AN interesting account of some pathological re-
search on a fatal case of diphtheria was given
by Dr. Guillin at a meeting of the Société Médical
des Hopitaux. The case was that of a man aged 29,
who, after an attack of pharyngeal diphtheria,
developed complete paralysis of the palate and then
bulbar paralysis (hiccough, vomiting, bradycardia,
and dyspnoea), to which he rapidly succumbed. The
cerebro-spinal fluid showed no cellular reaction, and,
innoculated into the rabbit, did not produce any
trouble. Portions of the bulb were then taken in
the region of the nuclei of the nerves, and after
being washed with running water for 24 hours and
traced with physiological serum they were injected
into rabbits. These animals died rapidly, whereas
control animals inoculated with other portions of
the nervous system were unaffected. At the autopsy
the blood from the hearts of these animals was
sterile. These experiments would appear to show
that the toxin was confined to the bulbar region.
The author states that further observations have
shown that nervous tissue placed in contact
with the diphtheria toxin fixes it, and that even
after lavage for 24 hours inoculation of the tissue
in animals will determine paralysis and death. The
lipoids extracted from the nervous system with ether
appear to be specially instrumental in fixing the
toxins; but, apart from this interesting question of
the fixation of the toxins, this case would seem
to demonstrate the cerebral origin of diptheritic
paralyses in man.

At the annual meeting of the Italian Society of
Medicine at Milan, Dr. C. Colombo read a
paper advocating the use of the Galvanic Current
in Cardiac Cases where it is especially required to raise
the muscular tone of the heart; in fact, in any case where cardiac tonics are indicated. The muscular
fibres of the heart are affected by the electric current
either directly or indirectly through the sympathetic
nerves. The effects can easily be confirmed by
means of cardiograms taken before and after gal-
vanisation. These effects only last a few hours after
the first application, but after 20 or 30 applications
the effect is more lasting, or at least the patient is
relieved for a large portion of the day. The author
admits, however, that after a certain time the effect
of the galvanisation diminishes, and it is then des-
sirable to suspend the treatment for two or three
weeks and have recourse to cardiac tonics. If gal-
vanic treatment is then resumed again it is found
to be as efficacious as at first. The technique of the
application is as follows: A large negative pad elec-
trode is placed on the back between the second and
eighth dorsal vertebrae. The positive electrode with
a surface of 50 to 60 square centimetres is placed on
the precordial region corresponding to the base
of the heart. A current is then allowed to pass
through, gradually increasing to eight or ten mil-
liamperes. It is then rapidly increased to 40 to 60
milliampere's and immediately reduced again to the
original strength. The rapid increase of the current
should not last more than one or two seconds; and
should be repeated a dozen times every half minute.
The application should be made every day at the
time when the patient is most distressed.

At the same meeting Dr. R. Robinson, of Paris,
drew attention to a vegetable substance known
to the Arabsians by the name of "Gamyr," which he
finds has the same curative properties in cases of
renal disease as tincture of cantharides, but is de-
void of the toxic action of the latter drug. Reference
has already been made in these columns to the
observations of Lancereaux, by which he claimed
to demonstrate quite astonishing curative effects of
very small doses of tincture of cantharides in cases of
Bright's disease. Dr. Robinson believes that
equally good results may be obtained with this new
drug called "gamyr." Injected into rabbits, it pro-
duces oliguria, considerable oxaluria and hyper-
acidity of the urine. Histological examination of the
kidneys shows marked changes in the tubules and
Malpighian glomeruli, indicative of an acute epie-
thelial nephritis without involvement of interstitial
tissue. In man, under normal conditions, 10 to 12
grammes of this substance induces marked oliguria
with oxaluria and casts. On the other hand, if it is
administered to a patient suffering from chronic
nephritis it produces a considerable polyuria and
the albuminuria disappears in a few days. It is
evident, therefore, from these observations that this
vegetable product "gamyr" is a renal irritant,
which, administered with care and in small doses,
may prove of considerable utility in certain renal
affections.
the morbid agents, which may also be shut up in other leucocytes or free in the tissues. In this way may be explained the frequent failure of the internal administration of antiseptics in infective cases. It is suggested, further, that in cases of microbial infection too much food or drugs may encumber the leucocytes and disable them from carrying out their functions of absorbing and eliminating the microbes and their toxins from the system.

As a result of an extremely able and critical survey of published cases, Dr. A. E. Martin concludes in an article contributed to Brain that long Remissions and even Recoveries occur in Tuberculous Meningitis. Further, he concludes that such recoveries are possibly more frequent than is believed, as no fewer than twenty cases have been recorded since 1894 which will bear the most rigorous investigation; and in addition there are many other cases in which the evidence, though not of the nature of proof positive, leaves little doubt that the diagnosis has been correct. Such recoveries are brought about either when the resistance of the patient is so much greater than usual that the disease is checked early in its course, or when the virulence of the bacilli is so much less than usual that the lesion in the meninges becomes localized and later undergoes a fibrous change. Such an arrested lesion may, however, at a later period form the focus of a fresh infection, which usually terminates fatally; consequently prognosis must, even when recovery has apparently occurred, be guarded. Lastly, no treatment has so far produced any specific effect in promoting the favourable termination of the disease. It is disquieting to notice that after analysing the Reports of seven London hospitals from 1897 onwards, Dr. Martin was compelled to reject 21 out of 22 recorded recoveries from this disease—sometimes because the patient died and not recovered, sometimes because the diagnosis had never been satisfactorily established. This is distinctly a serious matter, because Hospital Reports are generally regarded as so completely trustworthy as to be beyond suspicion.

The relation of Syphilis to Tabes Dorsalis presents a problem which is certainly as yet unsolved. In the Quarterly Journal of Medicine a research on this subject by Drs. Judson Bury and A. Ramsbottom is summarised. These authors were confronted by a case of tabes occurring in a woman twenty-two years of age, who, they felt convinced, had never suffered from syphilis. On examining the cerebro-spinal fluid they found no lymphocytosis, thus confirming their conclusion as to syphilis, but raising the old question of whether there can be tabes dorsalis without antecedent syphilis. They then systematically investigated the cerebro-spinal fluid of a series of consecutive cases of tabes, and also of some cases of cerebro-spinal syphilis and of other non-putrid cerebral lesions. The counts were done on a uniform plan, and the results are of considerable interest. Of ten patients suffering from cerebral tumour, Ménière's disease, bulbar paralysis, and the like, but not, as far as was known, the subjects of syphilis, no lymphocytosis was found in any. On the other hand six patients with cerebro-spinal syphilis had each a very considerable lymphocytosis. In thirty-four cases of tabes and general paralysis, twenty-nine presented lymphocytosis; of these twenty-seven admitted syphilis, two denied it. Of the remaining five, in which no lymphocytosis occurred, no history of syphilis could be obtained or reasonably assumed. The authors sum up, contrary to the views of Dr. Purves Stewart and many others, that lymphocytosis is not a constant event in tabes and general paralysis; and that, though syphilis may play an important part in the production of these diseases, it is not an essential factor.

The Oral Administration of Tuberculin and its possibilities have attracted a good deal of attention lately in the profession, chiefly owing to the papers recommending this treatment read before the Royal Society of Medicine by Drs. Latham and Inman. The conclusions of these two observers were summarised as being chiefly two: that tuberculin (T.R.) administered orally exerts a definite influence on tubercular disease, and that such action bears a constant and inverse relation to the patient's temperature. As these are at variance with the previous researches of other experimenters, Drs. Lawson and Gettins have endeavoured to settle the matter by a new research from which every source of fallacy has been as carefully as possible excluded. They set themselves two questions, and succeeded in answering them. The first was, Can tuberculin given by the mouth exert an action on the blood content, as indicated by the variation of the opsonic index, of a person suffering from tuberculous disease? The answer is that in 64 per cent. of cases a negative phase immediately appears, and therefore they support Latham and Inman. The second was, Is the inverse relation of the temperature curve to that of the opsonic index so constant that the latter, and therefore the varying resistance of the patient to tuberculous disease, may be safely inferred from the former? The answer is that in 55 per cent. such an inverse relation definitely occurs, but that this proportion does not constitute sufficient basis for an affirmative answer to the question. It will be noticed that they took for granted that the opsonic index faithfully reflects the resistance of the patient to microbial invasion, an assumption which, in the case of tuberculosis especially, is still of very doubtful validity.

An interesting discussion on the Etiology of Psoriasis took place at the annual meeting of the American Dermatological Association, and is reported in the Medical Record. Dr. Pollitzer, who opened the debate, summed up thus. Rheumatism, gout, neurese, and heredity are not direct etiological factors in the production of psoriasis; but it can, in the present state of our knowledge, be neither affirmed nor denied that they may have some bearing on this obscure condition. Psoriasis is one member of a group of parakeratoses, to which seborrhœa corporis and eczema seborrhœicum also belong. It is probably due to an external microbic agent. Dr.
Schamberg, while declining to commit himself to the parasitic theory, formulated three propositions for consideration: that psoriasis may be due to the circulation and deposition of a micro-parasite, analogous to what is observed in syphilis and variola; that it may be the result of the implantation of an exogenous parasite, as are favus, ringworm, and linea versicolor; that it may be caused by one of the common facultative parasitic organisms when constitutional predisposition favors their development. No one of these is to be lightly brushed aside; there are points which tell in favour of each, as well as others, which indicate the reverse. Two or three speakers regarded the parasitic theories as unlikely, for various reasons; but the majority—seemed to think that, though unproved, it is in one or other of Schamberg's three forms most probably the true explanation of the etiology. It was agreed on all hands that much mystery still surrounds the condition, and that much research will be required to dissipate it.

The meaning of the somewhat lately introduced term Anaphylaxis has been recently explained in these columns (The Hospital, October 30, p. 126). In the Journal of Tropical Medicine and Hygiene, Dr. J. B. Cleland propounds some suggestions as to the rôle anaphylaxis may play in the etiology of certain obscure diseases. Pupeural eclampsia has lately been attributed in America to anaphylaxis following the absorption by the mother of fetal syncytium at intervals sufficient to allow of toxic results. Dr. Cleland had arrived at some such conclusion independently, but was forestalled in the matter of publication. He now suggests the possibility that anaphylaxis and blackwater fever are causally connected. He supposes that a number of the small free forms of the malarial parasite die naturally, or are killed by quinine; that their protoplasms, after solution in the plasma, sets going the process that may eventuate in the formation of a specific precipitin: that, after an interval sufficiently long to set up anaphylaxis, a second batch likewise die and enter into solution: and that blackwater fever is the resultant condition, the evidence of anaphylaxis to (dead) plasmodium material. This conjecture will, he thinks, explain the rôle that quinine has been believed by some to play in determining the onset of haemoglobinuria: the occurrence of cases in malarial subjects after returning to temperate climates: the rarity of the disease in new arrivals in the tropics: and even its somewhat local incidence.

Psittis, or inflammation of the psoas muscle, a condition which has been discussed recently by Verdun in the Gazette des Hôpitaux, is rarely of primitive origin, and is usually due to extension from some neighbouring focus of disease. Nearly always unilateral, and in 70 per cent. of cases occurring on the right side, it is most commonly the result of some appendicular trouble. When found on the left side, it is the outcome either of pupeural infection or of disease of the uterine appendages. Pupeural in-

fection and osteomyelitis may bring about psittis on either side, though it is rare for both sides to be affected at one time. The muscular lesions are diffuse or localised according as the disease is the result of a generalised or of a localised infection. The muscle is affected in its upper, middle, or lower portions according as the primitive focus of inflammation is nearest respectively to one or other of these. Thus the upper portion will be affected as the result of a perinephritic abscess, the middle when the hypogastric glands are inflamed, and the lower when the bursa between the muscle and the hip-joint is in a state of suppurition. The fact that it is the middle portion which is the most frequently affected is not due to any specific weakness of the musculature, but to the close proximity of the appendix and the internal iliac glands to the psoas muscle at this point. The clinical diagnosis of the condition is a matter of much practical importance, especially in so-called primary or idiopathic psittis.

In the Wien. Med. Woch. Kieufuchfs discusses the diagnosis of intrathoracic goitre. Previous to the discovery of the x-rays this condition was rarely recognised except during surgical operations or in the post-mortem room. Twelve cases have, however, been reported by Kienböck in which radiography was instrumental in leading to its discovery, in two of which the diagnosis was subsequently confirmed by operation. Three varieties of the condition are met with. In the first, the tumour is mainly cervical, but there occurs a prolongation downwards into the superior aperture of the thorax. The second type is half cervical, half intrathoracic. The goitre in the third type is mainly or entirely in the thorax. The first two varieties are not rare, and usually can be diagnosed without much difficulty. In view of the fact that exophthalmic symptoms may occur without obvious enlargement of the thyroid gland, it is not easy to diagnose the third variety, and, moreover, the condition being rare, the possibility of its existence is apt to be overlooked. Tumours of this kind vary greatly in size, and may occur in various situations. They may be median, retro-clavicular, retro-ster nal, or retro-vascular—that is, they may lie behind the common carotid or innominate arteries. Symptoms and signs, in addition to those due to Graves' disease, depend on the size of the tumour, and may be either absent or exceedingly obscure. The trachea is usually thrust out of position, and may be compressed and ulc erated or twisted. Stridor is sometimes a striking symptom. The presence of dilated veins over the upper half of the thorax and dulness over the sternum may facilitate diagnosis. Dysphagia is much rarer than tracheal obstruction owing to the pliability of the oesophagus. The pressure exerted by the tumour on surrounding structures may give rise to inequality in the pulses, cyanosis, and venous dilatation, especially in the neighbourhood of the sternum, and the sympathetic, vagus, and recurrent laryngeal nerves may be thereby compressed. In three of Kienböck's cases hoarseness was present, and in one under the author's care there was paralysis of the recurrent laryngeal nerve.