The patient showed well the day-dreaming without efficient activity, the exaggeration of the ego, the inability of adjustment in the face of recurring difficulties, and a well-marked love-complex. The writer cannot accept Freud's view of the causal nature of the complex in these cases, but rather holds with Bleuler that the complex, while not causing the disease, may determine the symptomatology. Meyer's paper on the "Analysis of the Neurotic Constitution" (*Journ. of Amer. Psychology*, 1910) is largely quoted, and his excellent description of the beginnings of deterioration in the adolescent is well worth reading.

W. STARKEY.

Cerebro-Spinal Syphilis. (*Bristol Med.-Chir. Journ.*, *March*, 1911.) *Clarke, J. M.*

In this, the Long Fox Lecture, Professor Clarke refers at considerable length to the three discoveries of recent times by which the study of syphilis has, as he points out, been enormously advanced, *e.g.*, that of (*a*) the *Spirochæta pallida* or *Treponema pallida* by Schaudinn, and its establishment as the infective agent and cause of syphilis; (*b*) of certain specific reactions in the blood and cerebro-spinal fluid of the subjects of present or past syphilis by Wassermann and others; and (*c*) the experimental communication of the disease to the higher apes. He then proceeds to describe the two different effects which the syphilitic virus has on the central nervous system—the selective action confined to what are known as para- or meta-syphilitic affections (he holds with those who consider that tabes and general paralysis are the sequels of a previous syphilitic infection), and, on the other hand, cerebro-spinal syphilis, in which there is no evidence of any such selective action. Speaking of late gummata, he says that it is possible that the spirochætes may remain long latent in the tissues, and yet be potent for mischief. Hoffmann succeeded in inoculating an ape from a gumma in a man three and a half years after infection. Passing to the clinical features of cerebro-spinal syphilis, he says they depend on several pathological processes which briefly comprise disease of the vessels and the results of this, new formations or gummata, and inflammations of a specific or gummatous character, especially in the meninges. The symptoms of cerebro-spinal syphilis are not so often produced by one of these processes, only as by two or more occurring together in varying combination and relative intensity. He divides the cases into cerebral and spinal, and the former into those with (1) vascular lesions; (2) gummata; (3) meningitis only; and (4) those with vascular and meningeal lesions or gummata in combination. Especially in the last group, both brain and spinal cord are affected together, and there is often a clinical combination at once suggestive of syphilis, a triplegia, a paralysis of one arm and both legs. In cases of cerebro-spinal syphilis some change in the mental processes is generally present. Of all prodromal symptoms the most frequent is headache, generally with nocturnal exacerbations. Of great importance are recurring paralyses, transitory aphasia, cranial nerve paralyses, and epileptiform fits. In cerebral vascular syphilitic lesions, hemiplegia, with or without aphasia, is common; syphilitic endarteritis

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in the retina is not uncommon, and is a valuable aid in diagnosis. Cerebral gummata are often associated with Jacksonian or general epileptiform attacks. It is rarely possible, he says, to diagnose a gumma as an isolated lesion. There is generally concomitant meningitis or vascular disease. He is opposed to the practice of giving very large doses of iodide of potassium indiscriminately in all cases of intracranial tumour on the chance of their being syphilitic. Cerebral meningitis may affect the base, the convexity of the brain, or the membranes generally. In the two latter forms mental symptoms are, as a rule, present. The prognosis is not so good as in basic meningitis. In gummatous basic meningitis, paralysis of the cranial nerves is the characteristic feature.

Turning to some special signs and symptoms of cerebral syphilis, he finds that out of forty-five cases optic neuritis occurred in nine, and in seven of these there were signs of meningitis with or without other lesions. In four cases, with diffuse cerebral lesions, optic atrophy was found either in one or both eyes. Epileptiform fits occurred in seven cases, in two being associated with Jacksonian epilepsy. They were not present in any of his cases of spinal syphilis. He does not believe that a fully developed Argyll-Robertson pupil occurs in cerebro-spinal syphilis, but that its presence is an indication of a further degenerative change in the central nervous system, that is, of para-syphilis. The ultimate prognosis in cerebral syphilis when the symptoms indicate extensive lesions is not good, he says, and in the majority of cases life is shortened.

Of syphilitic affections of the spinal cord, speaking generally, he finds the chief symptoms are spastic paresis or paralysis with some ataxy, early affection of the bladder, and root lesions. The most common condition in cases of spinal syphilis is that generally entitled meningo-myelitis, but he agrees with Holmes and other observers that there is seldom a true myelitis.

The onset may be acute, rarely sudden, or gradual, and disturbances of sensation are, as a rule, less than those of motion, and recovery from them earlier and more complete. The lecturer, after referring to the differential diagnosis of chronic syphilitic spinal meningitis and tabes dorsalis, gives a short account of Erb's syphilitic spinal paralysis, of some rare cases of spinal syphilis presenting the characters of sub-acute or chronic anterior poliomyelitis, and of spinal affections in hereditary syphilis.

Finally, speaking of treatment, he considers the most important points to be rest in bed and the prompt and efficient administration of mercury. A. W. WILCOX.

Senile and Presenile Insanity in Diabetes [*Psychoses Séniles et Préséniles dans le Diabète*]. (*Rev. de Psychiat.*, *Feb.*, 1911.) *Halberstadt and Arsinoles.*

The authors quote numerous cases, and go into considerable detail in some to demonstrate that there is much confusion caused by classing all persons who are insane and have sugar in the urine the subjects of diabetic insanity. They draw attention to physiological and nervous glycosuria.

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