pressed the speaker with the efforts of Nature to heal these chronic lung diseases through the deposition of fibroid tissue. This resulted in the contraction of the affected portions of lung, and the compensative dilatation of the unaffected portions. Hence, the medicaments went with the air to the healthy portions almost wholly. Then again the nebulisation of fluids in inhalation was, as usually done, accompanied by a lowering of temperature; and this taken cold, the moisture became diffused during breathing, and was not deposited within either the bronchial or alveolar tracts. 2. The residual and usual amount of air within the lungs became mixed with the inhalants, and thus these medicaments become diluted and not deposited. Further evidence was mentioned in the speaker's calculations, showing a far greater exhalation of moisture in a cold, dry, as compared with that in a warm, moist atmosphere. The bacilli were thrown off in the moisture exhaled in a cold dry atmosphere, as found in well-chosen high altitude climates.—Dr. GIBSON (Newcastle) advocated the employment of dry inhalations, as of antiseptics, sedatives and tonics, as nitrate of silver, etc., in suitable menstrua.—Dr. WILLIAMS, in reply, thanked the Section for a good discussion, and claimed its acceptance of the majority of his conclusions. He quite concurred with Dr. Lindsay in the importance of the receptivity of the patient for phthisis, and, with reference to what had been said about inhalations, he had yet to learn how medicaments could be specially directed into the unhealthy portions of the lung.

CEREBRAL SYPHILIS: TWO CASES IN ONE FAMILY.

Presented to the Section of Medicine at the Annual Meeting of the British Medical Association, held in Glasgow, August, 1888.

By FRANCIS WARNER, M.D. LOND., F.R.C.P.,
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M. P., father of the two boys whose cases I am about to give, told me that he contracted syphilis in 1868; he married in 1869, and is said to have lost all secondary symptoms in 1870. The first of the mother's eight pregnancies resulted in a stillborn child, then followed a child who died in convulsions when 3 months old; Henry was born in 1874; the next survived but one day; Percy born 1876, and three younger children who appear to be healthy, except one boy now aged 7 who still wets his bed.

Percy was brought under my care at the East London Hospital for Children in 1883. He was fairly well developed, but the epicanthic folds were pronounced; he was pale, flabby, and his skin felt cold, while his fingers were blue; no heart defect was discovered. His eyes appeared normal on ophthalmoscopic examination; no defects were seen in his teeth, and no scars could be found about the mouth or anus. Speech was very indistinct; he could only partially feed himself; he slept well and was clean in habits. Walking was clumsy, with irregular movements, and he often fell accidentally. The knee-jerks were rather increased; all these conditions were bilateral. As an infant he was jaundiced and had "snuffles," with raised and moist sores at the anus and mouth; they yielded to treatment in a few weeks. During teething ulcers appeared on the body and buttocks, lasting twelve months. It is probable that the boy never walked or talked well, but from 4 to 6 years of age he attended school, and though he learned nothing was thought to be healthy. He never had any fits. In 1883 he began to suffer severe head-pain, which came on in attacks with vomiting, such attacks becoming more frequent and attended with loss of control over the bladder. Mercurial treatment was employed without success. He soon had to leave school, being unable to walk there; headache and vomiting continued, and I have heard that he died in 1887 without the supervision of any fresh signs of importance to the case.

Henry P. appeared healthy at birth, and there is no history of the manifestation of the signs of syphilis in infancy; still we may infer that he was syphilitic from the history, the incisor teeth, and the brain disease. At six weeks old bilateral convulsions set in, and continued at intervals till he was six years of age, when they stopped. When nine years old he gradually became clumsy and dropped things. In 1882 he had a severe illness, and for six months was said to have "meningitis." There was a temporary squint and severe head-pain, with universal powerlessness.

He gradually recovered general power, but hemiplegia of the left side remained. When I saw him in 1883 there was complete left hemiplegia, with rigidity and athetoid movements of the fingers. The left face was partially paralysed. To sum up further notes to present date: traces of old optic neuritis exist, and the left upper incisor is defective, probably from infantile syphilis. On these points Mr. W. Tay and Mr. J. Hutchinson, jun., agree with me. The left pupil reacts well, but the right is larger than the left; it is inactive to light, but contracts slightly on accommodation. No keratitis. Left knee-jerk is exaggerated, the right normal. He is intelligent, and reads well, and has no head-pain. Mercury has been fully used, but no marked improvement has occurred. I last saw him two months ago, and his condition was practically unchanged. The left hemiplegia and the condition of the right pupil seem to indicate probable double lesion.

REMARKS.—These brothers appear to have suffered from syphilitic disease of the brain. It seems probable that there was some slight defect from birth in each case. Percy learned nothing at school, and Henry had a long series of fits in early childhood. In Percy the lesion was bilateral; in Henry there appears to be a double lesion, though each may have been more local than in his brother. The case of Percy was possibly a chronic meningitis similar to the case published by Dr. Fletcher Beach and myself in *Brain* (April, 1888), where a thick false membrane had grown over the convolutions and pressed upon them. In these two cases, as well as in that previously published, mercurial treatment was employed without success. It is interesting to consider whether a syphilitic taint may lead to defective development, as well as render the tissues of the brain, its membranes, and vessels liable to future pathological lesions.

THE PREFERABLE CLIMATE FOR PHTHISIS.

By CHARLES DENISON, A.M., M.D.,
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THE following is a synopsis of the author's argument, taken from the *Transactions of the Ninth International Medical Congress*, held in Washington, September, 1887. For lack of space, those portions only are copied in full which relate to the author's individual investigations in a climate peculiarly suited to the arrest of chronic pulmonary disease.

The proper sequence, as to the importance of different climatic attributes, is what the writer attempts to establish, and that is (1) dryness, (2) coolness or cold, (3) rarefaction, (4) sunshine, as opposed to their opposites, and (5) variability of temperature, as opposed to equability, being admitted as a necessity of these favourable attributes.

The argument is intended to apply to all climates, though the following, under the heading of Confirmative Propositions, are considered as modifying conditions: (6) marked diathermancy of the air to be preferred to the smoky atmosphere of cities or the dense air strata of moist currents; (7) radiation and absorption of heat by rocks and sandy loams better than latent absorption by water and damp clay soils; (8) mountainous configuration of country (quick drainage) contrasted with the flatness, etc., of level sections; (9) frequent electrical changes of atmosphere, also moderate winds (except in quite cold weather) preferable to continuous stillness of the air; (10) inland altitudes contrasted with sea air (total absence of land influence), but in certain cases sea voyages and island resorts to be preferred as compromise substitutes for high altitudes.

The discussion of this most important question of "Climatic Influence in Phthisis," to be fair must be general, with no unworthy prominence given to any one of its many elements. The subject is necessarily complex, and in order to reach right conclusions must be candidly considered, without reference to the convenience of the medical adviser or of the patient. Hitherto, the chief obstacles in the way of right conclusions have been:

1. Ignorance of the exact nature and progress of the disease, and
2. A lack of appreciation of the relative importance of different climatic attributes in its arrest.

With reference to the first obstacle, the writer accepts with confidence the germ theory of Koch, that is, that the bacillus of tubercle is the essential principle in all tubercular lesions. The worth of comparisons and conclusions as to climatic data largely depends upon the time involved and the area represented. It