

opposite to the wound, thus explaining the paralysis on the homolateral side. The author remarks that this case shows anew what mistakes may arise from an incautious assumption of a congenital absence of the decussation of the pyramids. He reviews cases of homolateral paralysis to be found in the literature expressing the opinion that they can all be explained as due to some such cause as secondary injury of the contralateral pyramid through pressure or hemorrhage, etc. Homolateral hemiplegia can also be counterfeited by functional paralysis, by multiple foci in organic brain disease, etc. A true homolateral hemiplegia as consequence of congenital absence of the pyramidal decussation could only be assumed if it were proved by unequivocal clinical signs, confirmed by the most careful anatomical examination of both hemispheres from the motor cortex to the crossing of the pyramids.

**Schmidt, Adolf.** HOMOLATERAL HYPERESTHESIA WITH HEMIPLEGIA.  
[Archiv f. Psych., 1919, Vol. 59, p. 501.]

The skin and deeper parts are often found to be abnormally sensitive, in new cases of hemiplegia, on the side which is not paralyzed. Even when in an unconscious condition the patients make motions of defense indicative of the hyperesthesia. The author describes two cases from his own experience. In one there was complete paralysis of both legs and arms on the right side, while the motility of the left side was not affected. There was, however, extreme hyperesthesia on the left. The section revealed apoplexia sanguinea on the left. This hyperesthesia is not merely a phenomenon of contrast for it is observed in cases where there is no impairment of sensibility on the paralyzed side. The hypoesthesia on the paralyzed side and the hyperesthesia on the non-paralyzed are not connected phenomena; one may occur without the other, both being dependent, not on the severity, but on the localization of the lesion. According to the author this indicates that the centers controlling sensibility must be situated near the point where motor paths of the contralateral side are most usually found affected, *i.e.*, in the medullary layer below the motor cortex region and in the internal capsule. In lesions situated in the brain stem the conditions seem to be otherwise; at least the author observed a case of hemorrhage in the pons in which there was very pronounced hyperesthesia of the skin and muscles on the side of the paralyzed extremities. The author believes that the homolateral disturbance of sensibility must be due to the stimulation of special paths in the brain which are distinct from the cortico-thalamic paths. It is known from other experiences that probably each half of the body is not exclusively connected with the cerebrum cortex of the other side, but that in some instances centripetal impulses from the homolateral side stimulate the cerebrum cortex. It could be assumed that in lesions of one of the cerebrum hemispheres, sensory fibers which lead from this to the other hemisphere are stimulated and that

from the intact brain cortex the stimulation is carried to the contralateral, intact side of the body. This idea is at least more simple than the wholly hypothetical assumption of a special uncrossed system of fibers from the periphery to the cortex.

## 7. NEUROSYPHILIS.

**Giannelli.** TABES ACCOMPANIED BY ACTIVE SYPHILITIC LESIONS. [I Policlinico, Sez. Med., October, 1919.]

The association of secondary or tertiary syphilitic manifestations during life, according to this author, is not frequent, though such an occurrence is not absolutely rare. Adrian collected 65 cases from literature, to which must be added 4 reported by Gutzmann and those of Nonne, who, though he does not give the exact number, states that he has repeatedly observed this association. Giannelli reports a typical case of tabes of ten years' duration in a man, aged 42, who had contracted syphilis, for which he had had no treatment, at the age of 25. When seen by Giannelli he presented gummatous lesions of the perineum and left leg, and, in addition, a perforating ulcer on the sole of the left foot, in the tissue surrounding which a typical *Spirochæta pallida* was found. No previous instances have been recorded in which the spirochete has been found in connection with perforating ulcer.

**Pandy, K.** LEUKOPLAKIA BUCCALIS AS A SIGN OF PREVIOUS LUES. [Neurologisches Centralblatt, January 16, 1918, No. 2, Vol. 37.]

One of the most difficult tasks of the physician is to ascertain whether an individual has been previously affected by lues. This fact is of special importance for the nerve specialist and one which it is impossible to determine through the anamnesis, or by the Wassermann or any other reaction. The author claims that leukoplakia of the mucous membrane of the mouth is the most unequivocal, most easily recognizable, and most frequent sign of a previous luetic infection. Schwimmer in 1878 made important additions to the knowledge of leukoplakia mucosæ oris but was wrong in assuming both a luetic and non-luetic leukoplakia. It seems now to be fully proved (Landouzy, Gaucher, Kaposi) that leukoplakia is always due to lues and that the subject affected by it has formerly suffered from luetic infection or may still be suffering from the disease. Gutzmann whose opinion the author sought stated: "I am firmly convinced that pronounced leukoplakia is, without any exception, developed upon a luetic foundation. I would place this symptom in the category with tabes, paralysis and luetic sortitis as a secondary luetic phenomenon." The frequency of leukoplakia in those suffering from nervous and mental diseases is explicable on the ground that a large number of such patients are suffering from acquired or inherited lues. The question as to what the pupillary reactions were in individuals with leukoplakia naturally arose, as it is well known that the pupillary reac-