upon close questioning she was obliged to admit it felt a little harder than usual, and had also done so during her former attacks. This tumour was situated just under Poupart's ligament, its longer axis (about two inches and a half) parallel to it; it felt hard and movable, and lacked all the characteristic feeling of hernia, except that on coughing I thought I could detect a very distinct impulse. An attempt at taxis proving unavailing, anodynes and fomentations were ordered, and a mild aperient administered much against her will, as she feared the diarrhœa, which, however, had not troubled her since about 8 A.M. The symptoms continued much the same the rest of the day, and in the evening, the aperient not having acted, an enema was given. On Tuesday, the symptoms persisting, another ineffectual attempt at taxis was made under chloroform, and the rest of the treatment consisted of opiates and repeated enemas. On Wednesday, vomiting, which had been in abeyance since Monday, became a little troublesome, but not very persistent, and there was no other change in the symptoms, except that the tumour was rather harder, the impulse on coughing entirely absent, and the feeling more unlike that of hernia than at first. I advised a consultation with Dr. Lloyd, surgeon, of Llangefni, who agreed as to the doubtful character of the tumour, and counseled temporising for a day, giving small doses of calomel at intervals, with opiates and belladonna to allay pain and continuing the enemas. On Thursday Dr. Lloyd again saw the case with me, and as the symptoms were still not very urgent, a delay of another day was advised and agreed to, and the same treatment continued. On Friday the symptoms became more urgent, the vomiting being uncontrollable and the pains more severe, with some distension of the abdomen. The case altogether wore a more serious aspect. Dr. Lloyd was telegraphed for, and he agreed to adopt the safe old maxim—"When in doubt, operate." With his assistance I divided the usual superficial coverings and brought to view a dense fibrous mass, which we had some difficulty in recognising as an enlarged and altered inguinal gland. Having regard to the doubtful character of the tumour, my first impulse was to close the wound, and to look upon the case as one of ordinary intestinal obstruction. We determined, however, to dissect through it with a view to further exploration and perhaps its removal, when, on reaching the saphenic opening, I exposed the sac of a small enterocele just about to pass through that aperture, having, no doubt, been prevented from doing so by the enlarged gland which occupied that situation. The usual seat of stricture (Gimbernat's insertion) was divided, but not until some bands under the edge of the falciform process had been notched could the bowel be returned. The case eventually did well, recovery being slightly retarded by suppuration of the divided gland.

Remarks.—The points of practical importance in connexion with this case are: the occurrence of strangulation in hernia during or immediately succeeding a sharp attack of diarrhœa; that the character of the tumour should not deter us from operating; that if an enlarged gland should obtrude itself, it is desirable to ascertain what may be concealed beneath it; and that the division of Gimbernat's ligament is not always sufficient for the reduction of the hernia. I am aware that each and all of these points have been noticed and dwelt on by the authorities on the subject, and I am also certain that they are not seen in the common run of cases of strangulated hernia.—*The Lancet.*

CHARACTERS OF YELLOW FEVER THAT DILTINGUISH IT FROM MALARIAL FEVER.

By J. W. Compton, M.D., Evansville, Ind.

The prominent symptoms of yellow fever are thus condensed by Dr. Manning Simons, of Charleston, South Carolina:

"Onset with chill or sensations of chilliness, immediately followed by pain in the head, back, and limbs; rapidly rising fever of intense grade; red and injected watery eyes; sluggish capillary circulation; inward heat, pain, and tenderness on pressure over the epigastrium; irritable stomach; black vomit; albuminous urine; suppression of this secretion; hemorrhages, rapid course of the disease and the mahogany color of the skin."

Yellow fever very often makes its attacks after bed-time.

Malarial fevers usually make their attacks late in the forenoon or in the afternoon in daytime.

In yellow fever the intense pain is felt in the back part of the head and in the cerebro-spinal region.

The pain of malarial fever is usually in the front part of the brain.

In yellow fever the subsidence of the fever marks the termination of the attack.

The subsidence of malarial fever is only a rest, preparatory to a subsequent and more severe attack.

Periodicity is not a characteristic of yellow fever, though it is the essential diagnostic characteristic of malarial fever.

Attacks of yellow fever afford almost entire immunity from future attacks, while attacks of malarial fever increase the tendency to future attacks.

The preparations of cinchona have no specific controlling effects in yellow fever

The preparations of cinchona have a universally acknowledged and marked controlling effect in malarial fevers.