the tongue was nearly bitten off, and you were witnesses of the difficulties we had to meet with in keeping this patient from doing herself further destruction.

On the other hand, there are a few features in an epileptic seizure which are not so plainly marked in the uræmic—*e.g.*, the initial cry, the corpse-like pallor, the turning in of the thumbs. The presence of albumen and casts in the urine alone affords satisfactory distinction.

Coma.—After the usual premonitory symptoms, headache, vertigo, dimness of sight, or vomiting, coma is a rapid development, or it comes on without any premonitory symptoms at all, and either with or without convulsions. The face is pale, the pupils dilated, and react slowly to light, but in some cases the pupils are contracted.

Stertor is peculiarly deep, snoring and hissing. The coma deepens, and death is the common result, but in some cases the patient may rally, and continue free from symptoms, to succumb to another attack. Acute coma occurs in all forms of Bright's disease, but is more common in the inflammatory than in the cirrhotic variety.

As a general rule, all uræmic manifestations are bilateral. Hemiplegia and unilateral localized spasm are produced by other causes. Slight cases do occur, though with extreme rarity, where a hemiplegia may remain for a short time after a uræmic attack, and you will find a well reported case of localized spasms, clearly the result of uræmia, reported in the last number (June) of the *Canada Medical and Surgical Journal*, by our friend and former classmate, Dr. Williams.

Acute delirium has, in few cases, been observed to be one of the first manifestations of uræmia. Such a case occurred in our wards two years ago.

Dyspnœa.—This may be the first indication of renal disease, or it may supervene in the course of Bright's disease with uræmia. In the *Canada Medical and Surgical Journal* of November, 1884, you will find an admirable paper by your Dean before the Canada Medical read Association, on "Some of the Varieties of Dyspnœa met with in Bright's Disease," in which several instructive cases are embodied, illustrating the point that dyspnœa may occur in Bright's disease, not due to gross lesions in the lungs, pleura, or heart, and that its origin may escape recognition if the urine be not carefully examined, as well as the heart and pulse.

Such attacks of the dyspnœa may be continous, or they may resemble asthma, occurring paroxysmally.

Within the present quarter we have had in Ward 11 a fatal case of uræmia, in which dyspnœa was urgent, and evidently was the immediate cause of death. The patient was a strong, healthy-looking man; entered hospital upon the 20th April, complaining of headache and debility, and more especially of pains in the knees and ankles, so much so that at first sight we supposed we had a case of rheumatism to deal with. The urine was copious and highly albuminous. No casts were discerned. We believed the case to be one of interstitial nephritis. After being in the hospital some three or four days it was observed that the breath seemed very short, and this symptom gradually assumed an alarming character. There were no physical signs in the chest to account for such a manifestation, but there seemed to be an obstruction in the larynx or nose. The patient lapsed into a drowsy, semi-comatose condition, and died on the 25th.

The autopsy showed that our diagnosis was incorrect as to the cause of the disease. He had no interstitial nephritis, but there was on both sides a hydronephrosis. The left kidney was much distended, and almost devoid of healthy secreting substance, the right but partially involved. Both ureters showed a stenosed portion of their calibre. It would have been difficult to assign the origin of this condition, but the effect was plain. The elimination of urea was interfered with, and uræmia was the result.

A form of dyspnœa sometimes, though rarely, met with in Bright's disease is that very remarkable derangement of the breathing known as Cheyne-Stokes respiration. You will remember that I explained this phenomenon to you at the bedside a few days ago.

Three years ago, when I was attending the out-patients, a case of this kind presented