

jective symptoms of enteroptosis are sudden pain in the right lumbar region, weakness, constipation, emptiness, dyspepsia, neurasthenia, emaciation, pallor, etc. The objective symptoms are tenderness in the right lumbar region, diminution in the abdominal tension, movable kidney, the colon felt as a cord, the cecum being normal in size, prolapse of the liver, epigastric pulsation, and perhaps plenoptosis and metroptosis. Saline laxatives are given, and sodium bicarbonate; suppression of all acids, wine, cereals, and fats; a milk diet ordered, then green vegetables, cold bathing, warm alkaline waters. First the intestinal, then the gastric or hepatic, finally the neurasthenic symptoms appear. An abdominal binder must be applied. The movable kidney is not due to corsets, but the constipation and enteroptosis are. This primary enteroptosis occurs commonly in women with confinement or traumatism. Secondary enteroptosis is seen in men, due to gastric atony, probably hepatic in origin, for the liver plays an important role in all cases of secondary enteroptosis. Only after years of treatment do these patients recover their general health. Glénard employs his "belt-test" in the diagnosis of enteroptosis. The physician stands behind the patient, encircling the abdomen with the palms of both hands, supporting and lifting up the patient. If this affords relief, the diagnosis of enteroptosis is confirmed.—[M.O.]—*Phila. Med. Jour.*

CHANGES IN THE SPINAL CORD SECONDARY TO AMPUTATION.

Switalski (*Rev. Neurol.*) reported the results of the microscopical examination of 5 spinal cords taken from patients who had had amputations—namely, 4 cases of amputation of the thigh, and 1 of amputation below the knee, the pathological examination being made at the Bicêtre (laboratory of P. Marie). (1) In every case there was found an atrophy of the half of the spinal cord corresponding to the side of amputation; both white and grey substance participated in the atrophy. (2) In 3 cases the diminution of volume could be traced from the lumbar part of the spinal cord upwards to the dorsal region of the same side, and in 2 cases this was also traceable to the cervical region of the cord. (3) Simultaneously with the atrophy there appeared a sclerosis of the posterior columns. In 3 cases this could be traced in all levels of the cord, in 2 cases it appeared in the cervical region. (4) While the spinal hemiatrophy shows a tendency to diminish from below upwards, the sclerosis of the posterior columns (of Goll and Burdach) becomes more marked than from below upwards. In the discussion which followed the communication of the above (at the Paris Neurological Society), Pierre Marie remarked that whereas the current pathological belief was that in cases of amputation the spinal cord lesion consisted of simple