limb was completely paralyzed and in it sensation for touch and pain was diminished. The left lower limb was almost normal for both motion and sensation. Patellar jerks, Achilles jerks, Babinski's reflex and ankle clonus were not obtained on either side. Three months after the injury the right lower limb still remained weak and sensation was impaired. Sensation was normal over the left lower limb, but diminished over the left half of the penis and scrotum. The most interesting feature of this case is the peculiar form of Brown-Séquard paralysis, *i. e.*, the weakness and hypesthesia of the right lower limb, with hypesthesia on the opposite side of the penis and scrotum. This symptom complex is explained by the fact that the lesion in the case was above the decussation of the sensory fibers supplying the pudendal plexus, which is lower in the spinal cord than that of the fibers supplying the lower extremity.

C. D. CAMP (Philadelphia).

SPASTIC DIPLEGIA (SO-CALLED SPASTIC SPINAL PARAPLEGIA), WITH PSEUDO-HYPERTROPHY. P. W. Nathan (N. Y. Med. Journ., March 26, 1904).

Many of the cases of infantile cerebral palsy present trophic disturbances, but these are usually of a mild character. There is usually atrophy of the muscle on the affected side. The writer reports a case of a boy aged 10, of negative history and heredity except for asphyxia neonatorum following a prolonged labor. Convulsions occasionally appeared, and when he learned to walk his gait was peculiar. He ceased to walk at all after awhile. At present he is unsteady. His feet are in an equinovarus position; when lying down he cannot rise himself. The calf muscles stand out prominently and are evidently hypertrophied, which with the lordosis, gives him very much the appearance of a patient with pseudo-hypertrophic paralysis. There is no apparent atrophy of the muscles elsewhere. He has good power over the hands, and can flex the thighs without difficulty. When compelled to walk he does so with a typical spastic atactic gait. The reflexes are exaggerated, as is the electrical reaction to both currents. He speaks slowly, with slightly imperfect articulation, and his mental development is nil, though this is more from neglect than from absolute mental defect.

W. B. NOYES.

SYPHILITIC LESIONS OCCURRING DURING TABES. Dalous (Revue de Médecine, January, 1904).

The author has collected from his own observations and from the literature a series of twenty-one cases illustrating the possibility of the co-existence of syphilitic lesions with tabes. He takes pains to state that the evidence here given is not a sufficient basis for an assertion of the syphilitic origin of tabes, but thinks it points strongly in that direction. Of these twenty-one cases nine were unaware of previous infection or absolutely denied it. Although these symptoms are sufficiently pronounced to make it impossible to confuse them with anything else, the length of time which has sometimes elapsed since the original infection and the denials of the patient often cause tabes to be referred to a trophic origin. The examination of these cases is interesting in that it demonstrates that syphilis may remain latent for many years and then at a given time manifest itself anew, and a consideration of its relation to the slow evolution of tabes, unanimously declared to be an incurable condition, may throw some light upon the treatment of the last-named disease.

JELLIFFE.

CLASSIFICATION OF SEVERAL VARIETIES OF FACIAL NEURALGIA. H. Verger (Revue de Médecine, January and February, 1904).

A lengthy and detailed study of the varieties of facial neuralgia, differentiated and studied by means of injections of cocaine *in loco dolenti*. The author states that the first result of his studies was to banish the

idea of neuralgia existing as a disease in itself, and revealing it as a symptom referable to different origins. He divides those manifestations commonly called facial neuralgia into two classes: (1) Those in which the injection of cocaine temporarily stopped the pain, from which he inferred that the cause was situated in the nerve endings, and (2) those in which the injection only brought on the neuralgic crisis, demonstrating that the exciting cause is situated further up. Those of the first group are certainly neuralgias of peripheral cause, while those of the second may be of funicular or central origin. Under these two classifications he records a series of eighteen observations, with detailed conclusions drawn from each, laying stress on the advantages in diagnosis offered by the use of the cocaine injections. He also gives the history of three additional cases where the neuralgic symptoms entirely subsided after the cocaine injections *in loco dolenti*. He also details a final case where the cocaine injections caused remission, but not entire subsidence of the symptoms. Throughout the article he emphasizes the advisability of medical treatment before resorting to surgical interference, and arrives at the following conclusions: In a case of neuralgia in default of etiological diagnosis, which is often impossible, diagnosis should be made at the seat of pain. (2) This diagnosis can usually be made by clinical evidence, but it should always be confirmed by the proof of cocaine injection. (3) *A fortiori* this proof is indispensable in all doubtful cases.

JELLIFFE.

MULTIPLE NEURITIS. A Case Resulting Probably from Morphine Toxemia. By Frank Halleck Stephenson (N. Y. Medical Journal, April 16, 1904).

Electrical tests in multiple neuritis give all possible changes from the normal. The muscles supplied by the affected nerves in multiple neuritis undergo changes only in less degree than those in simple neuritis and degenerative nervous diseases. The escape of numerous fluids in the nerve trunk is probably to be correlated with the persistence of numerous apparently normal fibers in the atrophied muscles, and the paralysis is, therefore, seldom complete. The diagnosis rests on the motor and sensory symptoms, their symmetrical distribution, their predominance in the extremities, the marked affection of the extensors, the modification of the reflexes, the marked tenderness of nerve trunks and muscles, and the history or presence of some toxic agent capable of producing the neuritis. In multiple neuritis we do not get the girdle pains, gastric and intestinal crises, the Argyll-Robertson pupil, the ulcers, joint lesions, arthropathies, optic atrophy, and very seldom the vesical troubles observed in locomotor ataxia. The peculiarity of gait is due more to paresis than to incoordination. The development of multiple neuritis is much more rapid than tabes.

TUMORS INVOLVING THE CAUDA EQUINA. George Gilbert Davis (Journ. A. M. A., March 19, 1904).

The following symptoms are regarded as typical of a lesion of the cauda equina. The patient first experiences pain on movement of the lower extremities; then the pain becomes spontaneous and persistent, with exacerbations. Later anesthesia begins. Symptoms of disturbance of the functions of the bladder and rectum may appear early, and are usually present before anesthesia becomes permanent. Muscular weakness is present in proportion to the pressure on the motor fibers, and as a rule does not appear until pain has become pronounced. The paralysis is characterized by loss of muscular tone; an early examination may show exaggerated reflexes; later they are diminished and lost. Atrophies of the muscle develop and electrical reactions may be altered; decubitus has been noticed. The involvement of one extremity more than the other, as in Fraenkel's case; the slow development