the atrophy is pronounced at the shoulder girdle; the pectoralis major, supraclavicular muscles, supra and intraspinalis, the rhomboid, the serratus—all show considerable wasting. The scapula is displaced, its lower angle is elevated considerably. The muscles of the arm are fairly well preserved as seen from the power in functioning. The muscles of the forearm and especially the extensors, also the small muscles of the hand, are somewhat but distinctly atrophied. The patient has lost the power of elevating the arm and extending the wrist. The reflexes of the upper extremity—such as biceps, triceps, wrist reflexes, are all abolished. Moreover the supraclavicular musculature on the left side is beginning to be involved, also the calf muscles on the right are somewhat flabbier on the right than on the left. The knee jerks are normal and equal on both sides. Sensations are normal to all forms. Close inspection of the face shows a slightly greater fullness on the left than on the right, the left nasolabial fold is somewhat deeper than the right. The entire right side of the face seems smoother than the left. Fibrillary contractions, increased mechanical irritability and reactions of degeneration are all absent in the atrophied muscles. X ray examinations of the various articulations of the upper extremities have been negative. The case seems to be one of myopathy of the scapulohumeral variety with the possibility of Dejerine-Landouzy type. [Author's abstract.]

Barrie, J., and Schrapf, R. SYMPATHETIC DISTURBANCE (SENSORY, MOTOR AND VASOMOTOR) IN THE UPPER EXTREMITIES FROM INFECTIONS OF THE MID DORSAL AND LOWER DORSAL CORD. [*Revue Neurologique*, March, 1920.]

In three cases of injury to the dorsal region of the cord, in two of which there was a necropsy, the patient complained of sensations of numbness, tingling, stiffness or coldness in the last three fingers of the hand. The index and thumb usually escaped. There was no atrophy of the muscles of the hand. The reflexes were normal. The grip was a trifle weak. Generally these phenomena were bilateral. In one of these cases the injury was to the tenth dorsal segment, in another at the seventh dorsal segment and in a third from the tenth to the twelfth dorsal. The spinal cord above these levels was apparently normal. In two cases of Pott's disease, one with a lesion at the seventh dorsal segment and another with a lesion at the twelfth dorsal segment, similar phenomena were observed. Also in a case of serous meningitis, causing paraplegia, with the point of compression in the lower part of the cord, the same symptoms occurred. The author observed that these symptoms may precede a development of the paraplegic symptoms in cases of Pott's disease. According to Claude Bernard, the sympathetic nerves of the upper extremities are supplied from ganglia from the third to the seventh dorsal segments and Langley points out that these ganglia may have their spinal connections from the fourth to the tenth dorsal segments. The

above cases would lead one to think that the central connections of the sympathetic nervous system which go to supply the nerves of the upper extremities are from the sixth to the eleventh dorsal segments. The symptoms are of considerable clinical value because of the possibility that it might lead to error in localizing diagnosis. [Camp.]

Marinesco, G., and Radovici, A. A NEW SKIN REFLEX—THE PALMAR-CHIN REFLEX. [*Revue Neurologique*, March, 1920.]

The reflex is elicited by irritation of the palm, especially the thenar eminence, which causes a retraction of the chin on the same side and sometimes a series of folds corresponding to the insertion of the muscle. This reflex is fairly constant in normal individuals. It was present in 23 out of 31 normal subjects tested by the author. It is best taken with the patient reclining with the chin relaxed and the mouth slightly open. In cases of pyramidal tract involvement, the reflex is slower, more durable and of greater amplitude and may be obtained from other parts of the body than the palm. It is an indirect reflex, with an intercalated neurone, and is absent in *tabes dorsalis*, facial palsy, etc. [Camp.]

Hübner, A. A. SYMPTOMS FROM ANTIRABIES TREATMENT. [*Deut. med. Woch.*, January 29, 1920. *J. A. M. A.*]

Hübner reports several cases in which physical and mental disturbances followed injection of antirabic serum. One man of 27 was bitten by a dog, and although there was no evidence of rabies, he received eighteen prophylactic injections of antirabic serum. The last day he received two injections, as he was leaving the city. On the journey home he felt formication in the right side of the face and six hours later right facial paralysis developed, and five days later, the same on the left side, with pains in the right ear. Opening the jaws was painful, and frontal and occipital headache was present and pain in the back at times, testifying to neuritis of the cerebral and certain peripheral nerves, with a certain amount of psychic disturbance. In three months he seemed to have quite recovered and had resumed work. Nothing else was known to explain the facial diplegia; rabies itself, Hübner thinks, can be definitely excluded in the case. In eight other cases he noted weakness and psychic changes after antirabies treatment. His experience thus warns that antirabies treatment is liable to temporarily incapacitate to some extent for regular work and responsibility.

Pari. HYPERHIDROSES IN MYELOPATHIES. [*In Policlinica, Sez. Prat.*, August 16, 1920.]

Experiments on cats would tend to show that there may be a secretion of sweat below a spinal lesion, either temporarily following the trauma or for a longer period. Two mechanisms may give rise to hyperhidrosis in spinal cord lesions: (1) Direct irritation of the secretory