not hold true in women. The occurrence of blue or gray eyes in such a large percentage of cases examined is rather important and while this number is very small, still it is suggestive.

Dr. Charles W. Burr said any study of a possible relation between the color of the eyes and the occurrence of tabes to be of any value would have to include a very large number of patients. It was necessary also that the race of the patients and not merely their place of birth should be considered. Dark-eyed people were not as common at Blockley as light-eyed.

Dr. W. G. Spiller said that the widening of the palpebral fissure in hemiplegia, to which Dr. Weisenburg alluded, brought up the interesting question of paresis in the upper branch of the facial nerve distribution in hemiplegia. When Dr. Spiller was in Vienna in 1893 the paresis of the upper part of the face in hemiplegia was well recognized. In almost every case of hemiplegia where the face is implicated there is at first some involvement in the distribution of the upper branch of the seventh nerve. It is usually of transitory duration. The widening of the palpebral fissure to which Dr. Weisenburg alluded, probably depends on paresis of the orbicularis palpebrarum muscle.

Dr. Sailer called attention to the value of composite photographs for the purpose of determining the physiognomy of disease. The opportunities at Blockley for making such photographs are excellent, and they might be of great service in the conditions under discussion, that is, tabes dorsalis and hemiplegia. In the latter the difference in the palpebral fissure would probably be more accentuated in such a photograph than in any individual case.

Dr. D. J. McCarthy thought the involvement of the lids was due to secondary contracture pulling down the inferior lid. Dr. McCarthy also said that cases of tabes in the negro had been frequently reported to the Society. In all these cases, of course, the eyes were dark.

Dr. Spiller said in regard to the patients presented, they were old, and it is common to find in the aged a little drooping of the lower lid in paresis of the upper branch of the facial because of the loss of the elasticity of the skin.

Dr. Weisenburg in closing agreed with Dr. Burr that 35 cases of tabes in which blue eyes constantly occurred did not demonstrate much, but he thought that the fact that it occurred in so many cases was rather interesting. In the study of these cases, the race of the patients was considered, but there was no definite relation found. Dr. Weisenburg's main object in bringing this matter before the Society was, if possible, to obtain further information upon the subject, and also to stimulate further observations in the color of the eyes in tabetic cases.

Dr. Weisenburg did not agree with Dr. Spiller that the widening of the palpebral fissure was the result of the paresis in the upper part of the face, but thought that it was due to the paresis of the lower eyelid. He did not agree with Dr. McCarthy that this sign is due to secondary contracture as in secondary contracture we should have the opposite condition, that is lessening in the width of the palpebral fissure.

INCIPIENT TABES WITH SEVERE PAINS IN THE NECK.

By Dr. W. G. Spiller.

The patient was a male, 55 years of age. He had ataxia of gait, Romberg sign, difficulty at times in urination, numbness of the hands, very

feeble reaction to light, and gray degeneration of the optic nerves. The patellar reflexes were not diminished, possibly were a little prompter than normal; this is unusual in tabes but has been known to occur when the reflex collaterals in the lumbar region are not implicated. The pain in the shoulder was very striking, it occurred in severe attacks every few minutes, extended up the back of the head about as far as the ear on the left side and over the front and back of the upper part of the trunk on the left side. Sensation was diminished in this area. Spinal syphilis might be thought of, but Babinski's sign was not obtained. The pains in the left side of the neck resembled the shooting pains of tabes.

Dr. McCarthy thought these attacks of pain suggested the pain of cervical pachymeningitis. He asked if it was present from day to day.

Dr. Spiller replied that the patient had it constantly with exacerbations at times.

Dr. McCarthy reiterated that the type of pain was suggestive of the early stage of cervical pachymeningitis, but the great degeneration of the optic nerves and the ataxia of the lower limbs he had never seen in any cases of pachymeningitis he had examined. He had watched the crises of tabetics but they were not continuous as he understood the use of the term. They came and exhausted themselves and were not of the continuous type of neuralgic tic like Dr. Spiller's patient presented.

Dr. C. K. Mills said he had seen this man when he first came to the hospital and lectured on him on one occasion. He thought the case one of so-called high tabes. He had seen a considerable number of cases of this sort. He had also seen some cases of cervical hypertrophic pachymeningitis and forms of syphilitic meningitis in the cervical region. Confirming the diagnosis of high tabes were such symptoms as the ataxia, the condition of the pupils, and the atrophy of the optic nerves. Cases of high tabes vary considerably in their symptomatology. He had seen a case a week previously in a young man, a private patient, who had pains somewhat similar to the pains suffered by this man, but not similar in their continuance. The pains occurred at intervals but not almost daily. The patient had pains about the chest; he had lost the knee jerks and Achilles jerks and had dilated pupil on one side. It was a question in all these cases of the intensity, and above all of the peculiar distribution of the lesions. He had seen all sorts of commingling of phenomena in connection with dominating cervical tabes. He could recall 10 or 12 other cases; some with knee jerks lost, and Achilles jerks retained, others with knee jerks and Achilles jerks present, and so on through a considerable list of similarities and differences.

Dr. Sailer said he remembered some years ago seeing a commercial traveler passing through the city, who came into his hands suffering from tonsilitis. He discovered that he also had tabes dorsalis. The patient had continuous severe pain in the right arm, so severe that it practically disabled the arm unless he took huge doses of potassium iodide. There were no gross motor disturbances in the arm, no ataxia nor any sensory disturbances, simply the pain which compelled him to keep the arm quiet.

He remembered another case he saw with Dr. Musser a good many years ago, a man with tabes dorsalis evidently of the superior type. He had laryngeal crises, diplopia, ptosis of one eyelid, and Argyll-Robertson pupil. The case was typical, excepting that the knee jerks and the

Achilles tendon jerks were more lively than normal. There was, however, no ankle clonus.

LESION OF THE CAUDA EQUINA PROBABLY UNILATERAL.

By Dr. W. G. Spiller.

H. C., a male, thirty-one years old, was injured eighteen months previously by a bale of cotton falling against the abdomen. He was unable to work for about three weeks, but then returned to heavy work, feeling not quite so well as formerly. About a month after returning to his occupation, while lifting a bale of cotton, he felt something give way in the right inguinal region, and at the same time he heard a tearing sound. He immediately felt weak and limped on the right lower limb, but walked home, a distance of about two blocks, and went to bed. After one day he got out of bed but remained at home about a week. He then returned to heavy work, but he has not been so strong as he was before the injury.

After the accident he lost control of the bladder, so that when he coughed or exerted himself, the urine would escape. This condition gradually became worse until now he has no control of his bladder and has been wearing an urinal about a year. Sexual desire is not weakened, but only the dribbling of urine prevents the sexual act. During the past two months he has noticed that the rectal sphincter functionates feebly and that when there is a call to stool it is urgent. His gait and station are good. The lower limbs are well developed but the man thinks he is weaker than he was before the accident. The left side of the scrotum, left side of the perineum, and the left buttock near the anus have fully normal sensation to touch and pin-prick, whereas the right side of the scrotum except the upper outer portion, the right buttock in a small area near the anus, and to a less degree the right side of the perineum, show diminution of sensation to touch and pin-prick. The right side of the penis also is less sensitive than the left side. The sensation of the testicles is normal. The patellar reflexes are prompt, but the Achilles reflexes are slight. Babinski's sign is not present. The upper portion of the body is not affected. The lesion must be in the lower sacral roots, and probably confined to one side because of the unilaterality of the disturbance of sensation in the supply of these roots. This unilaterality also is contrary to a lesion of the conus. It is a question whether the vesical and rectal incontinence can be caused by an unilateral lesion but it seems probable. The cause of the symptoms was probably stretching of the lower sacral roots of one side by excessive straining, as has been seen also in lesions of the sciatic nerve.

Dr. Mills thought this a very interesting case. The only thing that suggested itself was as to how this stretching could occur in a case of this kind without other injury. That is, what were the exact mechanics of the process. It was difficult to understand how, with the nerves of the cauda equina, in the absence of accident locally interfering with them in some way, this stretching could be brought about.

Dr. McCarthy referred to a case he saw three or four years ago in Dr. Spiller's clinic of a man lifting a heavy weight, the case later coming to autopsy, in which there was a lesion of the cauda equina. It was bilateral. There was paralysis of the rectum and bladder (the rectum afterwards recovered). There was distinct sensory disturbance around the anus and scrotum. Dr. McCarthy's own impression was that