came generally blue, except his ears and his right hand, which were white and cold. His breathing became very rapid and laboured. He soon rallied, and at 5.5 P.M. his respirations were 36; pulse in right wrist 136. He seemed more deaf, and did not answer questions readily. In about half an hour his temperature had risen to 106°. He complained of no pain. At 8.15 P.M. his temperature had fallen to 105.2°. Pulse 136. No dulness or abnormal sounds in the lungs. He did not pass a very good night. This morning he seemed rather strange in his manner and tries to get out of bed; has perspired much during the night. The temperature this morning is 98°. The pulsation in the left carotid is rather more feeble than in the right, and the grasp of the right hand is weaker than that of the left. He can move both the right arm and leg. 5.45 P.M. Aspect bad; is perspiring; respirations 36; pulse in right wrist 136. In 15 minutes that it is no wonder. Right arm and leg are now completely paralysed; speech somewhat thick; tongue protruded to left side; takes food, but cannot swallow well. 9.15 A.M.: The patient had not slept during the night; he had passed urine unconsciously; the temperature had risen, and at 8 A.M. was 104.8°; at 3 A.M. the breathing became rapid and stertorous, but he was conscious till about 7.30. He was now lying on his back, sweating profusely; face cyanosed; large, weighing 24 oz; muscles firm; light side natural; left ventricle considerably hypertrophied and dilated; murmur audible at the apex, and often in the axilla. One cusp of the mitral valve completely destroyed by ulceration, with adherent clots. Abdomen: Spleen enlarged, weighing 26 oz; contains several recent infarcts, some partially breaking down in the centre; at the lower part of the viscus were several recent and partially infarcted and already decoloured, extending about an inch and a half above the profunda and for a short distance downwards into that vessel. The left popliteal artery contained a clot reaching about an inch above the bifurcation, and passing down into the posterior tibial artery. Head: Examination not allowed.

A SIGNIFICANT FACT IN THE DIAGNOSIS AND INTERPRETATION OF THE ALBUMINURIA OF ADOLESCENTS.

BY CLEMENT DUKES, M.D., B.S. LOND.,
MEMBER OF THE ROYAL COLLEGE OF PHYSICIANS, PHYSICIAN TO RUGBY SCHOOL, AND SENIOR PHYSICIAN TO RUGBY HOSPITAL.

(Concluded from page 1285.)

The significant fact, which has proved a valuable means of diagnosis to me, and which, I think, throws a vivid light upon the interpretation of these cases, has occurred in my practice with sufficient frequency during the last year or two to be unmistakable. I have already referred elsewhere to such cases, but here I have discovered and the boys submitted to treatment. But seats have now been provided, and my diagnostic helpmate has failed me, so that the cases have to be traced in other and less pronounced ways. Could a more classical set of circumstances be presented, not only for the purpose of diagnosing cases, but also for their interpretation? Here we had a large number of boys going to bed and lying in the horizontal position for about eight hours and a half, and suddenly falling down, cutting the back of his head on the fencer. The question arose as to whether he had had a fit or fainted. As soon as I felt his pulse I was confident that it was owing to early albuminuria; and, on analysis, this supposition proved to be the fact in nearly every instance. I have already referred elsewhere to such cases, but here I have a most marked class of them—boys getting up at 6 A.M. and rushing down to school. If they assembled in chapel where they could sit, faintness rarely occurred. The same set of circumstances existed, with the exception that the boys were required to stand for a few minutes, and thus by this differential examination the cause was at once discovered and the boys submitted to treatment. But seats have now been provided, and my diagnostic helpmate has failed me, so that the cases have to be traced in other and less pronounced ways. Could a more classical set of circumstances be presented, not only for the purpose of diagnosing cases, but also for their interpretation? Here we had a large number of boys going to bed and lying in the horizontal position for about eight hours and a half, and suddenly falling down, cutting the back of his head on the fencer. The question arose as to whether he had had a fit or fainted. As soon as I felt his pulse I was confident that it was owing to early albuminuria; and, on analysis, this supposition proved to be the fact in nearly every instance. I have already referred elsewhere to such cases, but here I have a most marked class of them—boys getting up at 6 A.M. and rushing down to school. If they assembled in chapel where they could sit, faintness rarely occurred. The same set of circumstances existed, with the exception that the boys were required to stand for a few minutes, and thus by this differential examination the cause was at once discovered and the boys submitted to treatment. But seats have now been provided, and my diagnostic helpmate has failed me, so that the cases have to be traced in other and less pronounced ways. Could a more classical set of circumstances be presented, not only for the purpose of diagnosing cases, but also for their interpretation? Here we had a large number of boys going to bed and lying in the horizontal position for about eight hours and a half, and suddenly falling down, cutting the back of his head on the fencer. The question arose as to whether he had had a fit or fainted. As soon as I felt his pulse I was confident that it was owing to early albuminuria; and, on analysis, this supposition proved to be the fact in nearly every instance. I have already referred elsewhere to such cases, but here I have a most marked class of them—boys getting up at 6 A.M. and rushing down to school. If they assembled in chapel where they could sit, faintness rarely occurred. The same set of circumstances existed, with the exception that the boys were required to stand for a few minutes, and thus by this differential examination the cause was at once discovered and the boys submitted to treatment. But seats have now been provided, and my diagnostic helpmate has failed me, so that the cases have to be traced in other and less pronounced ways. Could a more classical set of circumstances be presented, not only for the purpose of diagnosing cases, but also for their interpretation? Here we had a large number of boys going to bed and lying in the horizontal position for about eight hours and a half, and suddenly falling down, cutting the back of his head on the fencer. The question arose as to whether he had had a fit or fainted. As soon as I felt his pulse I was confident that it was owing to early albuminuria; and, on analysis, this supposition proved to be the fact in nearly every instance. I have already referred elsewhere to such cases, but here I have a most marked class of them—boys getting up at 6 A.M. and rushing down to school. If they assembled in chapel where they could sit, faintness rarely occurred.
can tell when it is present from the boy's appearance alone.

Another case which I have now under my care, and in respect of which I have grave anxiety as to the future, arose in the following way. The boy was returning to school for the summer term, and if it were not for school, he could not want, and thus removed, his flannel vest before starting, leaving his overcoat, which he had worn through the vacation, at home also. This happened in winter weather, although May was the actual month. He took cold on the journey; and although this occurred last May (1890), his urine is now for days together loaded with albumen; it is then absent for a day or two, then persistent all day, and so on.

In another case which I watched for several years (1886 to 1890), and which was one of the most troublesome, I gradually elicited the following remarkable fact, which I have never found before or since, and the meaning of which I have not yet said. Several years after, he subsequently quite recovered. Its origin dated from a drive on a cool summer evening, when the patient, unaccustomed to driving, omitted to wear an overcoat. Moreover, he had had a similar attack a year or two previously, and recovered.

The following points present themselves as the result of a consideration of the subject:—1. It is not safe to make a diagnosis in any patient without an examination of the urine. 2. Are not all cases of early albuminuria, in their early stage, identical with the class of cases I have described? 3. If so, it is perfectly clear that these cases of early albuminuria, which are so common in the young, constitute the early stage of what eventually may become developed into the chronic disorganisation of the kidney which is termed Bright's disease. 4. Would it not be well to direct attention to some unmentioned point in nomenclature, so that a uniform and appropriate name may be assigned to this disease, and that it may cease to be termed "functional"?

The giet of the whole matter seems to be this: That where the hyperaemia of the kidneys is severe the albuminuria is persistent, in whatever position the body may be placed, whether at rest or not, and whatever diet may be partaken; while if the hyperaemia be slight, from the cause having been trivial, or from a severe attack which is passing away, then the albuminuria only shows itself when the body assumes the vertical position, or under exeration, or after a full meal; but if the hyperaemia be prolonged, however slight in degree, the albuminuria gradually becomes persistent, owing to the hyperaemia of the blood-vessels, and tends to destruction of the kidneys. As in the eye the inflammation may be so severe that the eyelids cannot even be opened, or may be so slight that there is no indication of any hyperaemia except under work; so here the kidney may be involved but not so far, in which case it may cease to work, as in acute nephritis, or so slightly hyperaemic that it is only elicited under a stress of its circulation, such as arises in assuming the vertical position, undergoing active exertion, or partaking freely of food, with a pathological condition.

**EXCISION OF THE CONDYLE AND NECK OF THE INFERIOR MAXILLA FOR OSSEOUS ANKYLOSIS OF THE RIGHT TEMPORO-MAXILLARY ARTICULATION.**

**By David M. Greig, M.B., F.R.C.S. Ed.**

The rarity of osseous ankylosis of the temporomaxillary articulation makes it desirable that all cases of this condition should be placed on record, especially when operative measures have been adopted for its relief. In few text-books of surgery is the deformity even referred to, while in fewer still is any operation described.

J. C., male, aged twelve years, came under my care in February, 1890, complaining of stiffness of the jaw and inability to open his mouth. The following history was elicited. Apart from anything bearing upon his present condition, he has always enjoyed good health. In 1885 he had scarlet fever. This was accompanied by right suppurrative parotitis, which was followed by gradually increasing impairment of movement at the right temporomaxillary articulation. In 1887 he was able to separate the teeth for a quarter of an inch, and this was increased to one inch by forcing the jaws open, under chloroform, by means of a wooden wedge. Although this treatment was afterwards continued, the jaws were soon approximated more firmly than formerly, while the teeth could not be separated at all.

In February, 1890, his condition was as follows:—He was well-nourished, and presented nothing noteworthy, except in connexion with the condition of the right temporomaxillary articulation. A hard swelling, indicative of former inflammatory mischief or periostitis, extended from this articulation to the angle of the jaw, and produced undue prominence of the right cheek. The skin near the angle of the jaw was marked by cicatrizes. The incisor teeth were directed forwards, leaving a space one eighth of an inch wide between them. Through this opening the patient had...