WAGNER, CLINTON (New York).—**Colorado Springs and Davos Platz, as Winter Resorts, Compared.** *New York Med. Record, October* 29, 1887.

A VERY valuable article based on personal observation, and a reliable guide to an often perplexing subject. Among other things of interest, Wagner thinks that further experience is wanting before condemning, as is usually done, high altitudes for the relief or cure of laryngeal tuberculosis. While at Colorado Springs, he saw many cases of pulmonary tuberculosis that had recovered, and others advancing toward recovery. Although his experience is limited, he believes that cases of laryngeal phthisis may safely be permitted to remain at high altitude resorts, *provided* improvement in the pulmonary trouble and general condition has already taken place. Colorado Springs and Davos are described in detail by the author. **John N. Mackenzie.**

THOMSON, ST. CLAIR (Florence).—**Winter Climate of Florence and Genoa.** *British Medical Journal, January* 14, 1888.

A NOTE recommendatory of Florence as a residence for asthmatics. The cold is very sharp in the winter, and as at all times the difference between sun and shade temperatures is considerable, it is not suited to most phthisical patients until spring. The dryness of the climate suits people of a gouty disposition. Genoa is colder, bleaker, and has much less sunshine than Florence. **Hunter Mackenzie.**

DIPHTHERIA.

BRISTOWE, J. S. (London).—**An Address on Diphtheritic and Related Forms of Paralysis.** *British Medical Journal, February* 4, 1888.

THIS address consists mainly in the narration of a series of cases, with relative remarks :—

Case I.—This was the case of a clergyman, who in June, 1879, suffered from sore throat (doubtless diphtheritic), followed in October by paralysis. "The nervous symptoms tended to be symmetrical, and spread from region to region, affecting the hands and legs in larger proportion than other parts. The paralysis of the extremities was attended with the so-called reaction of degeneration, and the anæsthesia of the feet, with a sense of soreness and pain. In addition also to defective accommodation and to weakness of the soft palate, there was anæsthesia of certain circumscribed tracts, occupying the middle line of the body, including, amongst others, the epiglottis, and parts about the rima glottides, and some paralytic failure of the muscles of the larynx, which contributed to

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render straining difficult, and of the muscles of respiration, causing dyspnœa." The patient recovered in the following March.

Case II.—This case illustrates that the tendon-reflexes may disappear in diphtheritic paralysis, and is one of the first examples observed of this now well-recognised fact. The author directs attention to the circumstance noted by Drs. Herringham, Money, and Barlow, that though the tendon-reflexes do disappear in those cases, their actual disappearance is generally, if not always, preceded by a period of several days' duration, in which they present excessive briskness.

Case III.—The interest in this case lies in the fact "that not only was there this excess of tendon-reflex (already referred to as preceding abolition), but it was maintained practically throughout the whole of the patient's illness, and was only replaced by its abolition after paralysis and numbness had disappeared, and the patient seemed to be in good health."

Case IV.—This case shows that while, as a general rule, the paralytic phenomena of diphtheria are remarkable for their tendency to symmetry of distribution, the symmetry is not absolute, and local paralyses of single nerves may be met with. In addition to various symmetrical paralyses of the limbs, etc., the patient presented well-marked general paralysis of *left* portio dura. He completely recovered in a few weeks.

Case V.—In the record of this case is embraced a table containing an exhaustive account of the electrical condition of the paralysed muscles by Dr. Kilner. The muscles generally presented the reactions of degeneration.

In commenting on the above cases, which are very carefully recorded, the author states his opinion that while many of the phenomena can be explained on the theory that they are due to spreading neuritis, others (such as the sensory affections along the middle line, the early increase of the knee-jerk, and nystagmus) seem rather to point to some spreading central lesion—a sort of wave of slight inflammatory mischief, which extends not only through the medulla oblongata and cord, but also along the nerve trunks.

The author then goes on to speak of some nervous diseases which may closely simulate diphtheritic paralysis. He remarks that it is well to remember that paralysis often follows so mild an attack of acute diphtheria, that the patient may remember nothing about his sore-throat, and that paralytic symptoms may in tabes be of almost sudden onset—The paralysis of tabes ought not to be confounded with that of diphtheria.

It is, however, more in the cases of multiple (non-diphthertic) neuritis especially in alcoholics, that mistakes in diagnosis are apt to occur.

Case VI. This case, which might reasonably have been taken for diphtheria, was adjudged non-diphtheritic by the author. There was a history of sore-throat, and on admission to hospital the muscles of the trunk became so weak, that he could not turn in bed: the tendon-reflexes were entirely absent. The author came to the conclusion that the patient's primary attack had been, not diphtheria, but one of tonsillitis: the

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paralysis came on while the primary disease was still acute, instead of a few weeks afterwards. Permanent loss of muscular tissue has taken place with consequent permanent paralysis—an occurrence which the author has never found in diphtheritic paralysis. The author lays stress on the alcoholic habits of this subject as having been a factor in the induction of his malady.

Case VII. This case is quoted as an example of so-called "alcoholic" paralysis. It presented two symptoms which bear some relation to diphtheritic phenomena—loss of power in the respiratory muscles, and a curious kind of difficulty in swallowing.

Case VIII. The difficulty in swallowing alluded to in the previous case, was also present in this. A clerk, aged forty-four years, had had syphilis ten years previously. Latterly he had sore throat, with impairment of voice, and some difficulty in swallowing both fluids and solids, but fluids alone troubled him and induced attacks of choking. A laryngoscopic examination by Dr. Semon revealed some small growths below the vocal cords, and paralysis of the arytenoid muscle, causing defective approximation of the arytenoid cartilages in phonation, and the formation of a triangular chink at the posterior extremity of the rima glottidis. The author then proceeds to describe the manners of choking: "There was no doubt the patient could swallow solids with perfect freedom. He could also, when drinking, perform the act of deglutition without any hitch. But invariably, within a second or two after a mouthful of fluid had been swallowed, and at a time, therefore, when it had presumably passed beyond the larynx, and reached the lower part of the œsophagus, he began to choke, and presently coughed up some of the swallowed fluid. The phenomena were just what might be expected to happen, when there is a communication between the œsophagus and the trachea."

The author explains these choking-fits by the fact that, in consequence of the non-approximation of the arytenoid cartilages during deglutition, the supra-glottic laryngeal cavity was incompletely cut off from the gullet; fluids were consequently driven into this cavity, and were thence sucked into the windpipe proper, causing choking. It was afterwards discovered that these choking fits could be averted by the patient swallowing while stooping, so as to bring his head between his legs.

The author remarks upon the combination of anæsthesia (of the laryngeal mucous membrane) and paralysis which exists in these alcoholic cases.

[In reference to Case VIII. we could have wished for further information, and especially for the views of the author in regard to prognosis and treatment.] **Hunter Mackenzie.**

LEGROUX. — Diphtheria and Creosote. *Journal de Ruault, February* 19, 1888.

CREOSOTE is a powerful anti-parasitic, and Dr. Legroux, who has under his care the patients in the Hôpital Trousseaux, has treated 68 little children during the last two months with this agent, and he shows us the result of his researches. Of 68 cases he had 30 cures, that is more than 3-7ths, and of the tracheotomized cases he has had one cure out of three.

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These are very satisfactory statistics. The treatment was systematic, and as follows :—

1st. Constant pulverisation with creosote in the atmosphere.

2nd. Swabbings of the throat with creosote (repeated every 4 or 5 hours) with this solution :—

Glycerine, 20 grs.
Alcohol, 10 grs.
Creosote, 1 gr.

3rd. In the more serious cases administration of creosote hypodermically in the following mixture :—

Antiseptic olive oil, 180 grs.
Creosote, 20 grs.

1, 2, or 3 cubic centimètres of the solution are injected without causing local inflammation, and the temperature is thus lowered in proportion to the dose employed. **Joal.**

MOHAMMED, BEN. (Nekhach).—**Treatment of Diphtheria by Perchloride of Iron and Milk.** *Congrès d'Oran, March* 29, 1888.

THE author has treated twenty-one diphtheritic patients with perchloride and milk, and has obtained twenty cures, among which were two adults.

All these patients were treated from the beginning of the affection—before the period of asphyxia. The perchloride was administered (in a dose of from 25—30 drops in a glass of water, the dose of milk being from 1 litre a day). As adjuvants he recommends emetics, and pharyngeal swabbing, with a solution of perchloride. The author has obtained such brilliant results that he recommends this treatment as the specific for diphtheria. **Joal.**

BEAUPÈRE.—Chloroform Anæsthesia in Tracheotomy for Croup in Children. *Lyon Médical, March*, 1888.

THE author (a pupil of Professor Lerat) founds his remarks on twenty-six observations made at the Hôpital de la Charité. He maintains that the use of chloroform is indicated in tracheotomy for diphtheria in children, that it does not increase the asphyxia ; that it diminishes the laryngeal spasm, and that so far from predisposing to syncope, it is able to prevent it. The only cases in which its use is contra-indicated, are those in which there is extreme asphyxia, or which present pulmonary lesions. **Joal.**

NOSE AND NASO-PHARYNX.

LERMOYEZ.—On the Pathogeny of Hay Asthma. *Ann. des Mal. de l'Oreille, etc., March*, 1888.

A CRITICAL article àpropos of Leflaive's thesis, abstracted in the April number of this journal. Lermoyez says, "The nose is becoming

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