapted to these late inherited lesions; that is, a treatment into which the iodides enter largely in conjunction with mercurials. In some cases the iodides need to be given in large doses.

NERVOUS SYMPTOMS FROM OCULAR DEFECTS. THEIR RELIEF BY MECHANICAL AND MEDICINAL MEASURES.¹

BY R. W. AMIDON, M.D., NEW YORK.

THE subject of nervous symptoms from ocular defects has been voluminously written upon by ophthalmologists, but it is from the standpoint of a neurologist that it will be now approached.

That such a presentation may be somewhat novel and perhaps instructive is my only apology for writing upon a subject so trite.

People suffering from symptoms plainly referable to the eyes generally consult an ophthalmologist at once; but in a certain proportion of cases, the relation between the nervous symptoms and the ocular defect not being very clear, the general practitioner or

the neurologist is consulted. It is this class of cases with which the present paper has to deal: Cases in which the phenomena are chiefly sensory and resemble the symptoms of organic or functional disease of the nervous system. In selecting these cases care has been taken to exclude those of organic disease of the nervous system and eyes, and cases of functional disease where the symptoms were of extra-ocular origin.

The most common nervous symptoms referable to ocular defects are variously located headaches, occipital, vertical, temporal, frontal and general; various paræsthesiæ about the head, back of neck, shoulders and back; neuralgias, hemicrania, vertigo, staggering, diplopia, nausea, confusion, ptosis, photophobia, etc.

The ocular defects giving rise to these varied symptoms are, insufficiency, hypermetropia, myopia, astigmatism and presbyopia, either alone or in simple or very varied combination.

After a careful scrutiny of many cases, one hundred and sixty-two were found with sufficiently perfect histories to deduce the following conclusions:

(1) Patients in whom insufficiency of the internal recti muscles is a prominent defect are very apt to suffer from sensory disturbances in the occiput, nucha, shoulders and back. These disturbances may take the form of acute or dull pain, a heavy pressure feeling or various paræsthesiæ, hard to describe and at times exceedingly annoying to the patient.

(2) Patients in whom insufficiency of the other recti is prominent do not appear to be subject to occipital disturbance, but, next to asthenopic symptoms, which are almost always present, seem to suffer most from vertigo, diplopia and confusion.

(3) In hypermetropia and hypermetropic astigmatism the most frequent complaint, aside from asthenopia, is of frontal headache.

(4) In myopic and mixed astigmatism, frontal, temporal and general headaches are about equally common.

(5) In cases combining hypermetropia and myopia with presbyopia, frontal, temporal and occipital headaches and vertigo are present in about equal proportions.

(6) In pure myopia and presbyopia nervous symptoms are seldom prominent.

The natural inference to draw from these facts is that where there are sensory disturbances about the occiput and nucha, particularly if made worse by use of eyes, the internal recti muscles should be tested with a fair prospect of finding them weak, provided the symptoms alluded to do not depend upon organic disease of the nervous system or acid, flatulent dyspepsia.

When vertigo, unsteadiness, diplopia, and confusion with asthenopic symptoms are prominent, one can look with considerable confidence, in the absence of organic nervous or vascular disease and anæmia, for a disturbance of the equilibrium of the superior, inferior or external recti muscles. When frontal headache with asthenopia is prominent, strongly suspect hypermetropia or hypermetropic astigmatism, unless constipation, catarrh of the frontal sinus or Bright's disease is present.

In general headaches or different combinations of frontal, vertical, temporal and occipital varieties, in the absence of other provoking causes, always suspect and examine the eyes.

Many factors, besides use of the eyes, aggravate

¹ Substance of a paper read before the New York Academy of Medicine, Section on Neurology, October 14, 1887.

these various paræsthesiæ; excitement, worry, debility, fatigue and exposure to hot or confined air.

The relief of nervous phenomena due to ocular defects by the use of accurately adjusted correcting glasses is almost too well known to refer to.

I must, however, make one exception to this statement, and that is in respect to the treatment of insufficiency of the recti muscles. My opinion is that correcting prisms, when properly used, are much more often curative than is generally thought.

In the first place adjuvant medicinal treatment is very often utterly neglected. Experience teaches me that sufferers from insufficiency of the ocular muscles are seldom if ever well. An anæmic condition is often present; a neurasthenic, debilitated state from overwork, worry, excesses, confinement, etc., is very common; dyspeptic ailments are often seen, while the various paræsthesiæ, from which the patient suffers, induces a frame of mind, certainly despondent and hypochondriacal and often bordering on the melancholic.

For the anæmic condition I prescribe iron with bitter tonics, nux vomica, quinine or quassia and perhaps a laxative as belladonna, rhubarb or aloes in small doses.

In the neurasthenic and debilitated state an anæmia is often present and must be treated. Other tonics than iron seem at times indicated, and phosphorus, cod-liver oil, and occasionally alteratives such as arsenic, mercury or iodide of potassium seem beneficial. Laxatives are often needed and mild vegetable ones should be employed.

Plenty of digestible, nourishing food is needed in all these conditions, but in none more than in this state of neurasthenia, which so often means only malnutrition. Supplemental meals should be insisted upon if needed and, unless contraindicated, some alcohol in the form of milk punch or egg nog should be added to the dietary. At bedtime particularly, is this indicated, to help relieve the partial insomnia from which these patients often suffer. This insomnia is sometimes quite marked and annoying and demands special treatment. Chloral and the bromides should generally be avoided, the former because of its irritant action on the eyes, and the latter of their debilitating effects.

Our chief reliance should be upon simple measures, such as food or alcohol, or both at bedtime, and these failing, mild narcotics, such as assafoetida, camphor, valerian or cannabis, should be tried, opium being reserved for rebellious cases.

Dyspepsia occurs alone or with the foregoing condition; the most common form seen in these cases being the acid and flatulent variety. The most prompt relief is obtained from a diet rather free from starch and sugar, and the use of dilute nitro-hydrochloric before or an alkali after eating or both. A condition of intestinal dyspepsia often calls for carminatives and laxatives which, as a general thing, should be gentle and vegetable. Rhubarb, aloes or podophyllum in small doses, assisted by belladonna should suffice.

The melancholic tendency of these patients is very often relieved by treating the anæmic, neurotic or dyspeptic condition so often present at the same time. When general treatment fails, correction of the existing ocular defect often completes the cure. Occasionally, the depression is so marked as to call for a mild cannabis and opium course.

A rheumatic element sometimes crops out, often in

conjunction with the neurasthenic state, and it should be met by the oil of wintergreen, the salicylates, alkalies or counter-irritation.

Instability of the circulatory apparatus, so often seen in these cases, should be met by general tonic treatment and digitalis.

The patients, therefore, presenting themselves with an insufficiency of the recti muscles, are carefully examined and then put upon appropriate medicinal treatment as outlined above, each case being studied by itself. Sometimes a few days of this treatment will appreciably lessen this weakness of the recti muscles, particularly if rest be super-added.

When, after two or more examinations glasses are ordered, the refractive errors, if there are any, are properly corrected, while prisms, representing about three-quarters of the insufficiency in the case of the interni or externi, and equal to the entire insufficiency in the case of the superior or inferior recti, are added.

The amount of the insufficiency varying with the general health and strength, examinations of the recti should be made from time to time, when if the patient's general condition fails, the insufficiency will increase, and perhaps demand stronger prisms, while, if health and strength be regained, the insufficiency will rapidly lessen and disappear in favorable cases, rendering a discontinuance of the prisms possible.

This latter has been the result in at least three-quarters of my cases.

With respect to medicinal treatment, almost the same remarks will apply to those cases where errors of refraction only exist. All will attest that these errors of refraction often produce no symptoms until the nervous resistance or general health break down. Then all of a sudden a hypermetropia or astigmatism which has for years lain dormant, will suddenly give rise to most distressing symptoms.

As a counterpart to this, we see cases in which correcting glasses, worn for months, are finally discarded as unnecessary, the nervous strength and general health having been sufficiently restored to allow the patient to ignore strain produced by an ocular defect.

Medicinal treatment is of extreme importance in this class of cases also, and is, I think, too commonly ignored. The general line of treatment is the same as in cases of insufficiency, less reliance being placed upon special tonics such as strychnia and more upon a general tonic course.

A CASE OF RECURRENT PARALYSIS OF THE MOTOR OCULI.¹

BY O. F. WADSWORTH, M.D.

THE case which I wish to report appears to belong to a class characterized by a very distinctly defined group of symptoms. At intervals varying in length both in the individual cases and the same case, there occurs paralysis of all the branches of one oculo-motor nerve. The duration of the paralysis also varies. Always, it is the same nerve that is affected, the other nerves remaining free. In most cases, possibly in all, the attacks are preceded, or, at least, accompanied by headache, confined to the corresponding side of the head, and chiefly localized in the frontal region.

Pauline and Frances, twins, were born of healthy

¹ Read before the American Ophthalmological Society.