tions betray the luetic changes in a very refined, if not in an always reliable, manner. In the author's experiments the pupillary reactions of only twenty per cent. of patients without paralysis but with leukoplakia were good, while the reactions of forty per cent. without paralysis and without leukoplakia were good. In women the difference in the percentage was even greater. The author states that, in determining the presence of hereditary lues, the leukoplakia must be considered in connection with the other signs of lues and to illustrate this gives the case of a fourteen-year-old girl whose seizures were determined to be of hereditary luetic origin by the presence of leukoplakia and defective teeth together with the scapulae scaphoidae held by Graves to be a sign of hereditary lues in the sense of a defect in development of the bones conditioned thereby. The author also calls attention to the fact that leukoplakia in parents may permit the interpretation of pathological symptoms in children. [J.]

Lafora, G. R. GENERAL PARALYSIS. [Med. Ibera, Nov. 29, 1919, J. A. M. A.]

Lafora reiterates that three years of experience have convinced him that general paralysis in the first six months is capable of complete remission under appropriate treatment. The main thing now is to detect it during these first six months or better yet, before it has induced the classic symptoms. This is possible by systematic periodical exploratory lumbar puncture, and he describes two cases in detail to show the importance of this. The two syphilitic men of 36 and 49 presented an almost identical clinical picture, insomnia, a tendency to aphasia and absentmindedness but no hallucinations, etc. As only two years had elapsed since infection in the younger man, the diagnosis of cerebral syphilis seemed certain in his case, while progressive paralysis seemed equally certain in the other case, the symptoms not coming on until twenty-three years after infection. But the lumbar puncture fluid told another story, the findings showing general paralysis in the younger man and merely vascular syphilis in the other—all confirmed by the later course of the cases.

Grossman, M. THE MALONEY METHOD IN THE TREATMENT OF ATAXIA. [Med. Record, New York, August 16, 1919.]

The author writes that Maloney's method of treating tabetic ataxia is based upon the thesis that perfect thinking is essential to perfect moving, and that perfect moving is the outward sign of perfect thinking. Psychological treatment is as essential as physiological treatment. Maloney has shown that vicious attitudes in tabes are mainly due to mental causes. This mental state, fatigue and fear he combats with "rest exercises." The technique of the rest and other exercises must be read in the original; briefly put, they consist, as a preliminary, in

regulation of the breathing, the induction of complete muscular relaxation and the performance of varied passive movements. This is done in a darkened room and it is said that the tabetic thus trained to rest is endowed with the necessary preliminary to all effort—the power to recuperate. Attention is next directed toward training cerebral control. Movements are ordered which must be accurately defined and precisely performed; they must be carefully regulated in their time relations by means of a metronome. The more an ataxic walks uncorrected, the more ataxic he becomes. Certain mechanical devices to strengthen the weakened ankles, knees and back may be employed. Blindfolding is useful, because it decreases competition for attention between postural images and images derived from other sensory fields. Fatigue must be avoided. Grossman reports fifteen patients, of whom twelve were returned to a non-ataxic state and enabled to go about in public. It is further remarkable that attacks of pain and crises were much reduced in frequency and severity. Eight weeks was an average period of treatment. [Med. Jl. Austr.]

Goodwin, G. M. SYPHILIS OF ANTERIOR HORNS. [Journal, A. M. A., Feb. 7, 1920.]

Goodwin gives the following history of a young Spaniard, suffering from a paralysis of gradual onset without pain, but with symptoms of muscular atrophy and fibrillation. There were no bulbar symptoms, and sensory discrimination was retained. The picture generally seemed to correspond with that of progressive muscular atrophy, though the predominating atrophy in the leg suggested the Charcot-Marie-Tooth type of progressive neural atrophy. The blood Wassermann reaction was +, while the spinal fluid showed a ++++ Wassermann reaction, a cell count of 80 with 92 lymphocytes in the smear, a positive globulin reaction, and a colloidal gold curve of the taboparetic type. It was evident that the patient was suffering from syphilis in spite of his denial, and that the anterior horns were especially affected. This has been a very rare type in Goodwin's experience. A further report after longer observation, is promised.

Weeks, Patrick H. EARLY RECOGNITION OF PARESIS. [Penn. Med. Jl., Oct., 1919.]

Paresis is active syphilis of the brain and nervous system, rapid in progress and terminating fatally. The paretic is a dangerous individual to be at large, especially during the early stage of the disease. Repeated blood and spinal fluid examinations should be made in all cases of syphilis long after active symptoms have disappeared. Observations should be made for neurological symptoms and when they do appear the patient should be confined in a hospital immediately. No person showing a positive Wassermann on the blood and spinal fluid