an employé in one of the city hotels. Dec. 18, 1882, he entered the Hospital and was placed under my treatment. The case had been diagnosed as Enteric fever by another practitioner before the patient entered the Hospital. It was from the first a case of unusual severity. Diarrhœa, tympany, and abdominal tenderness, were marked symptoms. The temperature range was high. The lung was affected with pneumonia; delirium showed itself at night, but the patient was carefully watched and not allowed to leave his bed. During the first week of treatment, which was in reality the second week since the attack began, the evening rise of temperature reached 104° and even 105°; a few spots were visible on the abdomen. About the beginning of the third week the usual fall in temperature was noticed, and the case appeared to be progressing in a favourable manner.

Dec. 28.—At 2. a. m., this being the twenty-first day of the disease, the patient had a severe chill; he complained of excessive pain and tenderness in the abdomen; his mind became clearer than it had been, and he recognized the gravity of his situation. I saw him at 11 a.m., nine hours after the chill began; he had vomited, his face was of a bluish colour, he felt cold and shivered a good deal. The temperature was *normal*, viz., 98 2-5; his legs were drawn up toward his abdomen, tenderness in the right iliac region was excessive. I diagnosed intestinal perforation. The immediate cause did not appear to be quite clearly established. The nurse said that the patient had never been permitted to get out of bed; the coughing was severe and may have been the immediate cause.

Half an ounce of brandy every hour, ¼ grain of morphine hypodermically every four hours, were prescribed, and turpentine stupes were ordered to be applied over the abdomen. Some difficulty was experienced in continuing the treatment, as the patient, realizing his dangerous position, declined to take anything. Ultimately, however, by gentle persuasion, he was induced to take the stimulants and some beef tea. The temperature rose steadily during the ensuing four days, reaching 105° and 106°. He survived until 9 a.m., Dec. 31, four days and seven hours from the time the rigour began.

Post-mortem: On exterior examination of the body.—The body was warm; there was slight tympanitis; the abdominal walls were firm and unrelaxed.

On opening the abdominal cavity, a small quantity of serous fluid escaped. The abdominal walls and the coils of both large and small intestines were covered with lymph. The lymph was of recent formation, and from its appearance might have existed from four to six days. It was friable, thick, opaque, easily detached in many places from the coils of intestine. The coils of intestine thus adherent were carefully separated from each other in view of finding a perforation, as such a condition had been diagnosed, but none was found.

The bowels were not distended by gas; no fæces could be discovered, either in the bowels or in the abdominal cavity. The external surface of the whole intestinal tract was most carefully examined. It showed *marked arterial congestion of the ileum* and cæcum, also congestion of a less degree in the jejunum, but no perforation was discernable. The *intestines were then opened.* The ileum showed its mucous surface ulcerated in the position of Peyer's patches. In some cases the muscular coat of the bowel could be seen, in other places there was merely inflammatory swelling of the patch. In the lower part of the ileum these pathological changes were more marked; most of the Peyer's patches were completely eroded about four inches above the ileo-cæcal valve, where there could be seen a funnel-shaped point of ulceration, the apex of which looked white. On carefully examining this point, it was found to be a perfect perforation of the wall of the ileum, the apex of which was coated with lymph, layers of lymph