

phy which in many cases intervenes, and which develops far too rapidly to be due to mere disuse. Whether this atrophy be primary or secondary, is it reasonable to suppose that it can exist without accompanying degenerative changes in the cord, and is it not fair—from the clinician's view, to assume these changes to be similar to those found in anterior polio-myelitis?

Pathology points to the probable fact that the trophic nerves of the bones and joints are found in the mixed nerve trunk and that they issue along with the motor fibers from the anterior cornua, where they are, like the muscular trophic fibers, connected with a group of large nerve cells. Some connection must exist between these and the brain. Clinically the author has often seen arthritis induced by trauma of the cord or of the peripheral nerves which could not, except by the history of the case, be distinguished from the rheumatoid form. This fact has been known for years. In 1864 Drs. Weir Mitchell, Moorhouse and Keen published their observations on the subject and so far back as 1831, Dr. S. W. Mitchell reported cases where arthritic symptoms supervened upon injury to the spinal cord. These cases were successfully treated by applying a dozen cups and abstracting as many ounces of blood from the neighborhood of the cervical or lumbar enlargements. If the cupping did not afford relief, blisters were applied to the same areas.

Upon the foregoing data it seems not unreasonable to assume that the joint troubles in rheumatoid arthritis are due to spinal congestion or chronic myelitis, chiefly affecting the ganglion cells of the anterior horns but extending also, when the disease is associated with "glossy skin" to the ganglion cells of the posterior horns.

The author cites a number of cases in which blisters, 6 inches by 2½ inches, were applied to either side of the spine, the blistered surface being kept open for a week with savine ointment, daily local massage; arsenic and nitrohydrochloric acid, formed the basis of the treatment and in which marked improvement was the rule. In conclusion he states that in the early stages of rheumatoid arthritis continuous spinal counter irritation is of great value. After the bones have enlarged and the articular cartilages have been destroyed it is of little use. Nevertheless, in these chronic cases where exacerbations of pain and swelling occur, it may be used, often, with distinct and lasting benefit.

JELLIFFE.

**PATHOLOGY OF HYSTERIA.** F. D. Savill (*Lancet*, 1901, 2, July 20, No. 4,064).

Savill says that the sudden onset of hysterical paralysis (or other malady) suggests a vascular lesion, and the anatomic change is in fact a vascular one—a sudden dilation or contraction of the arterioles of a given area, accompanied in some instances by exudation, or disturbance of nutrition in that part of the nervous system the function of which is deranged. Just as subjects of the hysterical diathesis are liable to attacks of flushing or pallor of the skin, so also, it is believed, are they liable to attacks of flushing and pallor of various parts of the interior of the body. In the absence of experimental proof of the truth of this proposition, Savill directs attention to the clinical features of hysterical syncope, to the evidences of the hysterical diathesis, and to the causes of hysteria as tending to confirm his contentions. He states that the essential lesion in hysterical syncope is to be sought in the abdominal sympathetic, and that this lesion, whatever it may be, gives rise to a rapid dilation of the splanchnic arteries and consequently to cerebral anemia. The hyster-

ical diathesis is defined as a peculiar condition of the nervous system, inherent in the individual and for the most part inherited, consisting in its psychical aspect of a want of self-control and emotional instability, and in its physical aspect of a tendency throughout life to the development of various sensory, motor, visceral, or neurovascular disturbances unconnected with any definite organic lesion discoverable by our present means of investigation. With regard to the pathology of the hysterogenetic phenomenon, it is believed that pressure upon the inguinal region results in the production of the aura, etc., by producing dilation of the splanchnic area and consequent cerebral anemia—through the medium of the iliohypogastric nerve, the centripetal depressor nerve of the abdominal sympathetic. There may, apparently, be other depressor nerves in patients who present other hysterogenetic zones.

SMITH.

UEBER SENSIBILITÄTSSTÖRUNGEN DER HAUT BEI MAGENKRANKHEITEN). Haenel (Muenchener medicinische Wochenschrift, Jan. 1, 1901).

Head's conclusions are confirmed by the author, who finds that the dorsal areas 7-9 are most commonly affected in diseases of the stomach. At times, however, hyperalgesia may extend beyond these zones. Hyperalgesia of the arm, especially on the inner surface of the arm and over the deltoid muscle, does not negative disease of the stomach. The two points sensitive to pressure described by Boas, one to the left and the other to the right of the twelfth dorsal vertebra, are found to exactly coincide with the two maxima of Head, while the sensitive point in the epigastrium is probably also a reflex hyperalgesia rather than due to direct pressure. The writer gives brief histories and the localization of the hyperalgesia in five cases of disease of the stomach. The areas of pain coincide in the main with the deductions of Head.

JELLIFFE.