cal weakness, nine from impotence, and two from defective control of the anal sphincter; generally cystic and sexual weakness were present in the same patient; two patients complained of weakness of the legs at the first symptom, while in five others this symptom appeared at some time during the course of the disease. Paresthesia was present in eight of Diller's twenty-four cases, while Limbach recorded its presence in 64.5 per cent. of his 400 cases. Girdle sensation was present in eight of the twenty-four cases, and gastric crises in two of the cases, it being the first symptom to appear in these cases. Among the trophic disturbances of tabes, Diller mentions various changes in the bones, rendering fracture liable to occur, the Charcot joint, perforating ulcer, and herpes zoster. Diller concludes as follows:

"Upon the presence of how few symptoms may the diagnosis be made? The following symptoms, I believe, may be said to be the cardinal ones of tabes, and are named in the order of their importance: 1. Failure of knee-jerks; 2. Romberg symptoms (swaying with eyes closed); (3) Argyll-Robertson pupil; (4) Lightning pains; 5. Loss of functions of the bladder or sexual organs.

"With the presence of any three of these symptoms I believe the diagnosis may with certainty (and in the presence of any two with probability) be made when evidence pointing to multiple neuritis, paralytic dementia, or cerebro-spinal syphilis is absent.

"Among the important secondary symptoms or signs are: (*a*) paresthesia, anesthesia, or analgesia of the legs; (*b*) locomotor ataxia; (*c*) transient ocular palsies; (*d*) parasthesia in the ulnar distribution; (*e*) optic atrophy. With the presence of two of the cardinal signs of tabes and one of the secondary signs, I believe the diagnosis may be made with certainty, and made as most of the primary symptoms, and, indeed, it may be made with certainty in the absence of all the cardinal symptoms. Many combinations of symptoms are, of course, seen in tabes, and the evidence presented by each case should be carefully weighed. When this is done it will happen but rarely that the diagnosis cannot be made with certainty or probability."—*Maryland Medical Journal.*

ERRORS IN THE DIAGNOSIS OF APPENDICITIS.

Brewer (*Annals of Surgery*), in a recent communication to the New York Surgical Society, alluded to the frequency with which errors are made in the diagnosis of intra-abdominal inflammations, and to the fact that in the majority of instances of this kind the error has consisted in mistaking atypical forms of appen-