

On questioning, patient stated that he had had an acute attack of rheumatism (?) in the right leg and knee which came on abruptly two weeks before admission. He gave no history of attacks similar to gall stone colic and no history of attacks of jaundice at any time. Bowels were irregular, much constipated; appetite very poor. Patient has not eaten a good meal for over two months, is able to retain only soft eggs and milk. Micturition normal.

CONDITION ON ADMISSION: Complexion sallow; conjunctivæ faintly yellow; no cyanosis or dyspnoea; lips and mucous membranes of good colour; patient looks decidedly sick, is dull and slow-minded, but answers questions rationally. Tongue is slightly coated, breath very offensive; a few greyish spots on the posterior wall of the pharynx; no ulcers on membrane. Pulse slightly dicrotic, large volume, low tension. Patient has a distinctly typhoidal appearance.

LUNGS: A few fine râles at the end of inspiration in both upper lobes. Heart sounds clear; abdominal examination negative. Liver not enlarged; spleen not palpable. Abdomen soft and full, tympanitic on percussion, but not distended, no tenderness and no foreign mass to be felt; no rose spots.

The right leg is much enlarged, the tissues of the calf being swollen and indurated, the superficial temperature is elevated, there is considerable tenderness on palpation. About the middle of the calf is a ridge-like swelling, hard and sensitive, just below the line of the popliteal vein. In the popliteal space the tissues are swollen, œdematous and tender, there is much induration over the course of the popliteal artery and vein. The whole leg is swollen and œdematous pitting on pressure the circumference of right calf measuring 4 c.m. greater than the left.

COURSE OF DISEASE: The patient's temperature on admission was $102\frac{2}{5}^{\circ}$. It rose immediately to 104° and then to $105\frac{2}{5}^{\circ}$, when the patient had a hard shaking chill. It dropped again to 103 and rose to 105, and at this time the patient was covered by a most profuse perspiration. His temperature now gradually fell to $101\frac{6}{10}$. During the night the patient's temperature was very irregular and fell from $102\frac{9}{10}$ at 8 o'clock the day of admission, to normal at 10 o'clock and to 97 by the afternoon of the second day. During this time the patient looked considerably upset, the sweating was profuse, rendering a constant change of garments necessary.

There was no increase of the slight yellow tinge of the skin and conjunctivæ which had been noticed on admission and no pain in any part of the body. The spleen could not be felt, the liver was not enlarged, there was no tenderness over the gall bladder. The swelling and tenderness in the popliteal space had not increased, and if anything was slightly less than on the previous day.