functional activity of the right as well as of the left centre, especially as many of the nervous disorders due to alcohol are bilateral.

[If word-hearing were normal, and spontaneous writing were possible in this case, there might be some doubt as to the propriety of locating the lesion within the speech zone of the left cortex.]

**Spiller.**

**The Significance of Herpes Labialis in the Differential Diagnosis Between Suppuration and Tuberculous Meningitis.**

From Prof. Eichhorst's Clinic, University of Zürich.

Dr. A. Hubel (Deutsche Med. Wochenschr., Oct. 15, 1896) publishes a case of tuberculous meningitis in a young woman that ran subacute course, during which herpes labialis developed. Lumbar puncture was made but no fluid could be aspirated. The conclusions reached are: I. Herpes labialis is a rare symptom in tuberculous meningitis, but by no means excludes it, as maintained recently by F. Klemperer. II. Lumbar puncture is, in most cases, an excellent means of diagnosis, but frequently fails to reveal tubercle bacilli, and even fluid in the dura sack. III. In the aspirated fluid, mucous coagulations are found that indicate the tuberculous nature of the disease.

**MacAlester.**


Quincke reports a number of new cases of this form of meningitis, which at the autopsy usually presents no notable findings. He calls attention to the difficulty of making a diagnosis, which may be lessened by the lumbar puncture. The exudation in many cases is like that seen in joints, and in the acute circumscribed ödema of the skin and mucous membranes. It is probable that there are gradations from the purely physiological to the inflammatory exudations. It is not unlikely that in severe forms of migraine an actual meningeal exudation is present.

He recommends the use of mercury and the salicylates for the serous meningitis. Lumbar puncture relieves the pressure.

**Spiller.**

**Ein Fall von Polynieritis mit multiplen schwirllartenigen Granulationsgeschwülsten der Haut (A Case of Polynieritis with Multiple Callous Granulomata of the Skin).** Deutsche medizinische Wochenschrift, No 45, 1896. By A. Fraenkel.

Fraenkel reports a case of multiple neuritis, in which the left facial nerve was also affected, with dermal tumors in the extremities. These developed in the beginning of the disease and were symmetrically arranged. Histologically, the tumors resembled the granulomata. They consisted of small round cells, large epithelioid cells, spindle-shaped and giant cells. As bacilli could not be demonstrated and inoculation gave negative results, the process was not regarded as tubercular. The patient denied syphilitic infection and presented no signs of the disease. Gummata of the skin, if not cured by antisyphilitic treatment, usually soften and ulcerate, or more rarely contract in consequence of central caseation. In this patient contraction of some of the tumors was observed as long as the treatment was continued, and the contraction involved the whole of the growths. There was no epidermal desquamation and no pigmentation. It has not been positively shown that syphilis causes multiple neuritis. The patient had been exposed to lead poisoning. The facial paralysis, the severe parasthesia and spontaneous pain, the sensitiveness to pressure of the nerves, skin and muscles, are difficult to explain as symptoms of lead intoxication. Facial paralysis is rare, and granulomata of the skin seem to be unknown in saturnine poisoning. It is possible that the
tumors were of a rheumatic origin. They were probably due to the poison which caused the neuritis. Fraenkel acknowledges that he is unable to state the nature of these growths, but is inclined to attribute them to syphilis.

**Peripheral Neuritis in Phtisis.**

It has been known for some time that peripheral neuritis may complicate pulmonary tuberculosis. Not long since Carriere, of Bordeaux, published a thesis on this subject and he now adds two new cases (Arch. Clin. de Bordeaux).

The first case was a woman of thirty-five, whose tubercular trouble began in the intestines but soon involved the lungs also. About a month after the invasion of these organs the patient began to have almost continuous lancinating pains in the lower extremities, worse in the popliteal region and calves, with great tenderness of the sciatic nerve and leg muscles and hyperexcitability of the latter. There was some atrophy, corresponding weakness, and almost a disappearance of the knee-jerks. Sensation was normal, but the skin showed slight trophic changes. Soon after the beginning of the symptoms just detailed exquisite "dermalgia" appeared; the patient could not endure the weight of the bed-clothing.

The pulmonary and peripheral diseases advanced, the muscles of the lower extremities became atrophied to a marked degree and exhibited reaction of degeneration, all reflexes were lost and the patient became completely paraplegic. She died one and a half months after the inception of the neuritis.

The autopsy was very carefully made and included a thorough microscopic examination of the nervous system. There was advanced pulmonary tuberculosis. All the nerves below the knee were completely degenerated or very nearly so. The sciatics at the notch were practically normal. Spinal cord, spinal meninges, lumbar nerve roots and nerves of the upper extremities were normal.

The second case was one of pulmonary tuberculosis, following pleurisy, in a man of fifty-one. When first seen, about the only indication of neuritis was atrophy of the small muscles of the right hand, especially the thenar eminence; feeble knee-jerks and occasional lancinating pains in the thumb and first two fingers of the right hand were present. There was in addition some appearance of glossy skin on the same hand. While in this condition the patient suddenly died of hemoptysis. In this case also careful post-mortem examination was made, which showed the nerves of the lower extremities and those of the left upper extremities to be perfectly normal. On the right side the median nerve above the elbow showed very slight changes, at the wrist marked degeneration, and in the branches going to the thenar eminence the nerve fibres had entirely disappeared. The ulnar nerve was normal. As in the former case, the brain, spinal cord, membranes and nerve roots showed no change.

Clinically, the cases are of interest as showing the marked difference in the distribution of the neuritis and in the symptomatology of the same. Cases like the second, in which atrophy of the small hand muscles is the principal symptom, are exceedingly rare. The author considers at some length the modus operandi of tuberculosis in causing these cases of neuritis. Basing his conclusions on his own post-mortem examinations and experiments on animals, he proceeds to exclude as a cause congestion of the thoracic and spinal vessels (Leudet), purely functional disease (Weill), cerebral lesions (Blocq and Marinesco), spinal meningitis (Arthaud and others) and an affection of the cells of the anterior horns of the cord (Erb). This exclusion is, we think, quite justified, as the microscopic examination was made with the latest and most approved technique. He excludes also inanition as a cause, as the patients ate well, and, besides, guinea pigs that he starved to death never showed peripheral neuritis.