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amount of normal serum used in the tests was to be subminimal—i.e., no resolution of the agglutinated corpuscles would occur, at least within 24 hours. Having settled this procedure suitable and measured volumes of the agglutinated corpuscles and of normal serum were drawn into capillary pipettes and mixed after expulsion on to a slide. The mixture was then redrawn into the shortened capillary pipette or special glass tubing and stood vertically in a plasticine tray, and the same procedure was repeated, but using syphilitic sera in similar proportions.

In this way two series of tubes were arranged, and standing at room temperature the effects were visible to the naked eye. The majority of the syphilitic sera more or less quickly resolved the agglutinated corpuscles, which fell away from the red clusters (adherent to the wall of the glass tubing), and subsiding to the bottom of the tube left a deposit of red corpuscles and a clear supernatant fluid. On the other hand, the majority of the presumed normal sera remained unresolved, and only after one or two days became brownish in colour and hæmolysed by the slight acidity of the ferric chloride solution. This difference in resolving power appeared to persist, though retarded in speed, after heating the sera to 60° C. for 30 minutes.

In these comparison experiments no attempt was made to standardise the sera as regards complement content, nor were their ages since blood coagulation kept uniform. I also undertook no tests to ascertain whether the effects were due to a greater avidity for iron salts of the syphilitic sera, but the impression arose that the greater resolving power of the syphilitic sera was due to a greater content of some substance in them. Whether this difference can be elaborated into a test for the disease is a further point of interest which the future may decide.

London, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A NOTE ON A CASE OF MERICISM.

BY JOHN D'EWART, M.B. LOND., M.R.C.S. ENG., L.R.C.P. LOND.

MERICISM, or rumination—physical, not mental—is sufficiently rare to warrant the recording of the following case.

The patient, unmarried, consulted me on account of subacute arthritis. On her first visit she complained of eructations of food, and thinking this to be due to the administration of salicylate, an alkali was added to the medicine without effect—in fact, the eructations were worse. As the result of a demand for details of the condition the following history was obtained. The eructations come on a quarter of an hour after food and last for about two hours; they are usually accompanied by the actual return of more or less food; sometimes this could be swallowed, but often the return was so much that it was spit out of the mouth. The food at the end tasted just the same as at the beginning, and there was no control over the return or over the amount. All meals gave the same result, but milk and lemonade were very bad, and liquids were worse than solids.

The patient is 22 years of age, has had no serious illness, and has been troubled with rheumatism for three years, also with her "nerves." Two years ago she consulted her medical attendant for these "risings," and he told her she had acid dyspepsia, and for some months treated her accordingly, with no effect. The condition is worse at some times than others, being particularly bad if she is worried or excited—for example, the fear of leaving home on account of her rheumatism she thinks is the cause of the condition being worse now. As regards the family history, her father, mother, and two sisters have never been troubled in this way; her father is an only child, and his father and mother never had any trouble of the kind to his knowledge. Her maternal grandparents were also free, as were also her maternal uncles, aunts, and cousins. The known family history extends to 32 persons.

Assurance that there is nothing to worry about, and that the condition is more interesting than dangerous, has already made a great improvement, though no meal has as yet gone by without some regurgitation.

Manchester.

A CASE OF CEREBRAL TUMOUR PRESENTING AN UNUSUAL "CROSSED REFLEX."

BY E. B. GUNSON, M.D. EDIN.,
RESIDENT MEDICAL OFFICER, WEST END HOSPITAL FOR NERVOUS DISEASES.

THE patient, a male aged 15 years, was admitted to the West End Hospital on May 6th, 1912. Two months before admission he suffered from loss of speech, loss of memory, and mental dulness, without loss of consciousness. The symptoms lasted 14 days, when he appeared to recover completely and returned to work. He was well for four weeks when the symptoms recurred.

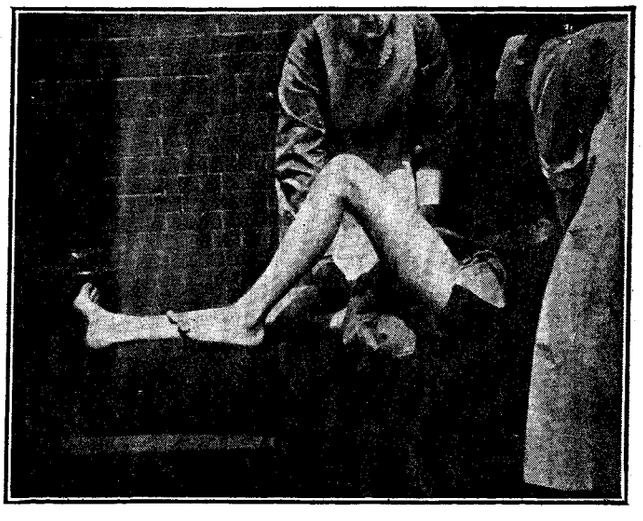
On admission the patient had not spoken for a week and had vomited once, before breakfast. The face was expressionless; he took very little notice of his surroundings. He gave his name and address correctly, but showed no further inclination to speak; he understood what was said to him and carried out simple instructions. There were no abnormal movements. Well-marked optic neuritis on right side; no muscular weakness; no incoördination.

Reflexes.—Superficial: Abdominal and cremasteric very active, equal on the two sides; plantar, feeble double flexor response; Oppenheim's reflex and Gordon's paradoxical reflex present on the left side only. Deep: knee-jerks exaggerated equally; ankle-jerks and supinator jerks brisk and equal; slight ankle clonus right side; no patellar clonus. Organic: incontinence of urine on two occasions.

Vaso-motor.—On eliciting the abdominal reflex along the area touched there developed in about half a minute a line of extreme pallor which lasted two minutes and gradually faded; at no time was there any suggestion of redness.

The boy became very dull and refused to speak, but took food well. Optic neuritis increased and affected the left disc. The left knee-jerk became more active than the right. An occasional extensor plantar response was obtained on each side; the reflex, however, was almost constantly flexor.

Diagnosis of cerebral tumour involving the right frontal lobe was made, and on June 6th Mr. C. A. Ballance performed craniectomy over this region. There was no obvious increase of intracranial pressure. The dura was opened, but no tumour was found. The wound rapidly healed. The patient became very suspicious, resented interference, and frequently refused food. The knee-jerks diminished, and on June 24th the following reflex was noticed for the first time. On grasping firmly the quadriceps extensor muscle with the thumb and fingers of one hand immediate flexion at the contralateral hip-joint took place. The reflex was present equally on each side; no response was produced by stroking the skin of the thigh or by percussion of the muscles or bones (see figure). There was no movement at the hip-joint



Reproduction of photograph showing "crossed reflex.