ity of cases. Many members of the profession must have met with cases, the true nature of which it was very hard to ascertain; and which, in their causes, clinical history, tendency to recovery, and involvement of the hands or feet, while the more proximate portions of the extremities escaped, or did so for a time at least, did not coincide with what one would expect were the signs and symptoms due to any definite lesion of the cord or brain. There has always been a somewhat vague idea running through the pathology of such cases, and but little has been done, that is at all satisfactory, in the way of treatment. The following is an epitome of the clinical history of the cases I am now considering: The person begins to feel a strange tingling in the feet and hands, or it may be at first only in one or other of these parts. This feeling of tingling, with a sort of numbness and loss of sensation, gradually extends up the members towards the body. For this condition the patient may be able to assign no real cause, further than the indefinite and unsatisfactory one of exposure on some previous date, to cold or wet. The sensation of the parts are first affected, and after the lapse of some days, or even weeks, the motor functions become impaired. The advance of the disease is constant, though not marked by any definite rate of progress. As this advance takes place, the entire lower or upper extremities become involved, or both may suffer, though not to the same degree. The patellar tendon reflex action is retained, and there is often well-marked hyperæsthesia, which may be more or less general or circumscribed to a small area. As the disease progresses, and the sensory and motorial functions become more and more implicated, there is a gradual loss over the organic functions.

The bladder now suffers and the patient can no longer void his urine, or can do so only with great effort. The bowels become deranged, and obstinate constipation is a source of much trouble and discomfort. The girdle pain, often complained of by paraplegics, frequently comes on about this stage, and causes intense suffering, while others are more favored, and complain only of great uneasiness from this symptom. The respiratory functions generally escape, or are but slightly interfered with; while the intellect remains intact.

With these remarks on the character of the affection, let us now try to ascertain the seat of the lesion. This point has been much debated, especially among the German authorities. Three places suggest themselves, namely, the brain, the cord, or the peripheral endings of the nerves. We will now take these up in turn.

With regard to the brain as the seat of the lesion it may be remarked, that paralysis from such a cause would be unilateral, except in three general cases: paralysis of the insane, when the lesion affects some portions where the nerves decussate, and when there is simultaneously either disease or injury on the opposite sides, there would be bilateral paralysis. Now, the cases we are considering are bilateral; but while this is true, it is equally clear they can not come under the three general cases just stated. The clinical history excludes all chance of their being confounded with general cerebral paralysis of the insane. On the other hand, if due to disease or injury so seated as to render the paralysis bilateral, the progress of the disease would be very different from that recorded as "peripheral paraplegia." We may, I think, safely set aside the brain or medulla as having anything to do with our present subject.

This brings us to the second part, whether the lesion is situated in the cord or not. Here the case is not so easily dismissed. In favor of the cord being the seat of trouble we note: (1) that the paralysis is bilateral as might occur from the cord; (2), that it is paraplegic; (3), that there is the girdle pain; (4), that there is the loss of motor and sensory functions, and (5), that the organic functions become impaired. Against the view that it is due to lesion in the cord, we have: (1), that the distal parts of the extremities first suffer; (2), that the paralysis then extends towards the body; (3), that sensation appears to be first affected and motion secondarily, but that sooner or later both are involved; (4), that the girdle pain comes on at an advanced stage of the disease, and (5), that the organic functions, as the movements of the bladder and intestines, also belong to an advanced period.

Leaving this for the present, let us ask if