to their natural strength, when the joint is again fully used in this way, there is a strong tendency to recurvature of the accident. Such a line of treatment is that which has been followed for years with the greatest success by Dr. Wharton P. Hood. In a certain percentage of cases it will fail and the trouble will recur. These must be operated upon. Similarly chronic cases that have already had numerous attacks when first seen require operation. Those cases, also, in which a quite loose body can be felt to move to widely different positions in the joint will not improve without operation. In all other cases in which a loosened cartilage protrudes from the cartilage, thickened synovial membrane, and osteophytic outgrowth; and (5) no obvious derangement. There are some points which help us in differentiating between these conditions, although it will happen not seldom that symptoms most strongly suggestive of one lesion will prove to be due to another. Thus Case 59 was apparently a typical example of semilunar damage, yet the lesion proved to be a perfectly loose body and the semilunars were natural.

In the cases of semilunar cartilage sometimes the symptoms present themselves till seven weeks before his death. He then relaxed his diabetic diet and his final illness appeared to date from this time. He developed a gradually increasing general weakness without malaise. He became exhausted during the process of dressing, the distance which he was able to walk grew daily shorter, and slight bilateral palsy developed so that he was unable to read for any length of time. He was very anxious not to minimise the gravity of the accident, which I choose for opening the joint, unless, of course, there is special indication, as the presence of a foreign body, for incurring at some other condition. An advantage over the transverse incision is that by the vertical cut, the extension of the vasto to the tibia, an important supporting structure is not divided; moreover, the vertical incision is easily prolonged upwards when this is necessary for examination of the large synovial pouch about the patella. Care must be taken to clip and to tie every bleeding point, and the joint is to be literally squeezed dry before it is closed. The joint should not be washed out with antiseptics and no drainage should be allowed. One exception to the rule of not becoming fixed presumably in the posterior part of the joint behind the crucial ligaments and gave no further trouble. The course of this case to a perfect cure seems to prove conclusively that rest, exercise, and massage may lead to the remedying of a condition within the knee-joint which might well have seemed incurable except by operation. It is, however, possible that the body became fixed owing to influences which would not have come into play had the joint not been opened.

It is hardly necessary to insist upon the strictest asepsis, which must, of course, be observed, but I cannot agree with Mr A. E. Barker that the finger should not be used within the joint. Without such use I cannot believe it possible in some cases to estimate the exact position of a body that may be present. It is necessary in some cases to examine with the finger every part of the joint that can be reached. Even then a small loose body may escape detection as in Case 45.

My experience favours removing loose semilunar cartilages rather than fixing them, and the same applies to torn or hypertrophied alar ligaments or local hypertrophy of synovial membrane.

In closing the wound the sutures are to be passed so as to include the cut synovial membrane.

After-treatment.—The splints are to be taken off within a week. Passive movements are begun as soon as the skin wound is healed, and these are combined with massage. In a well-functioning joint it may be permissible to move the body to such an extent that the knee is brought into widely separated portions of the joint. Such a cartilage, however, may be most confusingly imitated by an excrescence due to rheumatoid arthritis.

Results.—Viewed generally these cases show that operation for internal derangement of the knee-joint is in most cases highly satisfactory. There are generally quick recovery and no recurrence of the trouble. In one case after several years of freedom another operation was required and a large number of loose bodies were removed from the joint. I am, however, very anxious to insist on the correctness of the operation, which I hold to be considerable, and would lay stress upon Cases 22 and 51, which illustrate failure such as is probably inseparable from a certain proportion of all serious operations. Even short of the unhappy event of permanent stiffness, considerable trouble may be caused in convalescence by profuse secretion of synovia (Case 37) and by a tendency to stiffness of the joint (Case 23). Such cases cause great anxiety and require the most early careful and persistent treatment if a perfect joint is to be finally secured.

Grosvenor-street, W.

A CASE OF ACUTE MYASTHENIA GRAVIS.

By C. A. HINGSTON, M.B., B.Sc. Lond.,
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We have thought it desirable to place the following case on record, partly on account of the rarity of the condition and partly on account of the fact that our case presented some unusual features.

The patient, aged 71 years, was a contractor of Plymouth. He had lived a life of considerable mental and physical activity for about 30 years and during this time his health was above the average. At the age of 60 years he relinquished the greater part of his work; he became easily excited and fatigued and his business capacity obviously lessened. At the age of 63 years he began to suffer severe neuralgic pains in various parts of his body and limbs, for which there was no apparent cause. He was kept in hospital for a time with these pains became limited to the left leg and were sufficiently severe to confine him to bed for many weeks. At this time the urine was found to be of high specific gravity and to contain a considerable quantity of sugar. The glycosuria never quite disappeared, but it became so considerable as to be scarcely appreciable by the ordinary tests.

About 12 months before his death albuminuria set in and continued to the end. During the 12 months prior to his death he was subject to severe weakness without malaise. He became exhausted during the process of dressing, the distance which he was able to walk grew daily shorter, and slight bilateral palsy developed so that he was unable to read for any length of
time. As he did not improve, for the sake of a holiday, he paid a visit to his daughter in Essex. Shortly after his arrival he developed difficulty in swallowing and soon had to limit his food to semi-solids and finally liquids. The latter, however, frequently regurgitated through the nose.

After he had been in Essex about three days he was seen by one of us and again carefully examined. He was then very emaciated, but not more so than might have been expected from the severity of the disease. His temperature was usually from 103° to 104°, and his pulse was from 110 to 120 per minute and very soft. He was sponged night and morning. He was taking four ounces of bran and a small quantity (about half a pint) of beef essence; otherwise he had nothing but whey, of which he consumed from three to four pints in the 24 hours. On Dec. 4th there were some indications of heart failure and the first sound became faint. The patient therefore began to take the usual half a pint of milk and within a few minutes the pulse and respiration were normal for his age. A second attempt to do this involved great effort and it increased daily until his death on July 13th.

No necropsy was obtained in this case, but there appears to be little doubt that our patient suffered from myasthenia gravis or asthenic bulbar paralysis. The unusual features to which we would draw attention are the patient's age, the exceptionally acute course of the disease, and the association with diabetes. From previously reported cases (about 70 in number) it would appear that the disease belongs to the fourth decade of life, and so far as we have seen in the literature no case of a patient who had full control of his bowels and bladder. At this time the urine contained both sugar and albumin in moderate amounts. The patient rapidly grew worse and returned to Plymouth on June 27th. On the 29th difficulty of swallowing became pronounced and it increased daily until his death on July 13th.

In the Lancet of Nov. 2nd, 1901, p. 1182, Mr. Prideaux G. Selby of Teynham, Kent, published a paper concerning the treatment of enteric fever by whey instead of milk as a staple food, his death-rate for 73 cases being 2.7 per cent. Since that time Dr. S. J. Gee of St. Bartholomew's Hospital has treated four cases entirely, and one case partially, by this method. It is stated that in a number of cases (at least recorded by Widal and Marinesco; their patient lived only 14 days after the onset. The association with diabetes in our case appears to have been somewhat intimate since the patient's intestines were distended with gas. From the size and thickness of the sloughs I am convinced that had the patient's intestines been distended with gas instead of milk the patient would probably have lived longer than of an enteric fever patient treated with milk, being dry and cracked and difficult to keep clean.

MILK OR WHEY IN ENTERIC FEVER?
BY ARTHUR TREGEELLES PRIDHAM, M.B. LOND.,
HOUSE PHYSICIAN AT ST. BARTHOLOMEW'S HOSPITAL.

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