One month and twenty days later he returned, when there was paralysis of convergence and slight ptosis of the left upper lid. The pupils reacted normally; the accommodation was not affected, and the patient said that he could work at his desk very comfortably when one eye was closed. The fundus was normal. He was referred to Dr. H. N. Moyer, who made the diagnosis of myasthenia gravis, and exhibited the patient before the Chicago Neurological Society.

Although the findings in this case will be more completely published later, it seems appropriate to call attention here to some of the facts pointed out by our notes. The most important one is that already cited, that the eye symptoms in this disease may be the first signs of trouble. Of course, this is assuming that our patient was afflicted with myasthenia gravis when he complained of double vision in November and December, 1899. Even if it is not granted that the disease existed at that time, it seems safe to venture the opinion, in the light of the after-history, that as marked a variation in the muscle balance as this case showed between Nov. 6 and Dec. 8, 1899, must attract unusual attention and be carefully studied, and, if possible, satisfactorily explained.

The absence of involvement of the muscles of accommodation in September, 1902, (when he could work at his desk very comfortably if one eye was closed) is interesting. Based on observations up to that time, this case agrees with the findings of Myers, who notes the absence of involvement of the ciliary muscles in the cases studied by him. The possibility of the escape of the ciliary muscle in this disease, and the fact of the difference histologically between it and the external muscles, could well give rise to some speculation. This, however, is upset by Gowers' report, in whose case there was interference with accommodation, and the same is now true of our patient.

The variation in the refraction may have some significance. According to our examinations, which were made with homatropin (homatropin hydrobromate, gr. x; cocain hydrochlorate, gr. x; water, $\bar{3}$ i, of which mixture a drop was put into each eye every five minutes for thirty minutes, and the examination was made forty-five minutes after the last application), the myopia increased 0.75D, and the investigation of the subject brings a letter from the patient, which says: "In early life I seemed to be able to see fully as far as anyone, and, so far as I know, my vision was not shortened until just previous to my first call on you." It will be recalled that at the time of the first examination there was slight myopia. If there is any relation between the disease and the myopia, it would be curious. How is it to be explained?

The cessation of symptoms in this case for over two years calls attention to one of the three signs, which Myers says may be described as pathognomonic of this disease, viz.: exacerbations and remissions shown in its course, and warns us to be careful about pronouncing a recovery in any given case.

Clinical Report.

PYONEPHROSIS WITH A KIDNEY-COLON FISTULA.

GEORGE E. McLAUGHLIN, M.D.

Pathologist to Christ Hospital.

JERSEY CITY.

History.—The patient, a man, aged 37; white; occupation railroad conductor; entered the service of Dr. Gordon K. Dickinson at Christ Hospital, Jersey City, for operation, with a diagnosis of vesical calculus.

Family history was negative. The patient had the usual diseases of childhood; twenty-five years ago an attack of typhoid fever; five years later a gonorrhea and a slight stricture of the urethra. He uses tobacco and alcoholics in moderation. Two and one-half years ago he began to complain of a burning sensation, and often severe pain on micturition, with interference to the free passage of urine, and at times a sudden stoppage during the act of passing it.

He states that he has never passed blood in his urine. Lately he noticed that he was losing weight and appetite. He states he has had no chills or fever since the attack of typhoid fever 25 years ago. He gives no history of constipation or diarrhea, and the evacuations of the bowels are regular. His temperature for the three days previous to operation was normal and subsequent to it not above 100 degrees.

Operation.—A suprapubic lithotomy was performed and three calculi weighing collectively 168 grams were removed. There was no suppression of urine subsequent to the operation. The third day the patient died.

Necropsy.—All the organs, with the exception of those later mentioned, were normal, save that the intestines showed some slight adhesions. The bladder wall was much thickened. The interior of the viscus had a ribbed appearance. The veins were somewhat prominent and the mucous membrane was

of a yellowish color, and covered with shreds of mucus and urinary salts. The right ureter measured one inch and a half in diameter, and was of a leathery consistence. The left ureter was about three times the usual size, being somewhat tough to the touch.

The right kidney was normal in size and was adherent at its lower end to the colon. On sectioning it proved to be a typical pyonephrotic kidney, only a thin wall of kidney structure, possibly one quarter of an inch thick, remaining. It was connected, as shown in the illustration, with the colon, by a fistulous tract one inch long. The left kidney was much enlarged, the capsule non-adherent, and projecting from its surface were three cysts, the one shown in the illustration at its upper portion being two inches in diameter. All these cysts contained a urinous fluid. This kidney showed a chronic diffuse nephritis and contained two half-inch calculi in its pelvis.

41 Crescent avenue.

Rules for writers, as given by the *Saturday Evening Post*, are as follows: 1. Have something to say. 2. Say it. 3. Quit writing.