Dr. Taylor said Dr. Spiller asked whether Dr. Taylor had been able to examine other members of the family. This he had not been able to do so far as this generation is concerned, since with the exception of one sister in Canada, whom he hoped later in some way to be able to learn more about, they are all dead. This sister is reported to be still well; but owing to her reticence, it is difficult to get absolute facts. Dr. Taylor was interested in what Dr. Spiller had to say regarding the question of ptosis. This in itself is not particularly remarkable, but in combination with the glossopharyngeal paralysis constitutes a grouping which is apparently unique. None of the other cranial nerves in the case which he had carefully examined are in any way involved. The knee-jerks are perfectly normal, as are the other reflexes of the lower extremities. There is, therefore, no evidence whatever of involvement of the pyramidal tracts. There had been no other diseases of a motor sort in the family so far as ascertained. With regard to Dr. Camp's suggestion, that possibly the condition is one of myasthenia gravis, it may be said that this is altogether improbable because of the unique and constant localization of the paralysis in many members of the family, because the affection is steadily progressive, and because in no other regard does it in any way resemble myasthenia. Furthermore, the fact that it occurs only after the fiftieth year is strongly against the hypothesis of a myasthenia, as is also its manifestly hereditary or family character. Even were it to be included in this group, it would be none the less remarkable on that account. The condition is presumably a degenerative one, doubtless involving the nuclei of certain cranial nerves, analogous perhaps to progressive bulbar palsy, but differing in the nerve involvement, which so far as Dr. Taylor was aware has not hitherto been described.

THE PATHOLOGY OF TABETIC OCULAR PALSIES

By William G. Spiller, M.D.

Difference of opinion exists as to the nuclear or nerve origin of tabetic ocular palsies, and a distinction is made in the pathology of the ocular palsies of tabes and brain syphilis. The author has studied with microscopical serial sections a case of complete ophthalmoplegia in tabes. The subject brings into consideration the relation of parasymphilis to syphilis.

Dr. Fry asked whether in these third nerve palsy cases there is not more pain in the "syphilitic" ones than in those we have been in the habit of calling "post-syphilitic" from a clinical standpoint.

Dr. Fisher asked Dr. Spiller, as in many cases of tabes we have these early ocular palsies which just as in syphilis disappear and often never return, whether that fact does not indicate that the lesion affects the nerve roots rather than the nuclei.

Dr. Spiller thought that the so-called parasymphilitic affections of the brain are of more chronic type and therefore less likely to be with pain but many of the "syphilitic" ocular palsies are painless.

He believed a complete recovery would be more probable from a nerve lesion, but of course recovery is possible from nuclear lesions if they are not too severe, as is seen in poliomyelitis.