

shown by the thinned and somewhat everted mucosa. How the perforation took place from the inside is also hard to understand if this foreign body is nothing but a bit of silk thread, as its structure would indicate. It is suggested that possibly a threaded needle was swallowed, and had perforated, leaving a bit of silk behind, and the needle was overlooked among the coils of intestines. It certainly was not thought of at the time of the autopsy, and no especial search was made for it. Another suggestion is that it was a case of follicular ulceration, and the bit of thread had worked its way into that. But the loss of substance in the mucosa is rather less in extent than deeper in, and there is no evidence of any inflammation in the neighborhood that would warrant the assumption of such a process.

We are left, therefore, with the simple fact that the local lesions are all in the immediate neighborhood of the foreign body, and that the perforation and the secondary fatal peritonitis must be referred to it.

The appearances to the eye and under the microscope are well shown in the accompanying drawings made by Miss Byrnes.

A CRITICAL SUMMARY OF RECENT LITERATURE

CONCERNING

SOME RECENTLY DESCRIBED REFLEXES.

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SINCE the original discovery by Westphal, in 1875, that a blow upon the patellar tendon caused a contraction in the quadriceps extensor of the thigh, the subject of tendon and other reflexes has received an enormous amount of consideration, but even in this long period all the possible simple reflexes, so called, have not been recognized and described, or, at least, it would seem not, for nearly every year a new one is discovered or one that was forgotten resurrected. Among the most recent may be mentioned the *hypothenar* reflex. This was apparently first recognized by Stemho¹ in 1894, who noted that pressure upon the pisiform bone caused the appearance of a fold upon the ulnar side of the hand. He ascribed this to the contraction of certain small bundles of muscle fibres that arise from the edge of the palmar aponeurosis (the palmaris brevis). The reflex also involves the fixation of the

¹ Berlin. klin. Woch., 1894, No. 15.

palmar aponeurosis by the palmaris longus, otherwise, of course, the muscles could not produce a fold by their contraction. This article apparently excited very little interest, and it was not until four years later that Holtzinger¹ rediscovered it, apparently in ignorance of Stemho's work. He described the fold upon the ulnar surface of the hand, which, according to him, varies considerably in different people, being sometimes straight, sometimes arched, and agrees that it is produced by the contraction of the palmaris brevis. This contraction, he notes, is not the mere transient twitch such as occurs in tendon and periosteal reflexes, but is tetanic in character, lasting as long as pressure is continued, and varying directly with it in intensity. He also states that various parasthetic sensations are occasionally perceived on the ulnar side of the hand. If the irritation is continued for some time the contraction becomes intermittent—that is to say, there are a series of twitches. The reflex is usually best elicited by pressure upon the pisiform bone, but may also be caused by pressure upon the flexor tendons in the band, by pressure upon the end of the little finger, and by passive abduction of the little finger. It is not produced, however, by mere cutaneous irritation. Holtzinger, therefore, concludes that this is not a cutaneous but rather a tendon reflex. It differs from other tendon reflexes in part by the fact that it is produced when the muscle is slightly relaxed, and in part by the fact that the contraction is tetanic and not clonic in character. Neither Stemho nor Holtzinger claim that it is of any pathological significance. In a number of cases in which I have tested this reflex upon normal and pathological cases I was unable to determine that it occurred in connection with any particular condition. In three cases of hemiplegia it occurred distinctly in one and not in the other two on the paralyzed side. In one case of hysteria and in one of neurasthenia it was quite distinct. It does not seem to occur more readily, however, in cases in which the tendon reflexes are exaggerated. Although I have no notes of my observations, it seems to be present in about half of all normal persons. It is possible that more extensive investigations in functional cases of nervous disease will indicate that it bears some relation to them. I have also observed that instead of a single fold there are usually several that pass obliquely along the ulnar side of the hand, corresponding to the structure of the muscle.

The new reflex for the year 1898 was the toe reflex described by Bahanski.² It consisted in the discovery that in certain conditions the toes were extended (flexed dorsally) when the sole of the foot was irritated. It has been known for a long time that the retraction of the foot upon irritation of the sole—that is, the ordinary plantar reflex—was asso-

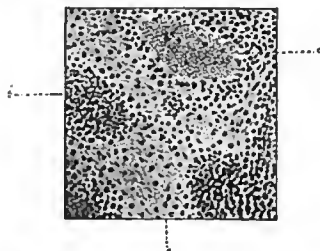
¹ Neurologisches Centralblatt, 1898, No. 19.

² Progrès Médical, 1898, p. 166.

mammary and axillary glands. Although slightly fibrous in character, it most resembles a lymphatic structure.

Histology. Spleen: The majority of the Malpighian corpuscles show only slight alterations. Many appear normal; others present a slight increase in the reticular tissue, and now and then a Malpighian body is found which shows considerable sclerosis. No marked degenerative changes are to be seen in the cells. The veins show a moderate increase

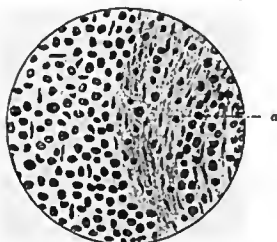
FIG. 1.



a. Connective tissue invading pulp. b. Group of lymphoid cells surrounded by connective tissue. c. Splenic vein.

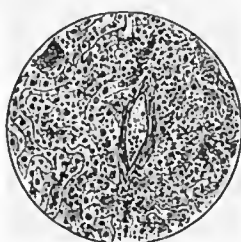
in the connective tissue which surrounds them; areas are found where this increase is very marked. Fibrous tissues extend some distance into the splenic pulp, enclosing within its meshes lymphoid cells, isolated and in groups (see Fig. 1). In many places the pulp appears normal; however, in general it is apparent that the reticulum is con-

FIG. 2.



Splenic pulp, showing area in which the reticulum is fibrous. a. Lymphoid cells.

FIG. 3.



Liver.

siderably increased. Now and then are to be found areas of marked sclerosis containing lymphoid cells in the meshes of the fibrous tissue (see Fig. 2). Nowhere in the spleen are signs of acute inflammation