

lack of delicacy in differentiation. Knee-jerks were absent. At midnight the facial muscles became involved and speech indistinct. The pulse was rapid and intermittent and cyanosis set in. One hour later death ensued. No autopsy was obtained. Rowden calls attention to the rapid course of the disease, the descending character of the palsy, the very slight impairment of sensation, the absence of rigidity, twitching pain, or spasm, the unimpairment of the mental faculties and the control of the bladder and rectum. He does not regard the trauma as a causal factor.

WITMER.

BROWN-SÉQUARD'S PARALYSIS. Woods, of Philadelphia (*Amer. Journ. the Med. Sci.*, Aug., 1900).

The author records a case with the clinical symptoms exactly as described by Brown-Séguard in hemisection of the spinal cord. The patient was stabbed in the back of the neck, and as a result suffered from paralysis of the left arm and left leg. The reflexes were normal, but there was incontinence of urine. On the fourth week some slight power was returning to the left hand, and the next week to the left leg. In the seventh week he was able to walk awkwardly, there still being present a paresis and dragging of the leg. A year later, at the Pennsylvania Hospital Dispensary, he was found to have an excessive knee-jerk and some ankle clonus in the paralysed leg. In the paretic arm the tendon reflexes were also exaggerated. As regards sensory alterations they closely conformed to Brown-Séguard's type—namely, hyperalgesia and tactile hyperesthesia in the paralysed limb, anesthesia and analgesia in the non-paralysed limb. Muscular sense and consciousness of position were lessened in the paralysed limb, but unaltered in the non-paralysed limb. Thermal sensibility was lost in the sound limb and increased in the paralysed limb. In surface temperature the paralysed leg was warmer. Similar differential conditions prevailed as regards the paralysed and non-paralysed arms, and the facts confirm the view of Brown-Séguard that the paths of tactile and painful sensibility decussate after entering the spinal cord.

JELLIFFE.

ARSENICAL PERIPHERAL NEURITIS. Several authors (*British Medical Journal*, Dec. I, 1900).

A number of observers have reported on a severe epidemic of poisoning by arsenic in the districts about Liverpool and Manchester. The cases of poisoning have occurred in patients who were beer drinkers, and one case is reported to have been the result of arsenical poisoning in stout. The investigation committee of the British Government, as well as the earlier observers, are reported to have found the arsenic in the glucose used in the manufacture of the beer. The symptoms noted have been many and quite bizarre in their distribution. Eruptions of the skin were common, consisting of herpes, erythematous and papular eruptions, scaly desquamation and a peculiar pigmentation, at times suggesting the bronze coloration of Addison's disease. The urinary organs were not often involved; hepatitis was not infrequent and the general digestive disorders were diarrhoea, epigastric pain, anorexia and vomiting. Nervous systems were very common and severe in character. Tremor was almost universal, the knee-jerks were diminished or abolished. Numbness, tingling, pain and cramps in the extremities almost invariably pre-

ceded paresis or paralysis of the extensors. The respiratory tract was also involved. Coryza and bronchitis were common manifestations.

JELLIFFE.

HYPERTROPHIE OSSEUSE DANS UN CAS D'HEMIPLEGIE INFANTILE AVEC ATHETOSE-CHOREE (Bony Hypertrophy in a case of Infantile Hemiplegia with Athetosis-chorea). Lannois et Fayolle (Lyon médical, Nov. 18, 1900).

The introduction of radiography has enabled the authors to demonstrate the rare condition of bony hypertrophy in the case of hemiatetosis due to cerebral apoplexy in infancy. A case had already been reported by Lannois in 1898, because one of the breasts had undergone hypertrophy. At that time it was stated that the pareto-athetotic muscles had undergone hypertrophy. The author's case together with a hemiatetotic epileptic, were selected for radiographic measurement. Both these cases had distinct muscular hypertrophy, but radiography failed to reveal any corresponding changes in the bones. In a third case of the same nature however, not only the muscles, but the bones were hypertrophic. The wrist of the athetotic side measured 16 cm. to 15 cm. on the sound side. Mensuration was confirmed by the radiographic test. Not only the bones of the carpus but the lower ends of the radius and ulna were distinctly enlarged. The patient had ordinary infantile cerebral hemiplegia of the face and limbs, followed by athetoso-chorea. The affection was due to a hard labor and obstetrical intervention. The author's conclusions are:

This phenomenon may possibly be due to the athetotic movements. Why then does it not always occur along with the muscular hypertrophy? Excessive use besides, does not explain the hypertrophy of the breast in one of the cases, nor the enlargement of the testicle of the paralytic side in a case of Bourneville's. The cause must be trophic.

CLARK.

UN CAS DE PARALYSIE BULBAIRE AIGUE CHEZ UNE ENFANT (A Case of Acute Bulbar Paralysis in a Child). J. Kollarits (Nouvelle Iconographie de la Salpêtrière, 14th year, Jan.-Feb., 1901, No. 1, p. 2).

A case of a young girl of seventeen, who, at the age of five years, was attacked by some febrile disorder, during which there developed a bulbar syndrome which has remained constant to the present time. The most pronounced symptoms are difficulty of deglutition and phonation. The cranial nerves are affected as follows: Some ptosis on the left side shows that the oculo-motor on that side is affected. Hypesthesia of the upper gum and of the cheek on the left side, as well as the lower gum results from a lesion in the second and third branch of the trigeminal; the loss of taste and of tactile sense at the base of the tongue shows an affection of the glosso-pharyngeal; the anesthesia of the throat and of the roof of the palate depends upon an affection of the glosso-pharyngeal and of the vagus; the accessory nerve likewise affected, contributes to the difficulty of deglutition; the hypoglossus nerve is completely paralysed, the tongue is flattened and remains inert upon the floor of the mouth; the optic nerves, the trochlear, and the external nerves of the eye-ball and the acoustic are not touched by the morbid process. In respect to