pupils and knee-jerks, and an inquiry for a history of lightening pains, girdle sensation, diplopia, or difficulty with micturition, will usually settle the question. But the diagnosis of tabes does not necessarily exclude the possibility of peritonitis in addition. The two conditions were combined in the following case—one of the most difficult we can remember—

C. U., labourer, aged 40. History of indigestion ten years ago but absolutely none since. Denies syphilis. Three years ago was laid up for six weeks and had "a lump as big as a hen's egg" in the right side of the abdomen. On July 24th he got up at 4 a.m. in perfect health; while walking about at 6 a.m., sudden onset of very intense abdominal pain, at first in the right hypochondrium, later, generalised. Vomited three times. Bowels open before onset; not since. Brought up to hospital at 9 a.m. Was evidently in great distress; abdomen retracted, rigid and universally tender. Flanks resonant, liver dulness normal. Pulse 94, temperature 98°, respiration 32, tongue clean. Pupils unequal and almost inactive to light. Knee-jerks absent. On further inquiry into the past history, no trouble with micturition, no eye symptoms and no ataxy; but he owned up to "screwing pains" in the legs during the past year. As there was such strong evidence of tabes, it was decided to watch him. At 3 p.m. pulse 96, temperature 99°; said he had no pain; abdomen not quite so rigid, but still very tender. At 9 p.m. pulse 100, temperature 102°; said he had "no pain to speak of"; abdominal tenderness now confined to right iliac fossa. Liver dulness normal. At 10 p.m. laparotomy; pin-point perforation of duodenum with very scanty exudate in vicinity. Recovered. This, then, was an example of a duodenal perforation in a tabetic.

Another perplexing case was that of a one-legged and one-eyed mariner who was sent up to hospital with the diagnosis of perforated duodenal ulcer. His solitary pupil was myotic, inactive to light and active to accommodation, and no knee-jerk could be elicited from his one leg; for obvious reasons Romberg's sign could not be investigated, nor could one compare the sizes of the pupils. He gave a characteristic history of lightning pains so that, since there was no evidence of peritonitis, one was able to diagnose a gastric crisis with some confidence.

(*b*) **Posterior Nerve-root Lesions.**—Any lesion which causes posterior root irritation of the nerves supplying the