

tion on the left ear and two days later a complete Jansen-Neumann intracranial labyrinthectomy. Recovery was uneventful and the patient was back at work three and a half months after operation. Three years later he stated that he had had no recurrence of the vertiginous attacks, tinnitus or other symptoms referable to his ear, and was in excellent health.

Lermoyez, M. LABYRINTHIC ANGIOSPASM. [Presse Méd., Jan. 2, 1919.]

Lermoyez has noted cases resembling reversed Menière's syndrome, *i.e.*, a progressive tinnitus, with increasing deafness, which becomes almost absolute, but which recovers after a sudden and violent attack of vertigo. He thinks the train of symptoms may be due to a spasm of the vessels of the labyrinth analogous to the blindness due to a spasm of the ocular vessels. Owing to the transient nature of the symptoms, hemorrhage into the labyrinth is improbable. Vertigo corresponds to pain in the vestibular nerve; subjective noises represent pain in the auditory nerve and deafness indicates anesthesia.

Cheval, V. PHYSIOLOGY OF THE EIGHTH NERVE. [Revue de Laryngologie, June 30, 1919.]

V. Cheval finds the rapid component of vestibular nystagmus is comparable to the tendon reflexes, as the nucleus of the trigeminal is connected with the nuclei of the third, fourth and sixth nerves and the contraction of one set of muscles produces a contraction of the antagonists. As the rapid contraction of the antagonists occurs always suddenly and the sensation of kinesthesia of the ocular muscles is transmitted by the trigeminal, it follows that the reflex of the rapid phase has a trigeminal origin. The afferent impulses from the extrinsic muscles of the eye presumably travel by the trigeminal. Injection of novocaine into both orbits of a rabbit caused disappearance of the rapid phase. Unilateral section of the trigeminal trunk sometimes suppressed it, while section of both trigeminals was invariably followed by disappearance of the rapid phase and onset of persistent conjugate deviation.

Maxwell, S. S. EFFECTS OF REMOVAL OF OTOLITH ORGANS AND SEMICIRCULAR CANALS. [Jour. Gen. Phys., Nov. 20, 1919.]

The assumption of a clear differentiation of function between the otolith-bearing vestibular portions of the labyrinth and the semicircular canals seems indefensible. Maxwell points out that between the effects of extirpation of the one and of the other set of structures there is more resemblance than contrast. Certainly they reinforce each other. Reactions produced by either one alone are always slower and less vigorous than when both sets of organs are intact, but it is not safe to affirm that the functions are identical. In one respect a difference is obvious, namely, in the response to rotation in a horizontal plane. If

the ampullæ are uninjured, compensatory movements occur when the animal is rotated around its dorsoventral axis. This reaction in the absence of the ampullæ of the horizontal canal has not been noted by the author.

Gregory, L. T. LARYNGEAL CRISIS WITH AN UNUSUAL COMPLICATION.
[*Jour. A. M. A.*, March 20, 1919.]

The author's case was apparently a syphilitic laryngeal paresis, corresponding to a gastric crisis. It might have been an unusual type of diphtheritic paresis, but this is not likely, as there was no history of any diphtheritic process and no local evidence of diphtheria in an active form. Furthermore, it was a paresis, transient in type, and not a paralysis, as usually seen following diphtheria. Finally, the Wassermann reaction was strongly positive with other evidence of syphilis as seen in the sluggish pupil, perforated septum, scars on the back and chest, and painful and roughened tibia, with a history of chronic sore throat and nocturnal pains in the lower extremities. The immediate response to antisyphilitic treatment confirms the diagnosis.

Kickhefel, G. INFLUENZAL OR DIPHTHERITIC PARALYSIS OF SOFT PALATE? [*Berl. klin. Woch.*, October 13, 1919.]

Four cases of partial paralysis of the soft palate after a typical attack of influenza were seen by the author. The first was a woman, aged 33, who in October, 1918, developed high fever which lasted three weeks. Head and limbs ached, there was a severe cough and much catarrh of the throat, but she was not attended by a doctor. After the temperature had fallen her speech became nasal and slurred. On examination in hospital on January 16, 1919, the movements of the soft palate were seen to be slow on both sides, and occlusion of the rhinopharynx by the palate was incomplete. No regurgitation of liquids by the nose occurred. The quality of the voice was abnormally affected by closure of the nostrils (Gutzmann's test). The author notes that the febrile illness preceding the paralysis of the soft palate in all cases was invariably characteristic of influenza; pain in the limbs, violent headache, great lassitude, pain in the eyes, and catarrh of the respiratory tract were uniformly present. All patients denied the existence of a membranous deposit in the throat, of dysphagia or swelling of the cervical glands. Diphtheria could, therefore, be excluded. Paralysis was only partial, the subsequent course of which the author does not record. Such cases often clear up spontaneously, and when this does not occur the persistence of the symptoms may be due to functional disturbances having succeeded an organic lesion. A. Peyser (*ibid.*) doubts the existence of a genuine influenzal paralysis of the soft palate, suggesting that undetected diphtheria might account for some of the cases labelled as influenzal. He recorded a case of paralysis of the