paralysis of the muscles of both upper limbs and of the trunk, and also of the intercostal muscles, thus causing the breathing to be entirely abdominal. There was also partial paralysis of the lower limbs. No loss of sensation could be detected at any place. The temperature was 101° F. pulse 120, and respirations 30. No pain was complained of, but the child was very restless, constantly wanting to be turned from side to side. There was no headache, and the mental powers were perfect; there was no loss of control of the bladder or rectum, no priapism, and no rigidity or twitching of any of the muscles. The pupils were somewhat dilated, and seemed inactive, but equal. There was no squint. Swallowing was not difficult, and the speech was clear.

At 7.30 P.M. of the same day Dr. Barrs of Leeds saw the case with me, when we found that the condition of matters was very similar, except that the paralysis of the legs was more advanced, and the muscles of deglutition seemed somewhat involved, and sensation seemed slightly impaired as regards delicacy of differentiation. The knee-jerks were absent. The spleen was not felt. The respiration had at this time a most marked resemblance to that seen in a frog—that is, on inspiration a peculiar distension of the region below the chin took place. There was not, even at this time, any indication of cyanosis, and the number of respirations was not above 30.

At midnight the facial muscles became involved and speech indistinct, the pulse was falling and becoming rapid (120 per minute and intermittent), but the respirations were not much quickened, and there was no cyanosis.

At 1 A.M. (September 10th) the heart failed very rapidly, slight cyanosis appeared, and he died quietly ten minutes later. He was quite conscious and clear mentally up to 12.30 but after that he seemed to wander.

No post-mortem examination could be obtained.

The diagnosis of Landry's paralysis of a descending form was made from (1) progressive, symmetrical, motor paralysis, affecting first the muscles of the neck—the "stiff neck" complained of—then the arms, forearms, chest, legs, etc.; (2) sensation did not seem at all disturbed until a few hours before death, and even then only slightly; (3) absence of rigidity, twitching, pain, or spasm; (4) mental functions unimpaired, and no loss of control over the emunctories.

It is difficult to see any connection between the slip into the pit and the disease which caused death, as there was no sign whatever of any damage to the spine, and the symptoms do not seem to point to the possibility of the case being one of spinal injury or the results arising therefrom. Nor do I consider it was a case of infantile paralysis, although infantile paralysis has much in common with this disease. The case was an extremely rapid one, as will be seen by noticing the dates.

Little is known as to the pathology of Landry's paralysis, and I would suggest that it is caused by an acute anterior poliomyelitis, somewhat after the nature of that found in infantile paralysis, but instead of the lesions being at spots scattered about the spinal cord, commencing symmetrically at a certain level of the cord, and spreading thence rapidly upwards and downwards. In the case above described the lesion probably commenced in the cord about the level of the second cervical vertebra.

TWO CASES OF SEVERE FRONTAL HERPES.

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THE two following cases are of sufficient interest to merit publication:

CASE I.—In January, 1900, I first saw Mrs. T., aged 45. She was suffering from a severe attack of left frontal herpes. The eyelids were swollen, and together with the forehead and side of nose covered with scabs, the cornea was ulcerated, and there was severe iritis. By the end of March the swelling had nearly subsided, there was much corneal opacity, and opacity in the vitreous. The pupil was dilated and fixed, tension of eyeball + 1, vision $\frac{1}{2}$ and Jaeger 16 C + 2 D. The treatment up to this stage had been hot boracic fomentations, atropine, and attention to general health. She was now ordered solution of pilocarpin nitrate gr. $\frac{1}{4}$ to $\frac{3}{4}$ j, to be dropped into the eye three times a day, and a mixture of mercury perchloride. The treatment was persevered with till the end of May, when there was but little improvement. Galvanism was then tried for a fortnight. By the middle of June the inflammatory symptoms had subsided; there was much corneal and vitreous opacity, the pupil was dilated and irregular; the tension of the eyeball above par, and there were small ciliary staphylomata. Vision = $\frac{1}{2}$ C — 2, J. 14 at 6". I have not seen the patient since, but had a letter from her in February last, and from her description should

say that the eye is in much the same condition as it was in June.

CASE II.—Mrs. H., aged 49, was first seen on March 25th, 1900. She had suffered from frontal herpes ten weeks before. On the left side besides much scarring and cornitis with ulceration, there was complete paralysis of the third, fourth, and sixth, and the ophthalmic division of the fifth nerves. There was ptosis, moderately dilated pupil, complete immobility of the eye, and entire loss of sensation over parts supplied by first division of the fifth nerve. On June 6th I heard from the patient's medical man that she had muscular paresis of the right side of the body (that opposite to the affected eye), but sensation was not impaired. I heard no more of the patient until March 28th, 1901, when she came to see me. The motor paralysis had entirely disappeared, the movements of the eye being perfect; there was some numbness, pain, and itching in the forehead, but the sensation of the eyeball itself was normal; tension of the globe was slightly above par. There was dense partially vascular corneal opacity and some ciliary and conjunctival injection. She could count fingers at 3 feet.

AN UNUSUAL SYMPTOM IN SECONDARY SYPHILIS.

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DURING the last few years several cases of secondary syphilis of the throat have come under my observation in which itchiness of the fauces has been present. This was not a mere tickling, but a definite itchiness in every way comparable to the ordinary feeling experienced in the skin, and accompanied by a similar desire for counter-irritation by scratching. In two cases this symptom was most marked, and I was greatly struck with the fact that though both patients admitted that there was some pain in the throat, especially on swallowing, it was the *itchiness* that they complained of most.

In these two cases the desire to scratch the part was most urgent. One of them, who was at that time under treatment at Wiesbaden, used to scratch his throat—and obtain temporary relief—in an ingenious manner by swallowing entire portions of the crust of the "brodchen" supplied by the Badhaus in which he was taking his "cure." The other, a working man, said he sometimes felt "inclined to tear the throat out." Until relieved by local treatment he used to scratch his tonsils with his finger. In these cases the itchiness was felt most over the tonsils, but also over the pillars of the fauces and posterior part of the side of the tongue. The other parts of the mouth and throat were unaffected. In the Wiesbaden case, in addition to congestion, some ulceration was present on one of the tonsils, and this tonsil was the more itchy of the two. In both cases the itchiness had appeared very shortly after the onset of the sore throat, namely, about eight weeks after the appearance of the chancre. Marked cutaneous manifestations were present in the one, none in the other, nor did he afterwards develop any. The latter patient, it may be remarked, had been vigorously treated ever since the primary lesion, the former only on the appearance of the sore throat.

Marked itchiness of the mucous membrane is an interesting symptom, and, so far as I am aware, has not been referred to in connection with the interior of a cavity. It is of course of common occurrence at the margins of the various openings of the body where skin and mucous membrane meet, as at the urinary meatus, the anus, and vulva. The tongue and the larger part of the buccal cavity are lined with epithelium of the same character as that of the skin. Sensory nerves are abundant, and convey the normal cutaneous impressions of contact, pain, heat and cold, etc., in addition to others of a more special nature which the skin does not possess. In other words, the lining membrane of this cavity is practically moistened skin in some places of a specialised nature. The wonder, then, seems to be that an abnormal cutaneous sensation, such as itchiness, is not more often met with in connection with mucous surfaces. Probably it is present in a fair number of cases, but is either very slightly marked or is so masked by more urgent symptoms that it fails to attract the patient's attention.