Prompt action on the part of the physicians in attendance made it possible for operative interference to be successfully practiced in both of these cases. The cases show that perforation of a chronic gastric or duodenal ulcer may occur even in those who are, apparently, in fair physical condition.

These chronic ulcers are, no doubt, often present when not suspected. Prolonged symptoms of indigestion should invite careful inquiry, lest some condition relievable by timely surgery be overlooked. Not only should perforation be thought of as a possibility, but the incidence of cancer after gastric ulcer. It is hoped that before long patients with carcinoma of the stomach will be sent to the surgeon before a tumor can be proven by palpation. When a middle-aged or old patient has had sour stomach for some weeks, with great loss of flesh and strength, for reasons not apparent, it is wise to have the anemias excluded and gastric findings scrutinized without delay by an able surgeon so that should an exploratory incision be necessary to complete the diagnosis it can be done; for then it is that partial gastrectomy offers a fair chance of cure.

It is better to insist on an early diagnosis, even though some less formidable condition be discovered, than to have been medically asleep while a savable life was ebbing away. Too often waiting for the tumor means hopeless visceral and glandular involvement when explored.

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SEPTIC PYEMIA.

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Since the introduction of antiseptics septicopyemia has become a rather rare affection. But cases occur occasionally which are beyond the power of the surgeon to forestall, or the patient may present himself after the disease has made considerable headway. The report of a case therefore is attended with some interest, first, from the comparative rarity of the disease; second, from its very logical pathology, and third, from certain errors in diagnosis which may occur, an example of which appears in the present case.

History.—J. B., male, aged 13, gave an excellent family and past history. Twenty-eight days previously, in playing basket ball, he received an abrasion on his right heel just over the tendo Achillis from having a player step against his foot. An ulcer formed and more or less soreness developed. Improvement however was noted and the wound showed signs of healing, when one night three weeks after the reception of the wound, the boy was seized with a chill followed by a marked rise of temperature with the attending subjective symptoms of fever. He also complained a few hours later of pain in the right ankle joint. At this juncture a physician was summoned and the case was pronounced one of acute articular rheumatism. For six days this diagnosis held sway. At the end of this period the boy was removed to his home a number of miles distant. On the eighth day of the disease I was called in consultation by the attending physician. The boy lay in a semi-stupor interrupted by both delirious and lucid intervals.

Examination.—The patient's right foot and leg presented a high degree of edema. Over the tendo Achillis was a rather superficial ulcerated area the size of a quarter of a dollar. Over the dorsum of the foot the cuticle was raised into one huge bleb filled with slightly turbid serous fluid. Along the edge of the bleb a little fluid oozed through the ruptured cuticle. The leg showed edema as far up as the knee. The surface of the skin was uniformly red. The slightest movement of the

ankle was extremely painful. The thigh was not swollen nor was the saphenous vein palpable or tender. Marked tenderness, however, was noted in the popliteal space and along the base of Scarpa's triangle. The inguinal lymph glands were enlarged. The left wrist joint was swollen, red and excessively tender as was also the left shoulder joint. The abdomen was hard and board-like and very tender, making positive determination of the spleen problematical. The heart sounds were replaced by loud blowing murmurs heard over the precordial area and well outside of it. There was a pleural friction rub on the left. Pulse 132, and of fair quality; respiration 26, and rather shallow. The facial expression indicated distress. The tongue was moderately coated.

Subsequent History.—The treatment was solely expectant. Under general stimulation and local antiseptics there was no marked improvement.

On the ninth day examination of the serous fluid in the bleb revealed streptococci. Cocci was present in the urine in such numbers that casts made entirely of them were noted. Cultures of the streptococcus and staphylococcus were obtained from the bleb and the urine. The patient died at midnight of the eleventh day.

As the case stands, complete error in diagnosis would seem unlikely. The focus of infection, and its local extension; the appearance of multiple arthritis; the enlarged inguinal glands; the appearance of acute endocarditis and pleurisy, and the symptoms of grave general intoxication make a picture of dreadful certainty. Added to this is the result of bacteriologic examination. In the beginning of the disease, however, a number of the symptoms might be confused with those of acute articular rheumatism, and it is well to bear in mind such similarity and apply all possible discriminating tests.

GORDON'S PARADOXIC FLEXOR REFLEX AND ITS DIAGNOSTIC SIGNIFICANCE.*

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PHILADELPHIA.

HISTORY.

On Oct. 24, 1904, Dr. Alfred Gordon demonstrated before the Philadelphia Neurological Society a new reflex,¹ namely, extension of the great toe on pressure or irritation of the deep flexor muscles of the calf of the leg. This he claimed was indicative of the motor tract disturbance, and was called by him the "paradoxical flexor reflex." At this time he remarked on an apparent antagonism between the paradoxical reflex and Babinski's sign. In December of the same year a further contribution on the subject by Dr. Gordon followed, in the form of a paper, with presentation of cases, before the same society.² At this time he emphasized the importance of the reflex as a sign of diagnostic value, particularly in irritation or early stage of a motor tract lesion.

Gordon's next paper,³ read before the same society, cited two cases as anatomic proof of the value of his reflex. In one of these cases (localized hemorrhagic pachymeningitis) the clinical findings were verified by operation and autopsy, and in the other case (localized cerebral trauma) by operation. In a fourth paper,⁴ read

* Read before the Philadelphia County Medical Society (Central), Oct. 23, 1907.

1. Amer. Med., viii, 23, p. 971; and Jour. of Nerv. and Mental Dis., February, 1905, 123.

2. Jour. of Nerv. and Mental Dis., June, 1906, 415.

3. Amer. Jour. of the Med. Sciences, August, 1907.

4. Jour. of Nerv. and Mental Dis., July, 1907, 430.