

port to Dejerine's view, that atrophy is due rather to peripheral neuritis than to involvement of the anterior roots or horns in the cord, and points to the new views in regard to the pathological anatomy of this affection, which locates the primary changes in the nervous tissue of the posterior roots, and even in the peripheral sensory trunks and nerves, rather than in the posterior horn and columns of the cord.

The fractures observed in this case are chief elements of interest, the fragility of the bones being caused undoubtedly by the same influences, which produce the muscular atrophy, and are the result of destruction of the conducting tissue between these parts and their trophic nerve centre, or possibly some defect in the sensory portion of the nervous arc. Although we have a symmetrical condition at present in the two hips, the fact that several years elapsed before the second fracture occurred, would show that the degeneration was not so much of primary spinal origin, as from the roots, or peripheral, as its progress was unequal on either side. The brittleness and fragility is explained by *Richardière* to be due to a thinning of the bone throughout, owing to enlargement of the Haversian canals, and destruction of the osteoblasts. It is interesting to note in this connection a description of a similar resorption of bone, in a form of Greek Lepra, or Elephantiasis, described by Dr. Evaristo Garcia, called in Columbia, South America, where it is very prevalent, *mal de San Antonio*; and reported recently by Dr. A. S. Ashmead, in *New York Medical Journal*, in which a slow form of disease of the nerves, beginning with anæsthesia of the extremities, is followed by atrophy of the muscles, and complete resorption of the bones.

Among the rarest of the complications of Tabes is ossification of the muscles. Obersteiner, in the last issue of the *Annual* of the Universal Medical Sciences, states that this condition has been thus far but seldom observed, mentioning a case reported by Lockering, of Sheffield, where a substance of bony consistence, seven inches in length, appeared in the right rectus femoris muscle of a tabetic patient.

In this case the bony plate occupies the position of the tensor vaginæ femoris, and is quite movable beneath the skin, the base of the triangular mass corresponding to the attachment of that muscle to the anterior part of the outer lip of the crest of the ileum, and appearing as it did some three years after the spontaneous fracture here, cannot be regarded as the result of calcification of callous thrown out at that time, but apparently is a calcareous infiltration of a muscle undergoing atrophy.