

not very clearly limited and without mention of paroxysms. On the other hand the true pain is well located topographically and is of a definite character, continuing with exacerbations, and there are also par-esthesia symptoms, tingling sensations of heat or cold. Objective symptoms show also a distinction. Cutaneous sensibility with the true case shows a peripheral topography or a radicular one and besides all manner of sensory disturbances reveal themselves, while the simulator betrays on examination no hyperesthetic zone. In the test of the sensibility of the nerve and its roots, through the tests known as Dejerine's, Néri's, Ehrte's sign, etc., there is always pain evinced, but in simulation this is absent and so also are the classic movements and the reflex modification through pain, pupillary, pulse, arterial pressure, as well as absence of phenomena of ulterior sensation, relative hyperesthesia of Leyden, etc. Spinal anesthesia to novocaine might mislead the simulator.

There will also be a difference in the report of the disturbances of sensibility in muscles, tendons and articular bones. Examination of the muscular and cutaneous reflexes, and of the idiomuscular reflexes would not show in the simulator the characteristic reactions of the true sciatica. Electric excitability would also aid in the distinction. Motor difficulties would be very difficult to simulate consistently with the sensory complaints. It is finally very important to examine for trophic, secretory and vasomotor difficulties. There must also be examination of the cerebrospinal fluid in order to discover the characteristic modifications of the causal disturbance. At the same time psychic symptoms must be looked into to discover whether there is the disturbance produced by pain or the calmness and ability to sleep which the simulator would reveal. [J.]

2. CRANIAL NERVES.

McIndoo, N. E. THE OLFACTORY ORGANS OF DIPTERA. [Jour. Comp. Neurol., Oct., 1918, 29, No. 5.]

They are similar in structure and position, but different in number from those of hymenoptera, coleoptera and lepidoptera. The decrease in size of the hind wings of diptera, which diminishes their ability to fly is paralleled by a great increase in their olfactory pores to receive appropriate stimuli.

Eppenstein, A. TEST OF THE CENTER OF THE SIGHT AREA AND THE BLIND SPOT WITH THE AID OF THE UNIVERSAL PRISM APPARATUS. [Klin. Mbl. f. Aughkl., May, 1918.]

Eppenstein has substituted the use of the Bielschowsky double prism apparatus for the Bjerrum method of discovering the scotoma which in certain cases extends itself from the blind spot. The latter method is an efficient one but a tiring one and errors may creep in with less observant or intelligent patients. The double prism apparatus is binocularly

placed, the picture brought toward the blind spot with the aid of the prism and the latter palpated with the picture. Eppenstein finds that the blind spot may be extended vertically from 7° to 8° and horizontally from 5° to 6° without being abnormal, though van der Hoeve considers a lesser degree as possibly pathological. Tube- or chimney-like growths appear at the upper and under ends of the blind spot. This extension of the blind spot, known as van der Hoeve's symptom, may be referred to a retrobulbar neuritis. A semicircular scotoma appearing thus at the border of the blind spot should be watched as it may be the first sign of a glaucoma.

Magitot. MODIFICATIONS OF THE PUPIL FOLLOWING CERTAIN OCULAR CONTUSIONS AND THE TRAUMATIC ARGYLL-ROBERTSON SIGN. [Anal. d. Ocul., May, 1918.]

The author treats of certain cases in which he believes the symptoms are due to injury of the choroid ganglion rather than of the ciliary ganglion. In the latter case the mydriasis would be more severe. The injury is in a region less profoundly located and therefore more subject to surface contusion. In fact the contusion in these cases reported produced sometimes a paralysis, sometimes a spasmodic state, sometimes a disturbance of the ganglionic nervous force. There was complete immobility of the pupil with mydriasis, the latter, however, as a rule incomplete. There was also in other cases a combination of myosis, myopia and diminution of tension with or without lactescence of the retina but without retinal hemorrhage. A spasmodic state of the intraocular sympathetic was produced. In still other cases there was dissociation of the pupillary reflexes, either that known as the Argyll-Robertson sign or its inverse, the disappearance of the orbicular pupillary reflex, or again it was the abolition of the sensory reflexes. [J.]

Cumston, C. G. THE ETIOLOGY OF CONGENITAL OPHTHALMOPLÉGIA. [N. Y. Med. Jour., May 25, 1918.]

Congenital ophthalmoplegia is an affection which appears to be more prevalent among boys, the proportion being sixty-five per cent. in these and thirty-five per cent. in girls, this high percentage in boys coinciding with the malformations in general, which are much more frequent in this sex. The affection is hereditary and familial in nearly fifty per cent. of the cases. In one case the affection was transmitted by the mother to her three children; in another, by the mother to her daughter, and the latter in turn transmitted it to her son, who also had a son afflicted by congenital ophthalmoplegia. In Gourfein's case the affection passed from the grandfather to the father and to his four sons. In Lawford's case the disease was transmitted by the father to three out of seven of his children, one of the remaining four presenting a congenital ptosis. Generally speaking, the affection is familial, several members of the same family being afflicted. In Gourfein's case, it would even appear