previous she had not felt as strong as usual, and had been somewhat drowsy and stupid. She did not consider herself sick, however, and was able to work every day at her occupation, that of a saleswoman. Twenty-four hours before entrance to hospital through accident room, while at work in the store, she was seized with a sharp, stabbing pain in the abdomen, especially on the left side high up, which was so severe that she fainted. The pain increased in severity and became general over the abdomen. The most severe pain was described as starting just below the ribs on the left, radiating into the left groin. She required large doses of morphia during the night. The pain continued with increasing severity, accompanied by hard chills and frequent vomiting. After entering the hospital she had two chills and vomited several times.

*Examination*:—A fairly well-developed and nourished young woman. Somewhat anemic, evidently very sick. Nothing abnormal found in heart or lungs. The abdomen was everywhere extremely rigid and tender, the greatest amount of muscular spasm, however, was in the left hypochondrium. There was marked tenderness in the costo-vertebral angle on the left. Vaginal examination showed some tenderness and increased resistance on the left of the uterus, but no mass could be felt. Uterus normal in size and freely movable. Temperature 104 deg. F.; pulse, 140; poor quality. Leucocytosis, 26,000. Examination of urine showed no pus, blood or albumin. Neither kidney could be palpated, but attempts to palpate the left kidney caused exquisite tenderness anteriorly and posteriorly. While the symptoms and signs pointed with definiteness to an acute abdominal infection, probably gastric perforation, the marked tenderness in the costo-vertebral angle made me consider an infected kidney, yet because of the positive abdominal signs and the absence of blood and pus in the urine, it seemed wise to make an anterior incision first.

A short incision through the left rectus muscle above the umbilicus was made and the abdominal cavity opened. There was no evidence of peritoneal infection. The right kidney was normal in size and position. The left kidney was found to be enlarged and the perirenal tissue edematous. The anterior wound was rapidly closed and the left kidney cut down upon through an incision in the flank. It was covered with characteristic small dark and yellow spots, the multiple septic infarcts. The kidney was removed, the renal vessels having been tied with silk. A gauze drain was left in and the wound closed about it with chromicized catgut and silkworm gut. One pint of salt solution was given intravenously before the patient left the operating room.