spinal tumor, cause considerable disturbance of the reflex. Lesions of the cauda equina within the spinal canal do not affect the reflex, but it is lost in the lower limb when the sympathetic is divided below the origin of the pilomotor nerves of the lower limbs. Any lesion of the roots, plexuses, or peripheral nerves modifies the reflex, either increasing it or abolishing it, according to the nature of the lesion. The reflex is modified in lesions of the sympathetic. Interruption of the sympathetic chain above the spinal origin of the pilomotor nerves of the brachial plexus abolishes the reflex in the upper limb, and if the section is at the level of the first dorsal ganglion and lower cervical ganglion, the reflex is abolished also in the neck and face. A loss of the reflex occurs in herpes zoster. When a divided nerve is regenerating, reappearance of the pilomotor reflex is an early phenomenon. Lastly, in some persons even a slight lesion of the limbs or trunk may cause an exaggeration of the pilomotor reflex in the corresponding half of the body with its maximum in the immediate neighborhood of the lesion.

Sicard, J. A., and Paref, J. THE OCULO-PILOMOTOR REFLEX. [Bull. et Mém. Soc. Méd. des Hôp., May 20, 1920.]

A new reflex, the oculo-sympathetic or oculo-pilomotor reflex, is here described. It is induced by compression of the eyeballs, as in developing the Aschner reflex. Its centripetal tract is the trigeminus nerve. Its synapse is in the midbrain, and its centrifugal tract the sympathetic of the midbrain and spinal cord. If a subject in whom horripilation is readily produced has his eyeballs compressed, the cutaneous erection at once ceases, and does not reappear (in spite of energetic friction) as long as the ocular compression lasts, and even for some time afterwards. Unilateral ocular compression produces almost the same effect as bilateral ocular compression. Injection of adrenalin does not appear to have any effect on the cutis anserina or its inhibition. The occurrence of this inhibitory reflex shows, on the one hand, that there is a sympathetic tonus in the midbrain which influences the spinal tonus, and on the other hand, that ocular compression may have various effects, as it acts not only on the vagus, as in the oculo-cardiac reflex, but also on the sympathetic, inhibiting the pilomotor reflex.

Abadie, C. PERICAROTID SYMPATHECTOMY. [Presse Médicale, September 1, 1920, J. A. M. A.]

Abadie explains that certain forms of atrophy of the optic nerve are probably the result of constriction of the arterioles which nourish the nerve trunk. This special atrophy is characterized by restriction of the visual field on the side toward the nose. The internal and lower visual field may have been long lost when the external and superior shows no signs of impairment. Instillation of atropin produces only a moderate effect, and the papilla is branched; the findings are like those in the eye

with severe quinin poisoning, the arteries filiform and empty of blood. This contraction of the arterioles is variable in degree and duration, but it entails in time this form of atrophy of the optic nerve. To arrest the permanent contraction of the arterioles in a severe case of the kind, he had a stretch, 1 cm. long, of the sheath of the carotid artery resected to interrupt the sympathetic innervation. The immediate effects were brilliant, the visual field rapidly enlarged until in two weeks it approximated normal, and vision improved to $\frac{1}{2}$. This favorable condition persisted for a month, but then, two months after the sympathectomy, the improvement retrogressed until conditions were the same as before the intervention. Ligation of the common carotid was also followed by marked improvement, but the benefit was transient. He has a record of four operations of the kind on the carotid, and although marked benefit followed, it was transient. But even this sustains the assumption of impairment of the circulation in the optic nerve and its sheath.

Ameline, M., and Quercy, P. PROGRESSIVE LIPODYSTROPHY IN PHARAOH. [Rev. Neur., May, 1920. J. A. M. A.]

Ameline and Quercy remark that since Boissonas' statement last October in regard to the rarity of progressive lipodystrophy in adult males, a second case has been discovered. This is in the Pharaoh Amenophis IV, as deduced from the mural tablets of ancient Egypt. The special features of the disease, the loss of subcutaneous fat in the upper part of the body and the pronounced increase of fat deposits in the regions below the crest of the ilium, are portrayed in the pictures of this ruler, and have been recognized and diagnosed thirty-five centuries later. Thirteen mural pictures are reproduced, and the question is raised whether the anomalies portrayed may not have been due to pulmonary tuberculosis. Necropsy of the mummy might give interesting results.

Zeak. VISCERO-VASOMOTOR ZONES. [Wien. klin. Woch., June 17, 1920.]

This author calls attention to a crescent-shaped skin flushing situated about the middle of the clavicles and the convexity over the sternum. In pronounced cases the crescent has a dark-red color, while in less marked cases the whole of the area affected seems to be traversed by a network of fine anastomosing capillaries. The horns of the crescent often are fairly symmetrical, but sometimes one horn is more prolonged than the other and extends beyond the clavicle to the supraclavicular fossa. In some cases the right and left halves of the crescent assume the shape of a butterfly's wings, united to one another by a small central portion on the skin over the manubrium. The sign is not constant, for numerous cases of aortic disease, including aneurysm, do not show a trace of the crescent, and it seems as if only certain stages and varieties of aortic disease not yet determined give rise to it. In cases of aortic disease in which the crescentic area of redness does not appear sponta-