there was no paralysis of the face or of upper or lower extremities.

It was somewhat affecting to witness his efforts, repeatedly made, to communicate with those around him. He wished, for instance, to give me the residence of his adopted daughter, whom he desired to be sent for, and tried for many minutes to tell me the address, but failed, and finally arose from the bed and gave me a letter containing the desired information. When he attempted to speak he would sometimes give some words correctly, but more often would misplace them, or would still more frequently utter a sound like the syllables "*ter*," "*ter*," and which, of course, was quite unintelligible.

The sight of the left eye was also very much impaired by this attack, and he was unable, for the first few days after the beginning of it, either to read or to write the shortest words correctly. The treatment adopted was perfect rest, low diet and arterial sedatives, together with bromide of potassium and chloral at bedtime to induce sleep. Under this treatment his power of articulate speech improved very rapidly, and he began in two or three days to be able to speak quite intelligibly, though occasionally, and indeed frequently, missing and misplacing words. His powers of reading and writing were much longer in returning to him than his use of speech, and he had, really, though a gentleman of unusual scientific attainments, to learn to read and write like a little child.

Finding that he had forgotten a number of the letters of the alphabet he purchased a large alphabet card, such as is used by little children, and laboriously acquired the missing letters. After a time, however, his progress became rapid, and in six months from the beginning of this attack he was able to resume his literary employment and read and write nearly as well as ever.

In regard to the *diagnosis* of the case my belief was that his was a case of Embolism, probably including the distribution of the anterior cerebral artery.

My reasons for so thinking were, first, that the sudden onset of the attack and rapid recovery of speech were unlikely to take place if there was hemorrhage into the substance of the brain; second, the condition of the arterial varix of the posterior occipital artery would, *prima facia*, indicate a like condition of some of the cerebral blood-vessels within the cranium, and would render such an occurrence as embolism not unlikely; and, third, the extremely limited and local character of the brain lesion, which would be unlikely to occur in cerebral hemorrhage. In the course of a month from beginning treatment, the sedatives were discontinued, or rather only prescribed occasionally, and he was placed upon small doses of bichloride of mercury and iodide of potassium with tonics.

His mental condition continued, as above mentioned, steadily to improve, but the *tinnitus aurium* still remained, and the patient was extremely anxious that some relief could be afforded him. As pressure upon the occipital artery arrested the *tinnitus aurium* and relieved the patient from this distressing sensation, the idea suggested itself, why not ligate the artery and permanently prevent its return?

Prof. Johnson Eliot was called in consultation, and he coinciding with me regarding the propriety of the operation, I proceeded, with his assistance, to ligate the vessel. This was done just over the groove in the mastoid process of the temporal bone. The operation was performed March 12, 1878, and the ligature separated without any trouble on the tenth day afterwards.

It is unnecessary to dwell in detail upon the case further than to say that the operation was entirely successful in relieving the *tinnitus* and restored the patient to a condition of perfect comfort.

In cases, therefore, in which *tinnitus aurium* is intractable to medical treatment, I would respectfully suggest the propriety of ligation, as above, premising, of course, that pressure applied to the vessel shows that the *tinnitus* can be thus controlled. As for the operation itself, it is hardly necessary to state that it is simple, easily done, and unattended with any special danger.—*National Med. Review*, Washington.

DIFFERENTIAL DIAGNOSIS BETWEEN SOME CASES OF ECZEMA AND CASES OF PSORIASIS AND SCABIES.

By F. C. Van Vliet, M.D.

I have been led to offer a few brief observations upon the best means of making a clear diagnosis between eczema and some cases of psoriasis and scabies, from the fact that while it is no easy matter to make a correct diagnosis in such cases, yet it is absolutely necessary that such a diagnosis be made, inasmuch as treatment beneficial to the one disease would prove more or less injurious to the others.

Let us first note the points of difference between a case of psoriasis and one of eczema squamosum.

Upon superficial inspection a case of psoriasis usually presents the following appearances: One or more dry inflammatory patches are observed; they are more or less infiltrated, and are elevated to a greater or less degree above the level of the epidermis. These patches are covered with a great number of shining, adherent scales, of a mother-of-pearl color, and which are noticed, under a magnifying glass of low power, to be more or less imbricated. There is considerable desquamation, but the loss is scarcely perceptible, being counterbalanced by