

## ABSTRACTS FROM OTHER JOURNALS

DESCENDING AUTONOMIC PATHWAYS IN THE SPINAL CORD: F. W. L. KERR and S. ALEXANDER (1964). *Arch. Neurol. (Chic.)*, **10**, 3, 249.

The authors of this study investigated the situation of the autonomic fibres subserving vasomotor control and micturition in 83 cats and four monkeys.

They initially stimulated the cord with surface and needle electrodes and measured the blood and bladder pressures by means of cannulae introduced into the aorta and bladder. They located the maximum response in fibres situated at the periphery of the lateral funiculus immediately beneath the pia.

Subsequently they divided the cord in 16 of the cats in the cervical region and again stimulated the cord in the same region; as the responses were still elicited they concluded that the responses were due to descending fibres. In a further series of experiments they stimulated the hypothalamus which again elicited marked responses in blood and bladder pressures. These were abolished when selective ablations of the cord were carried out, from the dorsal root entry zone to a point midway between the dentate insertion and the ventral root.

They concluded that the descending autonomic fibres for the control of the bladder and vasoconstriction travel in the most peripheral part of the lateral funiculus the largest number being immediately beneath the pia.

The vasomotor component extends from the dorsal root entry zone to a point approximately halfway between the dentate insertion and the ventral root exit from the cord. Vesicomotor fibres are concentrated in the area dorsal to the dentate insertion, with moderate numbers appearing ventral to this point in the cervical area and few ventrally in the thoracic region of the cord.

J. SILVER, M.R.C.P.E.

PARAPLEGIA FOLLOWING SPINAL ANAESTHESIA: GABRIEL A. SCHWARZ, M.D., and JOHN E. BEVILACQUA, M.D. (1964). *Arch. Neurol. (Chic.)*, **10**, 3, 308.

One of the untoward and rare complications of spinal anaesthesia is paraplegia. Because of its rarity, there have been few post-mortem reports.

The authors report the case of a 57-year-old woman who developed a persistent flaccid paraplegia below T<sub>9</sub> after a procaine spinal anaesthetic for a hysterectomy. The sensory level dropped to L<sub>1</sub> subsequently but there was no other improvement and she developed persistent root pains.

Initial lumbar puncture revealed no block, but subsequently one was found with a persistently raised protein in the cerebro-spinal fluid. Six months after the onset of the paraplegia she committed suicide.

Post-mortem revealed marked thickening of the meninges from T<sub>9</sub> downwards, being most prominent around the enlarged roots of the cauda equina. The lumbar cord was necrotic and the roots of the cauda equina showed extensive demyelination. The blood vessels of the cord and cauda equina showed intimal thickening and fragmentation of the internal elastic lamina.

The literature of 31 other cases was reviewed and the importance of the local interference with the blood supply stressed.

J. SILVER, M.R.C.P.E.

THE PROBLEM OF PARAPLEGIA IN WEST GERMANY: G. LEIMBACH (1964).  
*Hefte z. Unfallheilk.* 78, 285.

The author, the first German accident surgeon to adopt the modern treatment of paraplegics, discusses the problems of their proper care in Germany. According to Ministerial figures there were, in 1963, nearly 4000 paraplegic patients alive in Germany who suffered their injuries in the war or at work. No statistical data exist concerning traffic accidents, but he estimates an annual rate of three to four hundreded in West Germany. So far only those injured at work can count on receiving modern treatment in special units, which are now functioning or are about to be opened.

From his own experience of 124 cases he is able to show convincingly how important immediate admission to a special centre is. Only 14 patients were admitted within three days after the accident. Their average stay in hospital was seven months. The majority were admitted two months to three years after the onset of paraplegia. Of the 110 late admissions more than half had pressure sores, one-fifth more than five sores, two-thirds severe urinary infection, and more than 10 per cent. urethral fistula.

Considering this handicap, the author can claim satisfactory results of his clinical work. Social reintegration and return to work are only beginning to be achieved in Germany, where very high pensions and compensation payments obviate the financial incentive.

The author emphasises the urgency of proper provision of clinical centres and social re-education for paraplegics from all causes in Germany.

L. MICHAELIS, M.D.

TREATMENT OF PRESSURE SORES: F. W. MEINECKE (1964). *Hefte z. Unfallheilk.* 78, 281.

The author describes the prevention and the conservative and surgical treatment of pressure sores as practised at his Centre in Bochum. He follows the principles and, in many details, the practice of Guttman and others. The need for meticulous haemostasis is perhaps not sufficiently emphasised. He used no local antibiotics. The particular dangers of infection with *Streptococcus haemolyticus* and the use or non-use of drainage are not mentioned. He appears to be satisfied with catgut as a material for deep sutures. In this his experience differs from that of others.

L. MICHAELIS, M.D.