

THE DIFFERENTIAL DIAGNOSIS OF MULTIPLE SCLEROSIS. B. Onuf (Onufrowicz) (Brooklyn Med. Jour., Nov., 1902).

In speaking of the diversity of opinion as to the pathology of this disease, the author states that it may be due, in part, to various cases presenting differences in the anatomical process, or dissimilar stages of the disease having been observed. He suggests that a better understanding may be obtained by the careful analysis of a great number of autopsy cases with founded with multiple sclerosis. The pathological processes of the diffuse sclerosis, pseudo-sclerosis, syphilis, hysteria, general paresis, multiple softening foci, tabes, combined system disease, transverse myelitis and Brown-Séquard paralysis are most likely, according to his experience, to be con- and pseudo type are much the same as in the insular form, but the latter is differentiated, anatomically, by localization, not being chiefly confined to the hemispheres. Thus, clinically, a preponderance of mental symptoms would be somewhat indicative of the first mentioned disease. Cerebral syphilis, in its multiplicity of symptoms, may resemble multiple sclerosis. A correct diagnosis, oftentimes, necessitating a careful general, as well as special examination. Although of value, too great stress should not be given to the subsidence of symptoms under anti-syphilitic treatment, unless rapid (two weeks) and with marked improvement. Multiple sclerosis, without treatment, oftentimes exhibits a similar, but less speedy tendency. Typical scanning speech, is strongly diagnostic, while nystagmus is not pathognomonic. If well developed, without ocular defects present, it points decidedly in favor of disseminated sclerosis. Because of their constancy, the author regards facial expression and mimicry, also emotional liability, as evinced by the great tendency either to laughter or crying, to be two symptoms of cardinal importance in differential diagnosis between insular sclerosis and syphilis; not general nor specific pseudo-paresis. Optic neuritis, often, only symptom in incipient stage of disease. May almost clear up later on. Syphilis usually attended with more profound retinal and choroidal changes than multiple sclerosis. Evidence of past iritis favors diagnosis of syphilis in doubtful cases. Seventh and eighth cranial nerves not uncommonly found affected in disseminated sclerosis. Multiple cerebral softening, at times, strongly resembles disease. Senility and vascular changes differentiate in favor of cerebral softening foci. The speech disturbance, emotional liability and dementia of bulbar palsy may simulate multiple sclerosis. Symmetrical bulbar atrophies, more gradual onset, and symptoms pointing to an involvement of the anterior horns and lateral tracts aid in forming a correct diagnosis.

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ANGIO-NEUROTIC EDEMA. W. E. Deeks (The Montreal Med. Jour., July, 1902).

Patient, female, eighty-three years, asthmatic, with chronic cardiac disease. Urticaria at times. Prior to angio-neurotic attack, health quite good, although taking suprarenal extract because of threatened cardiac edema which appeared upon cessation of remedy. On morning of attack, urticarial swelling under one eye disappeared quite quickly. At noon, while in usual state of health, patient became dyspneic; constant irritable coughing and swelling of face. Whole face, including ears, cyanotic and swollen. Eyes decidedly prominent and bulging. Tongue edematous, speech almost inarticulate from preceding cause. Marked swelling of parotid and submaxillary glands. Pulse not affected to any great extent. General pulmonary asthmatic condition. No febrile disturbance. Large veins of neck not engorged. Thrombosis of deep jugular veins associated with cardiac affection considered probable, but rejected because of immediate relief afforded by hypodermic injection of morphine and atropine. Cyanosis disap-