

similar disturbances of these three functions. But the foregoing authentic example of disassociation, the author thinks, should justify his advancing the theory of different motor neurons in the anterior horns, the ones controlling reflex movements, the others voluntary motility and muscular tone, both of which, however, are connected with each other by the pyramidal fascicle of the cerebral cortex. Therefore, the hypothesis of the existence of a peripheral neuron in a spinal ganglion, the function of which is transmission of peripheral impulses to a motor reflex neuron, would not seem unreasonable, and might help explain the symptoms of the pseudo-tabes of peripheral origin.

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PARAPLEGIA: GUNSHOT WOUND OF THE SPINAL CORD. Whittaker, Rausohoff and Kramer. *International Medical Magazine*, November, 1896.

Under the above title, Whittaker embraces the occasion offered by an interesting clinical case to speak at some length upon lesions of the spinal cord. The cited case offered many peculiar features, both in symptomatology and treatment. A young married woman had five weeks previously accidentally shot herself through the abdomen. The pistol ball passed through the stomach and lodged in the vertebral column. Collapse and blood vomiting followed immediately, but no loss of consciousness occurred. The lower part of the body became instantly paralyzed. Sensation to touch and pain lost below the stomach line, bowels and bladder functionless. In a few days bed sores began to develop and great pain was felt in the upper part of the body. Status at time of admission: lower half of body markedly atrophic; paraplegia complete and absolute; all reflexes abolished; skin white and scaly; large, deep bed sores over the sacrum, trochanters, knees and ankles; cicatrix of the entering bullet in the median line, some inches below ensiform process. Diagnosis: Wound of spinal column with pressure on the cord. Treatment: Euphraphin paste on bed sores; catheterized; bowels flushed; placed on water-bed.

By means of X-rays the bullet was located in or near the eighth dorsal vertebra. Operation revealed its lodging-place there in the body of the vertebra. The cord was compressed by protruding bone at that point (eighth dorsal), and seemed considerably broken up.

After the operation the patient slowly rallied, but the bed sores persisted and the patient was placed in the water bath at 90° F. She was taken from the tank only for an hour a day and placed on a cot. Under this treatment improvement began and the bed sores commenced healing. Morphine reduced to four grains in the twenty-four hours. Whittaker's discussion of the case was aided by "Remarks on Surgery of the Spinal Column and Cord" (Rausohoff) and "Explanations on the Use of X-Rays in Diagnosis" (Kramer, who took the skiagraph). Taken altogether the subject was most interestingly treated. Rausohoff and Kramer warn not to make a too hopeful prognosis in spite of the successful operation. The remarks of the former, a noted surgeon, were especially noteworthy, as he maintains the lesion could readily have been located without the use of the X-rays. Whittaker, being intimately acquainted with the physiology and pathology of cord lesions, seems to take no very hopeful view of our efforts to rescue cases of cord lesions. Regeneration of the spinal tissue may perhaps be possible, but no sure signs are as yet known which would lead us to believe in such a possibility. The above article is of such importance and so clearly dealt with, that it should be read carefully in the original, notably on account of the prognostic conclusions.

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POTT'S DISEASE WITH EARLY ANÆSTHESIA.

Chipault (*La Médecine Moderne*, Aug. 15, 1896) describes a case