the absorption of toxins from the delayed resolution of the right lung. I have to thank Dr. Arthur T. Davies (under whose care the patient was in the hospital) for permission to publish the case.

Petersfield.

ATMOSPHERIC TEMPERATURE AND SMALL-POX.

By DAVID SIVEWRIGHT, M.A., M.B., CH.B.,
D.P.H. ABERD.

It is generally recognised, I think, that there is some connexion between the atmospheric temperature and the

bearing on the point. I have taken weekly averages of the maximum shade temperature and the minimum shade temperature, also similar averages of the admissions of cases to the hospitals of the Metropolitan Asylums Board. Allowing 12 days for incubation and an average of two days for the cases to be recognised and sent off I have compared the averages of temperature of one week with those of the admissions on the third week following. I find on putting these numbers on charts that a rise in the number of cases generally corresponds with a fall in temperature, and *vice versa*. The correspondence of each rise in the number of cases with a fall in temperature is not absolute, at the same time I think it is sufficient to warrant the assumption that the relation is more than a casual one. I have also in the same way compared the maximum solar radiation in vacuo with the cases admitted and find that the

CHART 1.

CHART 2.

CHART 3.

The dotted line in all the charts denotes small-pox cases (first week commences Dec 28th, 1901). In Chart I. the continuous line denotes the maximum and in Chart II. the minimum shade temperature in degrees Fahrenheit (first week commences Dec. 14th, 1901). In Chart III. the continuous line denotes the maximum solar radiation in vacuo in degrees Fahrenheit (first week commences Dec. 14th, 1901). The temperature curve for the last three weeks is not given because it rose to 77°, extending beyond the limits of the chart.

incidence of small-pox cases. During the epidemic in London in the winter 1901-02 I collected from the *Standard* a series of statistics from which I have made calculations

correspondence is even more striking in this case. The accompanying charts illustrate the article.
Catford, S.E.

CASE OF RUPTURE OF THE LEFT AURICLE.

By F. W. FOOTT, L.R.C.S., L.R.C.P. IREL.,

WITH A NOTE

By F. DE HAVILLAND HALL, M.D., F.R.C.P. LOND.,
PHYSICIAN TO THE WESTMINSTER HOSPITAL.

I WAS called to a man, an Arab, aged about 40 years, a stoker on the P. and O. line of very fine muscular development. There was a history of his having been in a Bombay hospital two years previously for "something." On my arrival I found that he was dead, having fallen "all of a heap." Previously to the fall he had been playing a game of cards. The game over, he rose suddenly to see if his

supper was being cooked, when he fell, as described, in the kitchen.

I suspected aneurysm and by the coroner's order made a post-mortem examination in the presence of two other qualified men and we found the following conditions present. The pericardium was full of blood (*none being outside the pericardium*), the left ventricle was hypertrophied, the auriculo-ventricular ring was stretched, the mitral valve was not nodular and was apparently healthy, the wall of the left auricle was exceedingly thin and stretched, and there was a small tear about half an inch in extent on the outer and posterior surface, the thinnest part. The muscular substance of the heart looked fatty—i.e., it was pale in colour and not firm. A microscopical examination was not made. The pulmonary and general venous systems were loaded with blood. The kidneys were very lobulated but otherwise normal.

The etiology appears to be as follows. The man was a