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vicinity of the small nutrient vessels, disturbing the parenchymatous tissue in the immediate vicinity. We have indicated the late effect of this inflammation upon the heart muscle as well as the disturbance of the media of the arteries. We now call attention to the effect of the inflammatory reaction upon kidney tissue.

In the milder conditions the reaction remains localized in the vicinity of the vessels, causing but little disturbance of the tubules or glomeruli. An ædema pervades the intertubular connective tissue in the interlobular zone. Relatively little kidney tissue is involved by this localized inflammation, although streaks of reaction follow many of the small cortical arterioles. Where the reaction is more intense the infiltration spreads for some distance into the cortex involving considerable areas in an irritative process. More or less tubular degeneration may be present and granular debris appears within the secreting structures. The glomeruli may be involved in congestion with proliferation or show the presence of a lymphocytic infiltration amidst the capillary loops. Some of the glomeruli may become occluded and undergo hyaline change. Crescentic spaces between the glomerulus and its capsule show the presence of debris and hvaline masses. Occasionally hvaline and granular casts are found within the tubules.

As these inflammatory lesions progress to the chronic stages, the perivascular areas of infiltration become replaced by connective tissue. There appears to be a large gap in the observations, both clinical and pathological, between the acute and chronic stages of the disease. Many individuals die during the height of the disease when the acute reaction is well evident in the kidney. Otherwise death does not overtake them, save through intercurrent accident, until the late sequelæ bring about these changes in the heart, kidneys, or arteries, which have been so thoroughly observed and studied. The intermediate stages of repair are infrequently seen. Nevertheless, one may observe combinations of the acute and chronic lesions in those cases where the disease has been of a recurrent nature. This is not so uncommon, and we have observed a number of instances where perivascular fibrosis was accompanied by an acute lymphocytic infiltration. The acute lesions of the heart were a further evidence that the inflammatory infiltration was a recurrent one and not that of a progressive disease.

The healing of the acute inflammatory exudate takes place by a fibrosis which is observed in radiating streaks advancing from the base of the pyramids through the cortex. The small artericies which ramify from the interlobular vessels carry with them an