cum's query as to sense of position: the patient had presented involvement of sense of position, but less of the sense of localization. The question arises whether one can have a case of pure astereognosis without involvement of the senses of position, pressure, movement, and localization. The fact that in this case there was involvement of all of these senses seems to show that in astereognosis there is involvement of the senses of position, movement, pressure and less so of localization.

FACIAL DIPLEGIA ASSOCIATED WITH LABIO-GLOSSO-LARYNGEAL PARALYSIS.

By Dr. Alfred Gordon.

The patient was exhibited, and Dr. Gordon stated that she had bulbar palsy and presented some unusual features. In addition to the involvement of the muscles of the power part of the face there was complete paralysis of the muscles of the upper part and of the forehead with RD in the latter. The orbicularis palpebrarum, also the external recti muscles were equally affected. This points to a probable association of the nucleus of the upper facial nerve (which as is well known is separate from the nucleus of the lower) with that of the 6th. Another interesting feature of the case is the total motor aphasia, which is quite unusual for the classical bulbar palsy where dysarthria or anarthria are only present. Finally, the patient presents a total suppression of salivary functions: her mouth is unusually dry. The most important point about the case is the involvement of both superior facial nerves, as such an occurrence in association with the typical bulbar palsy has been reported only in family bulbar palsy of children.

Dr. Spiller said he had seen several cases of palsy following diphtheria. He had never seen a case of bulbar palsy occurring in an adult with paralysis of the upper part of the face. Cases of muscular dystrophy involving the muscles innervated from the medulla oblongata and pons and cases of multiple cranial neuritis causing bulbar symptoms have been observed. This patient presented by Dr. Gordon has the ability to lower her eyelids when she looks downward, but she cannot close her lids when she tries to do so voluntarily.

Dr. Spiller thought the hypesthesia of the face and reaction of degeneration a strong evidence of multiple neuritis. Another point of importance was in regard to vision. The woman talked like a person with bulbar palsy, and not like one with aphasia. He regarded the case as one of multiple neuritis of cranial nerves.

Dr. McCarthy stated that two months ago he saw a case five weeks after an attack of diphtheria. The symptom group of cranial nerve involvement was rather irregular, the first symptoms were those following usually an attack of diphtheria with paralysis of the soft palate, with regurgitation of fluids through the nose, and followed after several weeks by a paralysis of the 7th on one side and later both sixth nerves, and later by involvement of the third nerve, and then paralysis of the ninth and tenth with disturbance of the diaphragm and very shallow respirations. The patient, however, finally recovered, but it seemed to Dr. McCarthy that there was some latent or post-intoxication indirectly connected with the previous attack of diphtheria. He thinks the case Dr. Gordon presented would correspond in a way to the case just narrated—some time after an attack of diphtheria or throat infection there has been involvement of the cranial nerves, multiple and more or less bilateral.

Dr. Gordon, in closing, stated that the "yes" that she says is very indistinct and the "no" is absolutely indistinct. As to the lesion in this case, he does not think it is of a cortical nature. He believes it is a case of poliomyelitis; the nuclei involved are those of 6th, 7th, 9th, 10th and 12th nerves.