Bradford, J. R. ACUTE INFECTIOUS POLYNEURITIS. [Lancet, September 18, 1920. J. A. M. A.]

Bradford writes that acute infectious polyneuritis is a very definite clinical condition, although on clinical and pathological grounds it is not a sharply limited neuritis but a diffuse affection of the nervous system affecting both nerve cells and nerve fibers in the spinal cord, spinal ganglia, peripheral nerves, and to a slight degree the cerebral cortex. It may at times be indistinguishable from the processes now termed encephalitis lethargica or poliomyelitis.

Stevenson, W. C. RADIUM TREATMENT ON WAR NERVE INJURIES. [Br. Med. Jl., June 26, 1920.]

Stevenson has found that following a nerve operation, or after less severe degrees of trauma to a nerve trench radium stimulation appears to aid and to hasten the return of function in a limb. The nutrition in the area supplied by injured nerves seems to be improved. It may be useful as an aid to diagnosis, and in certain cases will indicate or contraindicate the necessity of operation.

Laignel-Lavastine. PSEUDORADICULAR NEVUS. [Bull. de la Soc. Méd. des Hôp., July 23, 1920.]

The author reports upon an interesting distribution of a nevus. It extended from the neck to the finger and correspended to an illy defined radicular distribution of the cervical sympathetics of the chest and arm. He relates it in some manner to a dissociated sympathetic syndrome.

II. SENSORI-MOTOR NEUROLOGY

2. CRANIAL NERVES.

Brouwer, B. CLINICO-ANATOMICAL RESEARCHES ON THE OCULOMOTOR NUCLEUS. [Nederland. Tydschr. v. Geneeskunde, 1917, H 1, p. 1162.]

A middle-aged woman had for some years supraocular headaches with vomiting. A year before admission the left eye showed partial ptosis which soon became complete. Ankle jerks absent, Babinski present on left; a few months later the left knee jerk was absent, right diminished, and there was bilateral Babinski. Gradually the right knee jerk diminished and disappeared; ankle jerks still absent. Legs very slightly paretic. Slight left facial paresis of peripheral type, loss of left corneal reflex, and diminished tactile and pain sensibility of the whole left trigeminus area—greatest in the ophthalmic area—with preservation of thermal sensibility; left motor trigeminus root also affected. All this left trigeminus involvement gradually diminished; later the motor fifth paresis was imperceptible. Vision in left eye very bad (1/15); gradually optic atrophy appeared in it, without evidence of neuritis. Later,