

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. J. 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. J., 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

and any neurological symptoms should be permitted to hold a position of trust and responsibility.

Every practitioner should keep a case history file for his syphilitics; record each case that comes under his care and make it a practice of posting notes on each case at least twice a year. No patient should be discharged as cured after two or three years' regular treatment, even though all active manifestations have subsided. He should be warned of the serious conditions that might arise and advised to visit a reputable physician once or twice a year, and have his blood and spinal fluid examined for at least ten or fifteen years or even for the remainder of his life. When the patient changes localities his attending physician should furnish him a complete statement showing the treatment he has received, result of repeated blood tests, etc., in order that his next physician can continue treatment properly. There is no excuse for not having blood and spinal fluid examined. If the physician cannot make the tests himself the State Board of Health will make them for him free.

Much valuable knowledge relative to the incipency of paresis would soon be gained if these measures were carried out systematically. [Author's abstract.]

Freudenberg, A. THE PATHOGENESIS OF DISTURBANCES OF MICTURITION IN TABES. [Med. Klinik, November 9, 1919.]

The author says that it is frequently taught that the disturbances of micturition in tabes are due to a paralysis of the detrusor of spinal origin or to degenerative changes in its musculature. He regards both these views as incorrect, and maintains that the condition is to be explained by a lack of coördination between the detrusor and the sphincter vesicae internus when an effort is made to empty the bladder. The detrusor contracts and the sphincter, instead of being relaxed, also contracts to a greater or less degree. The grounds for this view are as follows: (1) The theory of a permanent paralysis of the detrusor or changes in its muscle is negated by the fact that the disturbances in micturition in tabes are an early symptom, and often the serious symptom, in the disease. (2) Cystoscopic examination of the bladder in tabes always shows the presence of trabeculae, which could not occur if there was a paralysis or primary change in the muscle of the detrusor. (3) The remarkable variability in the bladder symptoms, apart from the development or aggravation of complications such as cystitis. Thus the amount of residual urine may vary from 400 or 500 c.cm. one day to only 30 or 50 c.cm. the next. (4) Urethroscopy frequently shows a contraction of the sphincter vesicae internus when the patient strains or when pressure is made on the bladder region. (5) Division of the sphincter internus, which Freudenberg carried out in some cases, completely cured the condition—the external sphincter, which was not divided, taking on the work of the sphincter internus.