

ing to individual conditions of virulence of the bacilli, splenic tuberculosis may remain limited to this organ or extend to the liver in a strictly spleno-hepatic type, or, passing onward, become disseminated.

**Nervous Complications and Sequelæ of Malarial Fever.**—BUSQUET (*Rev. de méd.*, 1891, xxi., 411) reports the case of a patient who had four distinct attacks of malarial fever in three months, each of which was associated with interesting nervous phenomena. In November, 1897, the patient, while in Madagascar, had a pernicious comatose paroxysm. After his recovery he began to suffer from girdle pains, which, however, yielded to treatment with quinine. In January, 1898, he began again to have attacks of intermittent fever with a rapidly developing anæmia, as a result of which he was sent to Marseilles. On May 16th the patient had a chill. There was marked paresis of the right arm and leg, the right arm showing a rhythmical tremor which persisted during effort, and as a result of which he found it difficult to feed himself. The right leg when flexed showed spontaneous epileptoid tremor, with oscillations of great amplitude; general sensation good. The right patellar reflex was greatly exaggerated and accompanied by a clonus. The left was slightly exaggerated; there was ankle clonus on the right side; the plantar reflex absent on the right, increased on the left. There was incontinence of urine. The blood showed malarial parasites, both of the acute cycle and crescentic. (The observer states only that amœhoid and crescentic forms were found.—W. S. T.) Under quinine the fever and all the nervous symptoms entirely disappeared. In four days most of the symptoms had yielded. In two weeks the treatment was stopped. In five days the nervous symptoms reappeared, and three days later incontinence of urine. On June 10th there was a febrile paroxysm, and on the following day incontinence of feces. Under treatment by quinine the symptoms again cleared up in a few days, though the incontinence of urine lasted for eight days. Treatment by quinine was stopped after ten days. Four days later the incontinence of urine appeared, and on the following day there was another febrile paroxysm. He was then given a hypodermic injection of 2 grammes of hydrochlorate of quinine, and afterward a gramme a day for eight days, then 0.5 gp to July 12th. Three days later fever and incontinence of urine again developed, which yielded once more in a few days to quinine. On July 26th the patient left the hospital feeling well. The authors believe that the nervous phenomena were probably due to the direct irritation of the central nervous system by the parasites in the circulation.

**Polymyositis.**—LEPINE (*Rev. de méd.*, Paris, 1901, xxi., 426) adds an interesting case to the few instances in literature. The patient was a man, aged fifty-nine years, who entered his clinic on January 24, 1901. He was a cabinetmaker, of good family and personal history, and excellent habits. Eight months before entry he began to suffer from intermittent pains in the head, of moderate intensity, with occasional lancinating pains in the left side, in the mammillary region.

Three months before entry the patient discovered a swelling in the right temporal region, a small, œdematous, slightly tender, but rather hard tumor.

This lasted three or four days, during which there was considerable difficulty in chewing. After several days this disappeared, and a similar swelling appeared on the right, extending, however, to the eyelids so as to cause complete closure. After fifteen days these symptoms disappeared. At this time extremely severe pains appeared in the lumbar region, especially on movements of flexion and rotation. Six days before entry there appeared on the dorsal surface of his right forearm a small oedematous swelling, which was associated with sensations of pricking. From this the oedema spread over the entire forearm and dorsal surface of the hand. The patient was thin and pale. The forearm showed a glistening oedema, somewhat reddened, owing perhaps to applications of tincture of iodine, hard, but neither hot nor tender. A softer oedema was present on the back of the hand. Nothing was to be made out on physical examination of the back. The spleen was enlarged, and there was an anemia of two million red blood-corpuscles; the colorless corpuscles were apparently normal; the hæmoglobin relatively diminished. Cultures from the blood were negative. The urine was free from albumin. The patient was treated by aspirine. The lumbar pains disappeared, while the swelling of the forearm progressively diminished in the course of several days.

The author discusses the term dermatomyositis. He prefers the term polymyositis to dermatomyositis, inasmuch as the cutaneous eruption observed in some cases is not a necessary symptom. He does not consider Lorentz justified in separating dermatomyositis from polymyositis hemorrhagica.

**The Clinical Diagnosis of Infarctions of the Kidney.**—R. SCHMIDT (*Wiener klin. Wochenschrift*, 1901, xiv., 451 and 486), after calling attention to the fact that most observers have held that the diagnosis of infarction of the kidney is rarely possible, reviews seven cases, five out of the literature and two from the clinic of Prof. Neusser, in Vienna, in which the symptoms were carefully observed during life, necropsy proving the nature of the lesion. After considering the various symptoms he comes to the following conclusions with regard to differential diagnosis:

1. In every case of renal colic it would appear to be advisable first to settle the question as to whether it is of intrarenal (increased pressure, necrosis) or of extrarenal—that is, ureteral (passageverlegung).

2. Renal pain of intrarenal origin remains in general more localized in the actual renal region; the kidney, especially in infarction, is exquisitely tender on pressure, the pain is more continual; it is sometimes accompanied by very intense albuminuria of sudden onset or with a sediment similar to that in nephritis.

3. Colic pain of extrarenal—that is, ureteral—origin has a greater tendency to radiate in the course of the ureters; there is tenderness of the ureters on pressure; this may result in an acute hydronephrosis; the pain is more intermittent.

4. Renal colics of intrarenal origin may be caused by:

- (a) Torsion of the vascular pedicle in wandering kidney.
- (b) Sudden congestion in richly vascular malignant tumors.
- (c) Chronic nephritis with an acute inflammatory exacerbation.
- (d) Renal infarct.