Garland, J., and White, P. D. PARALYSIS OF LEFT RECURRENENT LARYNGEAL NERVE, ASSOCIATED WITH MITRAL STENOSIS. [Arch. Int. Med., September 15, 1920.]

These authors present nine new cases to the sixty-one already recorded in literature. The article gives a useful summary of the syndrome.

Parrel. DEAF MUTISM. [Il Morgagni, February 15, 1920; Paris Méd., December 27, 1919.]

The author says that absolutely pessimistic views about deaf mutism should not be held, for by careful and prolonged training encouraging results can be obtained. The condition is usually the result of bilateral deafness, acquired or congenital, total or subtotal. Consanguinity of the parents, syphilis, tubercle, rickets, alcoholism, or plumbism may account for some cases. In a few cases evidence of meningitis in intra-uterine life has been found; the condition is relatively common in certain mountainous regions. Acquired deafness may be the result of otitis (especially after scarlet fever), meningitis, injury, etc. Total deafness is rare, so that it is important to look for any residue of hearing that may be present. Having regard to later instruction in lip reading, one should test the visual acuity. Treatment may be divided into (1) early physiological treatment given before the age of 7, and (2) pedagogic treatment given subsequently. Any existing ear or throat trouble must be cured as far as possible and the general health maintained; respiratory and phonetic exercises should be assiduously practised, the tactile sense cultivated, and various speech movements practised by imitation. After seven years a specialized instruction should be given and continued for at least eight years.

Aboulker, Henri. MÉNIÈRE'S VERTIGO AND DECOMPRESSION. [Rev. Neur., 1919, No. 6, June.]

The term Ménière's vertigo, although discarded in modern otology, is here used to indicate nonsuppurative labyrinthine conditions, without reference to pathogeny. The syndrome is characterized by deafness, tinnitus, vertigo and vomiting. There is, moreover, a clearly localized occipital headache and a point painful to pressure at the lower edge of the mastoid. Aboulker believes that there is true intracranial hypertension in vertiginous individuals, which reacts upon the labyrinth. Lumbar puncture, demonstrated as of advantage in treating vertigo by Babinski, has almost always been of value. The amelioration can only be explained by the fact that the sudden decompression of the posterior inferior region of the meningeal cavity reacts upon the intrapetrous and extrapetrous labyrinthine passages. Contrary to the usual indication of intracranial hypertension the spinal fluid frequently flows drop by drop, even in dribblings. The patient nevertheless finds relief for a