

her; pupils were equal and responded quickly to light; no stiffness of the neck; although it was apparently distressing for the patient to bend the head forward so that the chin struck the chest. No paralysis, and knee-jerks well preserved. A week after her entrance in the hospital, and a month after the first appearance of the symptoms, ophthalmoscopic examination showed left optic neuritis in an incipient stage; right eye normal. At this time no headache and no pain on movement of the head. Considerable stupidity, some things are understood, others not. Uses words wrongly, instead of chin, says nose; instead of mouth, says ear, etc. No disturbance of sensibility or motility; pulse rather frequent; sphincters normal; three months later the patient had recovered.

The writer gives in detail the history of three other patients, and they have in common the localization of the process in the brain. Always in the foreground was the aphasia. This did not develop as it does after an apoplectic insult or an encephalomalacie, but after a headache lasting ten to twelve days, and after the beginning of an illness whose onset was characterized by malaise, fever, stupidity and the then aphasia. The absence of motorial irritation and appearance of paralysis, the deep disturbance of consciousness and the spinal symptoms, as well as the early appearance of aphasia spoke against the diagnosis of meningitis.

In the first and second cases absolutely no etiological factor could be attributed as the cause of the disease; in the second and third cases it would seem that influenza could be. In none of the cases was there any evidence of syphilis.

The disease must be distinguished from disseminated sclerosis, which the author thinks runs not infrequently an acute course and ends in recovery. He believes that multiple sclerosis is probably in many cases nothing more than a combination of myelitis and encephalitis. In acute non-suppurative encephalitis, very abrupt onset, severe symptoms, including high temperature, are signs of danger, while a slow onset, low temperature and protracted course are of good omen. J. C.

Influenzal Meningitis.—Cornil (*Semaine Medicale*, May 10, 1895), describes a patient who was admitted into his wards for influenza, complicated with cerebral symptoms.

The patient was a woman, forty years of age, non-alcoholic, who, on April 10 last, was seized with headache and general lassitude, followed in a few days by fever, prostration and drowsiness, which soon passed into coma, accompanied by stertor. On admission she presented hemiplegia of the limbs and upper area of the facial on the right side, incontinence of urine and feces, etc.

She died on April 24. At the autopsy, the pia mater was hard and infiltrated with an abundant, yellow, opaque liquid. In the right half of the brain there was a small hæmorrhagic focus, situated in the grey matter, and another in the first occipal convolution of the same side, which also was subcortical.

This was, consequently, a case of encephalo-meningitis, predominating in the convex part of the brain. Bacteriological examination did not reveal the presence of the influenza bacillus, though no conclusion can be drawn from its absence, as it is quite doubtful whether it ever passes into the blood. J. C.

A Constant Sign in Incipient Meningitis.—Simon (*La France Méd.*, March 29, 1895), in his *clinique*, called attention recently to the fact, that tubercular meningitis always presented no symptoms during the onset, the importance of which he considered indisputable. The sign is a disharmony, viz., an irregularity (dissociation) of the respiratory movements of the diaphragm and the thorax, which sets in during the first days of meningitis, and which can be of great assistance in detecting it, even in the most typical and insidious cases.

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