found a markedly dilated heart and rather extensive thickening of the aortic valves. The aorta showed advanced calcification. From the extent of the aortic lesion it seemed very probable that if the heart had been examined before the break in compensation the murmurs of aortic insufficiency might have been present.

As might have been supposed, however, systolic murmurs, heard with varying intensity either at the apex or base of the heart, were common in this group and occurred in thirteen cases. It will thus be seen that, while thickening, stiffening and calcification of the aortic valves frequently goes hand in hand with calcification of the aorta and endarteritis deformans, these changes seldom gave rise to true aortic insufficiency.

In the accompanying table the cases of chronic aortic endocarditis are tabulated and show definitely the comparative frequency of the combination of aortic insufficiency and mesaortitis.

AORTIC INSUFFICIENCY AND MESAORTITIS

	Mesaortitis (Pure Aortic Endocarditis).	Endarteritis Deformans (Pure Aortic Endocarditis).	Rheumatic Fever, Etc. (Combined Aortic Endocarditis).
Aortic insufficiency	18	4	21
Chronic aortic endocarditis without signs of aortic insufficiency	3	30	00
Total	21	34	21

It may thus be seen that of the 43 cases of true aortic insufficiency giving symptoms, 18, or 41.8 per cent., were associated with mesaortitis, and of the 22 cases of aortic insufficiency uncombined with lesions of any of the other valves 18, or 81.5 per cent., were associated with mesaortitis.

It is a matter of common knowledge that syphilis is an important factor in the etiology of aortic insufficiency, but until recent years it has been difficult to prove this matter satisfactorily and to determine in exactly what proportion of cases the condition could be ascribed to syphilis. Siehe and Saathoff¹¹ have recently called attention again to the frequent association of syphilis and aortic insufficiency. In 7 cases of aortitis luetica which they report aortic insufficiency was present in 6. Albrecht¹² believed, too, that syphilis is the most important cause of aortic insufficiency. Citron,¹³ investigating this same point, obtained a positive Wassermann reaction in ten out of sixteen cases of aortic insufficiency, or in 62.6 per cent. Investigations on this point are now being made, but at the present time the number of cases studied is too small from which to draw conclusions.¹⁴

The practical bearing which such findings have on the treatment of these cases of pure aortic insufficiency becomes at once apparent; for, though one cannot hope to cure the aortic lesion, still the process may perhaps be arrested and the progress of the disease of the aorta influenced by the vigorous use of antisyphilitic treatment.

SUMMARY

In these statistics it may be seen that aortic insufficiency unassociated with disease of the other valves is rare after the fifth decade, and that it is seldom associated with that type of arteriosclerosis known as endarteritis deformans. The majority of cases of uncomplicated aortic insufficiency (81.5 per cent. in the present series) are associated with a characteristic type of sclerosis termed mesaortitis. The involvement of the valves takes place probably by direct extension of the process along the wall of the aorta to the aortic valves. Syphilis is certainly the commonest cause of this type of sclerosis.

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ABSTRACT OF DISCUSSION

DR. RICHARD C. CABOT, Boston: Since Dr. J. H. Wright called attention to the presence of spirochetes in the aorta of five cases of heart disease postmortem, we have been able to identify during life some cases similar to those to which Dr. Longcope has called attention. Some patients with heart disease, particularly of aortic disease, without a history of rheumatic or pyogenic infection, but with a history of syphilis and a positive Wassermann reaction in the blood, do respond to antisyphilitic treatment better I think than one would expect such patients to respond to the ordinary type of treatment with rest, digitalis, purgation and cardiac stimulation. In other words, in cases which we believe to be the result of syphilitic infection, pushing the iodids and mercury gives better results than could be obtained under the ordinary treatment. This is a point of great practical value. We should push antisyphilitic treatment in all these cases of non-rheumatic cardiac disease in which there is a history of syphilitic infection, especially if the Wassermann reaction is obtained.

DR. ALLEN A. JONES, Buffalo, N. Y.: In the clinical history of these cases, was there any record of chest pain or anginal pain? In a recent case I studied, a man of 46 had syphilis and shortly before death he gave a positive Wassermann reaction, but there was no history of aortic insufficiency. He had two severe attacks of angina pectoris and died during the third attack.

DR. WARFIELD T. LONGCOPE, Philadelphia: The point made by Dr. Cabot is an important one and the probability is that many of these patients would be much benefited by antisyphilitic treatment. The patient whose case I reported had severe substernal pain and one or two definite attacks of angina. That, of course, is common in this type of cases on account of the involvement of the coronary arteries.

THE BLACK VOMIT (VOMITO NEGRO) OF IQUITOS, PERU, IDENTICAL WITH YELLOW FEVER

ENRIQUE A. VIGIL, M.D.
LIMA, PERU

REPORTS OF CASES

CASE 1.—On August 19, 1905, three months after my arrival at Iquitos, I was called to attend Mr. G. S., a German, aged 34 and robust, who had recently arrived from Brazil, where he had passed a few days in Manaos on his journey from Europe. He lived in Iquitos above a store.

A violent shivering, with intense rachialgia, cephalalgia and fever, had been the first symptoms of the patient's illness. Examining his abdomen, there was noticeable only a well-marked sensation of pain at the epigastrium. He had fits of vomiting and a temperature of 39 C. (102.2 F.). His eyes were red. I ordered him a saline purge.

On the following day I observed that the patient's liver was enlarged and the other symptoms continued. As the purge had

11. Siehe and Saathoff: München. med. Wehnschr., 1906, lili, 2050.

12. Albrecht: München. Med. Wehnschr., 1906, lili, 332.

13. Citron: Berl. klin. Wehnschr., 1908, xl, 2142.

14. Since the completion of this work Collins and Sachs have reported the results of their study of the Wassermann reaction in cardiovascular disease. In 12 out of 13 cases of aortic insufficiency they obtained a positive reaction. In contrast to these findings only 1 of the 7 cases of diffuse endocarditis affecting the mitral valve gave a positive result. They point to the importance of syphilis as a cause of aortitis insufficiency and emphasize the value of antisyphilitic treatment in such cases.

caused a good evacuation, I ordered him quinin as a draught and salicylate enemas.

On the 21st a subicteric tint was observable under his eyes and his very slow pulse contracted greatly with his temperature. His face showed anxiety and fear. The vomiting, always bilious, persisted, as also the other symptoms. In the urine were found 19 gm. of albumin per liter with 21.40 of urea. I discontinued the quinin and prescribed a tonic potion with lactate of strontium and alkaline draughts.

Early on the following day my patient was in a grave condition. The most minute examination showed no alteration in the spleen. The urine gave 9 gm. of albumin per liter and 21.40 of urea. I continued the previous day's treatment, adding caffeine to the potion and the enemas and alkaline draughts.

On the 23d the patient grew worse; there was delirium; he got up and endeavored to leave his room, falling at the door. I prescribed bromid of strontium. The quantity of urine was small and contained 4.50 gm. of albumin and 26 of urea.

On the 24th his condition was the same, the icterus being more pronounced. During all these days the patient drank small quantities of iced milk; and the vomiting continued, though at less frequent intervals.

On the 25th his condition was better; the fever abated and the pulse was in harmony with the temperature. On the night of the 26th the patient slept well, showed scarcely any fever and his urine, charged with bile, contained only 4.50 of albumin and 24.8 of urea. The liver was enlarged; the spleen could not be touched. The improvement continued and on the 29th there was only 1.50 of albumin per liter; fever, persistent icterus.

On the 30th the albumin was only 0.25 per liter and the general condition good. On September 1 the patient was able to leave his bed.

From the third day I diagnosed the case as yellow fever and my colleague reserved his diagnosis but did not contradict mine. This case was not followed by others.

CASE 2.—At the beginning of 1907 I was called to see a strong young man, J. S., who, after living for some time in Manaos, had come to Iquitos on business. He was a Portuguese, who had been taken ill the previous day with shivering, fever, vomiting and slight pain at the waist. His whole body ached. When I examined him his eyes were red, as also his face; he had high fever and epigastric pain. Neither the liver nor the spleen was enlarged. On the following day, as the vomiting continued, I ordered an antiemetic, an application of ice at the epigastrium and iced champagne to drink. The same evening, as I was taking his temperature, he vomited more than half a liter of a thick liquid like coffee-grounds. The fever exceeded 40 C. (104 F.). The urine contained much albumin. I immediately injected 800 grams of Hayem's artificial serum under the skin of the abdomen, and gave the patient a cold bath, repeating the bath throughout the night, whenever the temperature exceeded 39 C. (102.2 F.). The next morning he was in a dangerous condition; he had a subicteric tint in his eyes, slow pulse, high fever, little vomiting, enlarged liver, spleen painless and untouchable, urine very bilious and albuminous. I held a consultation with two colleagues, who diagnosed the case as the bilious remittent malaria of hot countries. I pronounced it to be a typical yellow fever. On consulting the family they decided to leave the patient in my hands, and I again injected a liter of artificial serum; I continued the iced champagne, cold baths and alkaline enemas, and in the end was successful. On the sixth day the patient entered into convalescence, with his liver enlarged, icterus, and a small quantity of albumin. His spleen had not altered in the least. In a few days he was able to leave for Portugal to take alkaline baths. No other cases followed.

CASE 3.—In June, 1908, I was called to see a Spanish youth, M. C., recently arrived from Spain, who had been ill for three days. He had been given various doses of castor-oil with lemon. When I saw him he vomited several times a dark liquid like coffee, resembling the vomit of yellow fever. His pulse was slow; the fever slight; liver enlarged, and spleen inaccessible. A subicteric tint was observable in his eyes; the mouth was furred, with the appearance of typhoid; urine

albuminous; epigastrium painful; sensory dull. Before so plain a picture of yellow fever I should have injected serum, but circumstances which are beside the case prevented my doing so. I administered tannin in a draught, iced mineral water and alkaline enemas. For several days I fought the disease, but after alternately improving and growing worse, the patient died.

Autopsy.—I invited all the medical men of Iquitos to the post-mortem. A general icteric tint covered the integuments, being specially pronounced on the chest. The liver was exceptionally enlarged, yellow, fatty and absolutely bloodless on being cut. The spleen was small, with its capsule wrinkled and turned back. The stomach showed black patches in the larger curvature and the mucus was thick and somewhat blanched. The kidneys, which were large and white, attested the acute nephritis. The cardiac cavities were full of semi-liquid blood. The patient had died of yellow fever in its most dangerous form of icteroid typhus.

CASE 4.—A few days later the municipal officer of health invited us to the autopsy of a suspected case of "vómito negro." The deceased was a highlander, L. M., recently arrived from the mountains, and his family afforded the following information: On June 20, at 8 a. m., he felt pains in the head, waist and calves; eyes red; feverish and slightly delirious. He was given two doses of saline laxative which acted on him twice, and on the morning of the 30th he appeared better. In the afternoon he was worse; he had pains at the mouth of the stomach, nausea and high fever, at night he was delirious. He was given an infusion of vervain, which produced five evacuations, thick and somewhat black. On July 1 he was in the same condition, urine thick, fever and nausea. Again he was given vervain. On the morning of July 2 he was better, without fever; the nausea remained but there was no vomiting. He was given vervain again. On July 3 he awoke without fever, but had passed a bad night; his tongue was dry and showed dark spots; he had trembling fits and epigastric pain. He took a little chicken broth and even ate a piece of the fowl; passed dark urine several times and had various evacuations like coffee-grounds. At 8 o'clock that night hiccough came on and at 10 the patient vomited twice, more than half a chamber-vessel of blood of the colour of coffee-grounds. He was given the saline laxative in sweetened water. He passed the rest of the night with hiccough; next morning he was unconscious, did not speak, and died at 9 o'clock.

Autopsy.—A post-mortem was held the same afternoon; the body was that of a young man, whose eyes and face showed an icteric tint, which, however, was only slightly visible on the rest of the body; from the mouth there issued bloody foam. Notwithstanding the fact that several hours had passed since his death, the body was very warm; cadaveric rigor had set in. When the abdomen was opened the liver was found to be somewhat large in volume and of a yellowish color instead of its normal characteristic dark color; on cutting it transversely it gave a small quantity of blood (not bile), and in one place near the edge, which was quite pale yellow, it gave only a very small quantity of juice. The spleen was almost normal as regards dimensions but the volume was diminished, the capsule somewhat wrinkled and the soft pulp could easily be penetrated by the finger. Blood was taken from the viscera on two microscopic slides. The stomach, tied at the pyloric and cardiac orifices, was removed and opened at its smaller curvature; it contained almost a liter of dark fluid blood. In the large curvature was a fair-sized dark greenish-black stain which strongly tinged the mucus; there were also hemorrhagic stains of recent origin; the mucus was not easily removed. The heart, bloodless, showed nothing abnormal; from one auricle blood was taken on a microscopic slide. The kidneys, slightly enlarged in volume, offered nothing worthy of attention on being cut. The bladder, distended, contained urine which was intensely yellow, without being dark, and albuminous. Dr. Irujo, who examined the samples of blood, said nothing as to the result of his microscopic analysis.

CASE 5.—A few days after making the post-mortem just described I was called to see a Spanish youth, the companion of Patient 3, with whom he had come to Iquitos. The patient had been taken ill in the morning with fever, pains in the

body and slight shivering. On examining him, his thickly-coated tongue, violent headache, and no other symptoms worthy of attention caused me to postpone my diagnosis and I contented myself with ordering the patient some mineral water. On the following day his eyes were red and he had some epigastric pain, fever and headache. As the water did not appear to do him good, I ordered him calomel, which caused abundant motions. Next day, in spite of the effect of the purge, his condition was the same, and I noted that the slowness of his pulse did not correspond with the fever. I called my colleague, Dr. Irujo, in consultation and expressed my doubts as to the nature of the present case; by common accord we gave him quinin as a draught. On the following day the condition of the patient was serious; he had a well-pronounced icteric tint; bilious vomitings and dark urine strongly charged with albumin; the liver was large and painful, the spleen inaccessible. In consultation with Drs. Irujo and Carvallo, I bled him, injected a liter of Hayem's artificial serum and gave the patient an alkaline enema. The patient recovered slowly and was sent to Yurimaguas to recuperate.

CASE 6.—In the early part of the same month I saw in *extremis* a highlander, P., who was dying on the fourth day of his illness, emitting black vomits. I was unable to arrange a post-mortem.

CASE 7.—About the same time Dr. La Torre called Drs. Irujo, Carvallo and myself in consultation over the case of an Italian, M., who had come from Lima by the Pichis Pass, and a few days after his arrival had fallen ill. He had been treated by his countryman, an apothecary, who, believing it to be a case of malaria, had administered quinin for four days. When we saw the patient he was yellow from head to foot, had hiccough, scarcely any fever, and a sample we saw of a recent vomit was of a dark color; the urine contained much albumin; the liver was enlarged; the spleen could not be touched or felt on sounding the patient. Notwithstanding treatment by injections of artificial serum, the patient died on the following day, and eighteen hours later La Torre and I performed the autopsy.

Autopsy.—From the liver, which was yellow and enlarged, blood issued in very small quantities on cutting it; the spleen showed no alteration; the stomach displayed much ecchymosis and hemorrhagic spots; the bladder contained a small quantity of urine, yellow and albuminous; the kidneys were large and pale; the heart, yellow, with semifluid blood.

Grave circumstances connected with the health of my family prevented my continuing to attend patients, and afterward I left Iquitos, taking with me notes of the clinical history of cases which I believe to be typical of yellow fever.

I now propose to give a few facts respecting the situation of Iquitos, its climate and its fertility in parasites transmitting yellow fever; and I will also enter into considerations indispensable to the further confirmation of my opinion, notwithstanding that the above post-mortems leave no ground for concluding that malaria is the generator of the disease. It is a notable fact, and I do not tire of repeating it, that in none of the patients was there during life any alteration in the spleen, and in no cases did the autopsy reveal in it the disturbances characteristic of infections by the hematozoon of malaria.

SITUATION OF IQUITOS

On a high bank of the Amazon is situated the town of Iquitos, and like a ring of water the rivers Itaya and Nanay and Lake Moronacocha surround it. There are numerous marshes on the side facing the *montaña* (forest region), while that side of the town which faces the Amazon is dry.

Dr. H. W. Thomas, of the Liverpool School of Tropical Medicine, gives some interesting data¹ respecting its public health, and I cannot resist recording here those which chiefly concern the subject of this paper.

Iquitos is remarkable for its swarms of mosquitoes, especially alongside the river and in the neighborhood of the marshes. The houses situated along the river bank are never free from mosquitoes, and if special nets were not used for the beds it would be impossible to sleep. It has been said that the yellow fever mosquito does not exist in Iquitos. This statement is false. The *Stegomyia fasciata* is found in great numbers; it is disseminated throughout the town; practically all the houses and stores are full of this parasite; a great number of houses have been examined, as also barrels and other water deposits, and the *Stegomyia* has always been found. Examination had been made of 69 houses belonging to the better class and the larvæ of *Stegomyia* were discovered in 65; in 63 cases the *stegomyia* larva was not associated with larvæ of other *Culex*; in two cases the *Stegomyia* and *Culex* were found together; in the other four cases the *Culex* was discovered in great quantities. In one house adjoining a store there were sixteen large barrels, nine shallow vessels, seven large empty oil tins and a heap of empty preserved meat tins, in addition to a collection of more than 300 bottles; in all these there was a small quantity of water, and in 90 per cent. there were larvæ of *Stegomyia fasciata*. This house is remarkable for the large numbers of mosquitoes which infest it, and on one occasion several persons succumbed to "vómito negro" in it.

Careful attention should be given to the marshes. We took samples of water from 120 springs, and allowed the larvæ to grow and develop; four samples contained larvæ of *Anopheles argyrotarsis*; the fasciolated form was found to be present in other samples; adult specimens of *Anopheles argyrotarsis*, *albipennis* and *albipes* varieties, were always found near the marshes, and once in a house close by. An examination of these mosquitoes for malaria parasites was negative.

Is the "vómito negro" of Iquitos a form of yellow fever, or is it perchance a new disease? We have already said that the commission had no opportunity of seeing a single case of this disease. The generality of the symptoms, the temperature, the pulse record, and the duration of the illness, all coincide with those of yellow fever. The fact that newcomers are most liable to contract the disease is characteristic. The presence of the *Stegomyia fasciata* is a most important factor. All these points have been discussed with the Iquitos doctors, and a typical case of "vómito negro," the progress of which was related to me by one of the doctors,² leads me to believe in the strong resemblance which exists between yellow fever and the "vómito negro de Iquitos." Unfortunately necropsy has been impossible on typical cases of "vómito negro," which would have been of vital importance in elucidating the diagnosis.

The town of Iquitos is comparatively free from malaria and the majority of the cases come from the neighboring rivers.

CHARACTERISTICS OF VOMITO NEGRO

Case 1, that of G. S., permits no doubt as to the fact of the illness being yellow fever. How could one think of malaria when the patient grew worse on taking quinin and when, at the end of his illness, there was not the slightest alteration in the spleen? It was an isolated case of yellow fever.

The case of my second patient, J. S., diagnosed by two of my colleagues as remittent malaria, presents a most typical picture of yellow fever, is cured without quinin and shows no alteration in the spleen. Only persistent icterus remained, for which reason I sent the patient to Portugal for alkaline baths and change of climate. It was perfect confidence in my diagnosis which made me run the tremendous risk of treating this patient.

Case 3 is a typical one of icteroid typhus. The poor man had taken much quinin in the first two days, and his illness was one of the terrible forms of "vomito negro."

The autopsy on the body of L. M. (Case 4) and the story we doctors heard from his family shows us a case of yellow fever in which nothing is lacking.

1. Thomas, W. W.: The Public Health of Iquitos, 1905.

2. Dr. Thomas refers to my Case 1, of which I gave him the clinical details.

Case 5 presents the "vómito negro" in an obscure form, for which reason I held a consultation. Not being sure of the case, I reserved my diagnosis, and, in accord with the doctor who saw the patient, I gave him quinin. As a result of this reagent the youth became worse; albumin appeared in the urine, and the icteric tint, and suspicious vomit were noticed; in this emergency we bled the patient, injected Hayem's artificial serum. The cure was slow but sure. The spleen showed no malarial reaction.

Poor P. (Case 6) was at death's door when I saw him; I found him surrounded by his coffee-ground vomits; it never occurred to me to think of malaria as the cause of his death. Unfortunately it was impossible to hold an autopsy.

Case 7, that of M., the Italian whom I saw with Drs. La Torre, Irujo, and Carvallo, presented a picture which admitted of no doubt. Serum was injected, but the poor fellow had already received from the hands of a quack enormous doses of quinin, and, in spite of everything we did for him, he succumbed. His autopsy, which I have noted above clearly, reveals, in accord with his symptoms, that the man died of yellow fever. His spleen showed no alteration at all; indeed, it was of normal size.

Why pretend to make malaria responsible for these deaths?

Soon after I arrived at Iquitos, a friend of mine, Mr. A. D., was taken ill with high fever, bilious vomiting, pain at the left hypochondrium, and two days later some albumin in his urine. As was natural, this patient was much afraid, because he thought he had been attacked by the famous "vómito negro" of Iquitos, of which we had heard so much on the Peruvian coast. I diagnosed this case as a remittent malaria of tropical countries, because I had no grounds for thinking that the patient's symptoms were those of "vómito negro." One of the doctors of the town who saw the patient diagnosed the case as "vómito negro de Iquitos," a special fever found in that locality, which, as I had only recently arrived, I did not know; he proposed to give the patient phenyl salicylate (salol) with acetphenetidinum, a remedy which at that time was the panacea for "vómito negro." I did not accept the diagnosis of the remedy, and consequently, on my judgment, I administered to the patient large doses of quinin hypodermically; in a fortnight he was better. Afterward he had a slight relapse, which compelled me to give him arsenic and iron to remove this clear infection of malaria completely.

I sometimes think that in Iquitos the same thing happens as does in Lima with typhoid fever. "Infectious fever" was the name given in Lima to a gastric complaint if it continued for some days; and the same name was applied to intestinal toxoinfection, typhoid, malarial typhus, and other similar diseases. Something analogous occurs in Iquitos with the "vómito negro."

Although the points I have noted leave no room for doubt, I venture to offer a few remarks to strengthen my opinion.

In the presence of the patients with the symptoms presented by those I attended, three thoughts arise in one's mind: First, is it a case of bilious remittent malaria of tropical countries? Second, is it yellow fever? Third, is it a special disease peculiar to Iquitos—a colibacillosis, as Irujo believes?

The symptoms of bilious remittent malaria are very similar to those of yellow fever, and there are cases in which, while the patient lives, it is impossible to distinguish; but the autopsies are very different; for while

in the bilious malaria the spleen is enlarged, and the liver enlarged, dark, bloody and full of bile when cut, in yellow fever the spleen suffers no alteration, while the liver is enlarged, of a light yellowish coffee-and-milk color, bloodless, gives scarcely more than a few drops of juice when cut and shows all the aspects of the tuberculous liver. The lesions of the stomach are very manifest in yellow fever, as also are those of the kidneys. If to this is added the circumstance that in Iquitos the mosquito most prevalent is the *Stegomyia*, as I have said, the *Anopheles* being scarcely met; and also that its climatic conditions of heat and atmospheric humidity place it in these respects in the same category as Pará and Manaos, the altitude of Iquitos above the sea-level being insignificant, it is easy to arrive at the conclusion that yellow fever and not malaria is responsible for the epidemic which raged in Iquitos and Yurimaguas last year. Bear in mind, too, the significant fact of the failure of quinin in the treatment of these patients, and the truth is so clear as to leave no room for doubt. Brought from Brazil, or originating locally, yellow fever is to-day endemic in Iquitos, where it is always present, appearing in the form either of sporadic cases, like Cases 1 and 2, or as an epidemic, such as began with Case 3 early in 1908 and has not yet terminated. It would not be far from the truth to suggest that it was this same disease, the famous "vómito negro," which destroyed the Junin battalion when it went there in 1895 with Colonel Ibarra.

On the coast we all see malaria perform its work of destruction, but, notwithstanding the abundance of cases, epidemics of bilious malaria rarely occur; the tertian and chronic malaria cause most ravage. Moreover, epidemicity is not distinctive of bilious malaria, whereas it is characteristic, in the majority of cases, of yellow fever. Again, those who are attacked by bilious remittent malaria are almost always persons who have suffered from malaria in some other form; it frequently happens, for instance, that a certain kind of intermittent malaria changes into remittent, in the same way as a simple tertian passes into a grave case of pernicious malaria.

Are we, then, dealing with a special Iquitos fever—a colibacillosis? This hypothesis has already occurred to certain doctors who have practiced in the Antilles. It is possible that colibacillosis may form part of the disease or may be wholly responsible for it; this is a question of etiology which I do not intend to discuss. It is still a matter for mature consideration to determine what is the precise cause and what is the germ of the disease. But I say to myself, "Why do we wish to make Iquitos the special locality for this disease when in Guayaquil, Pará, Manaos, etc., it always attacks by preference those who have recently arrived, as it does in Iquitos, with the same symptoms, with the same failure of quinin, with the anatomic and pathologic lesions which we all attribute to yellow fever? Why form new diseases from clinical observations which have already been well noted by others? Bretonneau, Dutroleau, Finlay, Freire, Lacerd, Silva, Lima, and others, all describe these observations of high fever, albuminous urine, black vomits, fatty degeneration of the liver and kidneys, no alteration of the spleen, in persons recently arrived in the tropics, by the name of yellow fever or black vomit?"

NOTE.—I wish to thank Dr. Albert H. Carroll of Baltimore for his very valuable aid in the preparation of this article.