

diminution of irritability of the labyrinth is possible by means of cold, and by galvanic current [anode]. Alcohol, chloral, paraldehyde, adalin, aleudoin, and luminal influence the labyrinth.

Castex, A. THE EAR AND DEAFNESS IN MUSICIANS. [Bulletin de l'Académie de médecine, June 10, 1919.]

This paper points out that among musicians various forms of deafness determine special symptoms not observed in other patients. Anatomically the musician's ear presents no special characteristics, but physiologically it does, perceiving details, such as harmonics, which escape the ear of the nonmusical. It is the musician's brain, however, rather than his ears which perceives these minor details. Grouping his cases, the author found that deafness may alter the intensity, pitch, and timbre of the sounds heard. The ear undergoing sclerosis can no longer hear any but the acute and metallic sounds. It hears nothing of the words uttered by the singer. As regards pitch, there are cases of diplacusia. One ear hears correctly and the other half a tone or even an octave lower. There are also faulty perceptions of tonality, and prolonged persistence of sounds. As concerns timbre, the sounds lose their musical quality and are heard simply as noises; or the instruments may seem to have a nasal or a silverlike quality. Painful hyperacusia is not uncommon among deaf musicians. Some fall into syncope from the action of intense sounds—organ or brass band—because their diseased ear has lost the services of its inhibitory apparatus. The prognosis depends on the temporary or permanent nature of the otic disorder; but incomplete deafness does not keep a musical ear from appreciating the qualities and accessory effects of sounds.

Marage. CAUSES AND DURATION OF WAR DEAFNESS. [Bulletin de l'Académie de médecine, June 10, 1919.]

Experiments with explosives are here discussed with bearing on this question. The curves obtained indicated that the initial excess of atmospheric pressure induced by discharge of modern explosives is at least 150 to 300 kilograms to a square centimeter and that the initial rate of displacement of the pressure waves is 2,000 to 3,000 meters a second. They showed also that the excess pressure and its rate of displacement decrease rapidly as the distance from the center of explosion increases, the pressure falling to two or three kilograms to a square centimeter at a distance of twenty meters, and being practically nil at a distance of fifty or sixty meters. In some instances, however, an excess pressure of one millimeter of mercury was registered 1,300 meters away from the explosion of a large caliber shell. Simple explosive charges showed a uniform diffusion of the pressure waves about the center of explosion. In the case of shells, however, there was a zone of very high pressure exactly lateral to the exploding projectile, cones of somewhat lower

pressure in front of and behind the projectile, and in between these, dead spaces, or rather spaces of negative pressure. Soldiers exposed to these dead spaces have experienced a sensation as of being expanded, drawn out, or emptied. Penetration of the shell more or less deeply into the soil, and the presence of obstacles such as walls, may considerably modify the results, *e.g.*, by inducing reflected waves which interfere with the primary waves. The wide variation in the clinical effects from nearby shell explosions is easily understood in view of these facts.

The enormous excess of pressure must in some instances produce permanent injury to the ears; hence the fact that in cases of war deafness, with or without dumbness, the patients are not recovering in a ratio of ninety-eight per cent., as had at first been hoped. This is illustrated by the fact that in the aural service at Bourges the degree of deafness has been found to remain unchanged after the third month, and that the number of men receiving special privileges for deafness is not diminishing as time elapses.

Lafon, C. NYSTAGMUS AND NODDING SPASM. [Jl. Med. de Bordeaux, Oct. 10, 1919.]

A boy of twelve with rotatory nystagmus is here reported. In early childhood he had had a nodding spasm, apparently a psychogenic compulsion neurosis from superficial description. Lafon has also seen horizontal nystagmus in youths and soldiers and in one man of thirty, accompanied in all with nodding spasm, but without isochronism, except that the nystagmus usually appears only as the nodding ceases. His attempts to force the two conditions into a formula are not very successful.

McNaught, H. Y. PARALYSIS OF THE ESOPHAGUS. [Calif. State Jl. Med., Vol. 17, No. 10. J. A. M. A.]

McNaught reports two cases due to occlusion of the right posterior inferior cerebellar artery probably the result of arteriosclerosis. He suggests that when confronted by a case of sudden inability to swallow, the syndrome of occlusion of the posterior inferior cerebellar artery, should always be kept in mind.

Heitger, J. D. DIAGNOSTIC SIGNIFICANCE OF VERTIGO TO THE GENERAL PRACTITIONER. [Kentucky State Med. Assoc., Sept. 22, 1919. J. A. M. A.]

Vertigo may be caused by (1) a lesion in the ear or of the eighth nerve, such as hemorrhage, effusion, labyrinthitis, inflammation of the middle ear producing congestion and irritation of the labyrinth, leukemic infiltrations, trauma, neuritis, low grade specific meningitis, etc.; (2) lesions affecting the intracranial pathways, such as hemorrhage, trauma, tumor, abscess, thrombosis, infarction, tubercle and gumma, multiple