food fairly well. On the 4th and 5th he passed brown semi-solid stools. On the 7th no abnormal physical signs were found in the chest, and there was no distension of the abdomen. The child appeared somewhat drowsy; but otherwise with the exception of the pallor, which has persisted, not ill. He was allowed to get up next day. On the 8th he was up for two hours only; but he was so increasingly drowsy that he was put to bed again. He vomited. The pulse was 80, and irregularly intermittent. At night his breathing was noisy, and he seemed but half conscious; during this night he screamed twice, and no urine was passed. On the 6th, 7th, and 8th no motions were passed. On the 9th the symptoms remained the same. He vomited once and passed a motion. On the 10th he seemed to have some difficulty in swallowing, and his breathing was rather snoring in character. He rested on his back, and appeared semi-comatose at times. He could put out his tongue when asked; it pointed somewhat to the right, the mouth being drawn to the left. The pupils were equal and active. A clear discharge was noticed from the left nostril. The abdomen, which was not distended or apparently tender, gave a sensation between gurgling and crackling on pressure, especially on the right side. The pulse was 80, irregular, and intermittent; respiration 32, regular, never suspicious. No rash. It had seemed strongly probable for the last few days that meningitis had set in, though the diagnosis of uræmia suggested itself as possible to one of my colleagues. On the 11th the child seemed much the same; at night he had a wet pack, and sweated freely, and when asked if he were better nodded intelligently. At 2 A.M. on the 12th he had a general convulsion, with loud stertorous breathing and foaming at the mouth, and died at 3.50 A.M.

The temperature from the 8th to the night of the 11th ranged between 99° and 101.6°. Six hours before death it was 101°; two hours before death 102.8°, five minutes before death 108°, and ten minutes after death 106.3°. No motion was passed after the 9th.

The post-mortem examination was made by Mr. Battams twelve hours after death. He noted as follows:—Abdomen: Omentum and intestine adherent to the walls. Intestines matted together with recent lymph; much arborescent deep injection, chiefly in patches, especially in small intestine. Intestines studded all over with yellow nodules, from the size of a pin's head to that of a pea. The abdominal peritoneum was also thickly studded, especially on the under surface of the diaphragm, which was adherent to the liver. Mesenteric glands: None larger than an almond, some cheesy. No fluid in the abdominal cavity; no ulcerations in intestines or enlargement of agminated or solitary glands. The surface of the liver was studded with small granulations; spleen also, both superficially and internally. In the chest there were grey granulations, though not numerous, scattered over the pulmonary pleura. The lungs were crepitant throughout, excepting a small cheesy patch at the right apex. No fluid in pleural cavity. The bronchial glands were enlarged and cheesy on section; one, surrounding the right bronchus, was the size of a pullet's egg. The brain was firm; the membrane over the left hemisphere was cloudy; over the right middle lobe there was blood-stained fluid beneath the arachnoid; same appearance, but less so, on the left. The sides of the longitudinal fissure were coherent with lymph. A few granulations in membranes were found over the cortex. The pia mater at the base was studded extensively with minute granulations; no excess of fluid in ventricles.

Remarks by Dr. DONKIN.—The chief points of interest in this case seem to be: (1) The recession of the abdominal symptoms—i.e., distension and pain after admission into hospital, and the absence of physical signs, rendering obscure the tubercular peritonitis so obvious after death. But a due estimate of the history of the case should have given more weight to the symptom of tympanites, so common at the outset of tubercular peritonitis, especially in view of the small favour which at any time was given to the theory of enteric fever. (2) The short time before death that the diagnosis of tubercular meningitis became reasonably probable, thus lending no help to the earlier diagnosis of tubercular disease of the abdomen. (3) The markedly acute character of the attack. A case of this kind gives a valuable clinical lesson, illustrating a malady of an acute order, the chances of whose occurrence we hardly as yet sufficiently recognise when seeking the causes of symptoms which do not at once explain themselves. The subject of

acute tuberculosis in children, other than ordinary tubercular meningitis, was, from its clinical importance, proposed, in a preliminary prospectus of the Section of Diseases of Children, for discussion at the recent International Medical Congress; but, unfortunately, it did not elicit the promise of any contributions. The present case may be looked upon probably as one of primary acute tubercular peritonitis, tending possibly to recovery, but ending in death by the supervention of a meningitis which ran an unusually rapid course. The occurrence of death so soon after the symptoms pointing to tubercular meningitis set in may account for the absence of many of the clinical indications of that disease. (4) The absence of any marked collateral evidence of scrofulosis.

MATER MISERICORDIÆ HOSPITAL, DUBLIN.

DISSECTING ANEURISM OF THE ABDOMINAL AORTA IN
A FEMALE, WITH THE FORMATION OF A DIFFUSE
FALSE ANEURISM CAUSING OBSTRUCTION
OF THE BOWELS.

(Under the care of Dr. J. M. REDMOND.)

M. B—, aged fifty-four, a widow, was admitted on the 9th of February, 1882, said to be suffering from obstruction of the bowels. She stated that during the last two years she had had repeated attacks of constipation, accompanied by more or less abdominal pain, which were relieved in the usual manner by taking pills &c. According to her statement, hot drinks had an almost immediate effect in allaying the pain. On the present occasion, domestic remedies having failed to relieve her, she sought admission into the hospital. About a year before she had a similar attack, but not of so severe a character, for which she was treated by an eminent suburban practitioner, who looked on it as being of renal origin.

On Saturday, Feb. 4th, previous to admission to the hospital, she complained of constipation, accompanied by pain, which was situated in the left iliac fossa. Twenty-four hours afterwards she was seized with vomiting, which persisted till she was admitted into the hospital. The patient could give no history of strain, or of having over-exerted herself in any way.

On admission her condition was as follows:—Pulse 130; temperature 99°; respiration 25; heart feeble, and intermittent every fifth beat; appearance healthy, and not at all anæmic. She complained of severe left lumbar pain, also pain in left iliac fossa, which was paroxysmal at times. Abdomen greatly distended with flatus, tympanitic over the greater portion, but dulness was detected in the left iliac fossa, which could be traced upwards to the margin of the thorax; circulation in the femoral arteries normal, but they were observed to be considerably enlarged, which suggested that the patient might be the subject of the aneurismal diathesis, but neither pulsation nor bruit could be detected on examining the abdomen and lumbar regions. There was no oedema of the legs. Her condition improved considerably under treatment, pain diminishing, and at one time ceasing for twelve hours, pulse and heart growing stronger. On the morning of the 11th she became faint, but recovered after a short time; towards evening she again grew weak, and sank gradually, till she died on the morning of Feb. 12th, at 2 A.M.

Necropsy, twenty hours after death.—Body well nourished; abdomen greatly distended; heart healthy; aorta dilated, and on the inner surface close to its origin a few small atheromatous patches were observed. Abdomen: No trace of peritonitis; intestines greatly distended with flatus; descending colon reduced considerably in diameter and pushed forward by a large diffuse false aneurism twelve inches in vertical length; circumference fifteen inches, anterior wall being formed by peritoneum, descending colon, and sigmoid flexure, posterior wall by iliac fascia, &c., and left kidney, which was situated at the upper and back part of the sac. The sac was filled with coagulated blood, and had a thick deposit of fibrin on the inner surface, being particularly well marked at the apex, where it averaged in depth about two inches. There was an extravasation of blood under the left broad ligament of the uterus. The posterior wall of the sac exhibited a large irregular opening exactly corresponding with a similar opening on the anterior and left lateral aspect of the abdominal aorta, about one inch above the bifurcation, and caused by the rupture of a

dissecting aneurism. The handle of the scalpel could be passed upwards between the coats of the aorta as far as the origin of the superior mesenteric artery and downwards between the coats till the origin of the common iliacs was reached. Common iliac arteries presented two aneurisms about the size of walnuts, the left one being much the larger. Femoral arteries were also in an aneurismal condition. In fact, there appeared to be a tendency to develop aneurisms at constant intervals.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

The Influence of Albuminuria on the Temperature of Phthisis.

THE ordinary meeting of this Society was held on the 14th inst., Mr. John Marshall, F.R.S., in the chair, who, on taking it for the first time as President, addressed a few words of thanks to the Fellows for his election, and referred to the position and work of the Society. The President announced that the Council had drawn up a memorial to be presented to Her Majesty the Queen on behalf of the Society, expressive of their sorrow and indignation at the recent attempt on Her Majesty's life, and their thankfulness at her providential escape. The announcement was received with marked approbation by the Fellows who were present. He also announced that as the credit of the Society had been compromised by the previous vote of money to the Harvey Tercentenary Memorial Fund, which had subsequently been declared *ultra vires*, the Council had resolved to open a subscription list among the Fellows, for the purpose of raising the required sum, which would be given to the fund as a contribution from the Fellows themselves, and not as from the Society as a corporate body.

A paper was then read on the Influence of Albuminuria on the Temperature of Phthisis Pulmonalis, by Dr. C. THEODORE WILLIAMS, of which the following is an abstract:—The author drew attention to the frequency of albuminuria as a complication of phthisis, to the insidious character of its approach, and to the grave prognosis it imparts to otherwise hopeful cases. Its influence on the clinical history of phthisis, and especially on the temperature course, was then considered, and sixteen illustrative cases were given. The patients were twelve males and four females, of ages varying from sixteen to forty-six. In all excavation of the lungs had taken place, and extension of the disease, either in the form of excavation or of tuberculation, was actively proceeding. In some there was in addition ulceration of the larynx or intestines; eleven out of the sixteen had diarrhoea more or less profuse. Albuminuria was present in all, and was generally accompanied by anasarca or by ascites, or by both. The temperature observations were made in the mouth five times a day, for periods varying from five days to six weeks. The effect of the renal disease was to mask the usual phthisical symptoms, and especially to lower the temperature. This was demonstrated by (1) temperature charts in a case of acute phthisis before and after the supervention of albuminuria; and (2) by comparing the sixteen cases with the temperatures of forty-three similar third-stage active cases, free from the complication, showing that while the curve under ordinary circumstances would be highly pyrexial, in the albuminuric patients it is sub-febrile; and the post meridian rise from 2 P.M. to 8 P.M., although present, is carried on at one degree lower in the scale. The maxima and minima show the ordinary extremes of ordinary third-stage cases. Thirteen of the patients died, and from twelve autopsies it appeared that the tubercular changes were proceeding up to death uninfluenced by the uræmia. The kidneys were found to be distinctly lardaceous in seven cases; large, white, and mottled in three; granular, or affected with interstitial nephritis in two. Lardaceous disease affected other organs besides the kidneys in five out of seven cases. These results were confirmed by post-mortem records of the Brompton Hospital, which show the existence of lardaceous disease in fifty-two per cent. of deaths from phthisis. Microscopic examination demonstrated the lardaceous change to generally begin in the vessels of the Malpighian tufts, and

later on to involve the epithelium of the tubuli Contorti. This evidence is contrasted with the statistics of Bamberger, Lecorché, and Southey, which give lower percentages of lardaceous disease in phthisis. The urine of the patients was as a rule scanty, the quantity falling in one case to seven ounces, and in another to two ounces and a half. The specific gravity in the lardaceous cases was high—in one instance reaching 1047. The daily excretion of urea varied from 337 grains to 54 grains; in the last instance it was accompanied by diarrhoea, and gave rise to no symptoms of coma. The rate of urea excreted daily compared with the patient's weight, estimated by Parkes at three grains and a half per pound in a healthy man, in these cases fell to two grains and under, in one case reaching 0.9, a very small percentage. The albumen was very abundant, even sufficient, on boiling, to cause the urine to become solid. The reason of the lowering of the temperature was then discussed, and the author concluded that it was not due to decrease or disorganisation of the red corpuscles, or to diminution of the albumen in the blood; but, judging from the experiments of Hammond, Stolnikow, Bernard, and Barreswill, arises probably from the toxic effects on the nervous system, caused by the retention within the blood of the constituents of the urine, though not of the urea alone; that coma did not often occur was probably due to the excretory influence of the diarrhoea, generally present. The prognosis of phthisis and albuminuria is very unfavourable, most hospital cases only surviving a few months after the appearance of albumen in the urine; in private practice patients have been known to last for several years, but in the majority albuminuria must be reckoned as of fatal import, and the ordinary duration of chronic phthisis, as extended by modern treatment, is much curtailed by this complication.—Dr. MARCET said that albuminuria was a very common attendant on phthisis, and had been but little considered. The chief point raised was the lowering of temperature coincident with the albuminuria. The determination of urea gave the inquiry great interest, but the amount of urea varies so much with kind and quantity of food, &c.—diarrhoea diminishes it—that it was difficult to assign much pathological significance to it. The appearance of albuminuria is frequently associated with diarrhoea, and possibly the fall of temperature partly depended on the latter. Wunderlich gives no information of value as to the influence of albuminuria in lowering of temperature, but he states that chronic Bright's disease is not attended with pyrexia—acute is. By increasing the action of the skin the temperature of the body can be lowered. The act of secretion of urine probably requires very little heat, because its constituents are so readily dialysable. But in pathological conditions there is also albumen, which is non-dialysable; and in order for this to pass through it requires much power, and therefore much expenditure of heat. It is not a question of inflammatory disease, but the mere transudation of albumen. If so, the absorption of so much heat would explain the fall of the general temperature, just as diaphoresis does.—Dr. ANDREW said that of course all the different forms of albuminuria might occur in phthisis, and he asked Dr. Williams whether any special form of phthisis was associated with a special form of renal disease. In such cases the albuminuria might precede the pulmonary disease, and he knew of cases where albuminuria was the first symptom, the phthisis supervening and continuing after the albuminuria had ceased.—Dr. JAMES POLLOCK did not think albuminuria and phthisis were very commonly associated. The paper had led him to think what was the cause of the high temperature of phthisis, and what is the mode of reduction of body-temperature generally. High temperature is invariably accompanied by great waste of tissues, and he believed that in phthisis it was due to the loading of the blood with effete material. He had seldom, if ever, known cases in which with waste of body there was not high temperature also. The fall of temperature, coincidently with albuminuria, was not sufficient ground for saying that the latter produced the fall. The mode of lowering temperature is through the skin; but he could not accept Dr. Marcet's explanation. He had observed in cases of progressing phthisis, where the urine became albuminous, that the pulmonary disease is temporarily arrested, and he would explain the fall of temperature by the arrest of the wasting of the body, leaving acute tuberculation aside.—Dr. GREEN asked whether only lardaceous disease was being considered; and if in an early stage there should not be much loss of albumen, but an increased flow of water? However,