children and no miscarriages, the father is alive and has some pulmonary affection.

The third day after birth a large swelling formed under the left ear and advanced forward to the cheek This was poulticed, and discharged a large quantity of pus. She was a sickly infant, and suffered much from colic. At eleven months old she had an attack of whooping cough; when she was two years of age it was noticed that she could not hear. At four she suffered from measles, and at the outset of this attack occurred the first hæmorrhage, three cupfuls of blood being vomited. Next morning there was a slighter hæmatemesis, and after this her condition was very weakly. When she was seven years old she vomited up a teacupful of blood without any premonitory symptoms, and without serious disturbance to her health. At eight she suffered a double rupture, for which she afterwards wore a truss. For the past five years her general health, if not robust, has been fair; she has been able to drive the cattle on the farm, has had a good appetite, and has not suffered either from diarrhœa or from hæmorrhoids.

Recently she was admitted to the Mackay Institute, and there learned to articulate a few words.

Upon December 30th last, she gave evidence of feeling unwell, and spat up some mucus stained with blood; later in the day, while in the housekeeper's arms, she brought up a large quantity of blood, estimated at about two quarts; she became very faint. Saline enemata were given with good effect, and she was confined to bed until January 1st, when she was admitted to the General Hospital under Dr. Finley.

Here her condition was found to be one of marked anæmia; the temperature was normal, the pulse 120, small and regular, the tongue large and fissured along the median line, with small fissures branching off.

Upon examination of the abdomen, some fullness was noticed in the left hypochondrium, and an oval tumor was made out, extending from the costal margin to just below and to the right of the umbilicus, while to the left it extended back to the line upwards from the middle of the crest of the ilium. It could be palpated bi-manually and was movable. The dullness extended upwards, merging apparently into an area of thoracic dullness, whose upper margin was 2 inches above the nipple.

The liver dullness was diminished, being 3½ inches across in the right mammary line.

The heart lay in normal position; both apex and pulmonary systolic murmurs were present, soft in character.

The blood was pale and scanty, the amount of hæmoglobin was reduced to 38 per cent., the red corpuscles reduced to 2,240,000, the white increased to 1,200, and in some specimens of blood examined by Dr. Finley, the proportion of white to red had risen to 1 to 80. No change in the character of the corpuscles was noticed.

The urine was normal, though small in quantity (16 ozs. in 24 hours). The stools were normal, one mass was of dark, blood-stained color, and with it came a little blood-stained fluid. The larynx was normal, the drum of the left ear concave.

The patient's condition improved in hospital; upon the 5th she was bright and cheerful, and seemed to have gained in strength. At half past five she had her supper of bread and milk. This seemed to bring on nausea, and after a few minutes she vomited with scarcely an effort 20 ozs. of bright blood, which rapidly clotted. She was immediately given ice to suck, an ice-bag was placed upon the epigastrium, and ergotin was injected subcutaneously. Ten minutes later a smaller quantity of blood was vomited. A stool passed at the time of the first hæmorrhage was normal and bloodless. Saline enemata were now given. At 6.20 a third hæmorrhage occurred, followed by three more; altogether, 48 ozs. of blood was brought up from the stomach. The patient suffered from great epigastric pain, and gradually sank, dying at 1.35 a.m. on the 6th.

We have entered into all these details in order to throw as much light as possible upon the condition found at the autopsy. This was performed eleven hours after death.

*Autopsy.*—The body was found fairly well developed and of large proportions for the age of the girl (eleven years). There was no excessive fat: the abdomen was sunken. The organs in the thoracic cavity were very pale, there was a little clear fluid in both peritoneal and pleural cavities. The blood present in all the cavities was fluid, and presented a peculiarly pale, diluted appearance. The heart was normal, the lungs rather sodden and œdematous.

Upon opening the abdominal cavity, the small intestines and other organs showed extreme pallor. The large intestines were distended and filled with almost clear fluid (the result of saline enemata given shortly before death). The liver was wholly retracted behind the ribs, save that below the ensiform cartilage the left lobe showed for the extent of three-quarters of an inch. The spleen, which was of a dull pale bluish color with well rounded edges, extended forward and downward to within an inch of the umbilicus.

The result of the examination of the various organs was as follows:

The spleen measured 20 x 8 x 3.5 cm. and weighed 410 grms. The surface showed a reticulated fibrous condition. The splenic vessels at the hilus were large, but not abnormally thick; there was no local evidence of interference with the circulation of the organs. Upon section the trabeculæ were distinct and prominent; the pulp was relatively scanty and pale, while the Malpighian bodies were not prominent. The microscopic examination bore out these naked eye characters, the most noticeable feature being the general interstitial fibrosis more marked in some regions than in others, although everywhere the trabeculæ were enlarged.

The liver was small, with sharp, irregular edges, and weighed only 610 grm.—one-half as much again as the enlarged spleen. The organ was very pale and had a distinctly cirrhotic appearance. On section, however, much of the fibroid change appeared to be superficial, and while the organ was firm and cut firmly, but few bands of fibrous tissue could be made out passing from the surface deep into the substance. Here and there were small, isolated fibroid patches in the liver tissue. The gall bladder was small and covered by an unusual layer of fat, more than 0.5 c.m. in thickness. The ducts were pervious. Microscopically the main characteristic of sections of the organ was its leuchæmic appearance; the capillaries throughout were large and easily recognizable, though there was not the slightest indication of central atrophy of the cells, of nutmeg liver; contrariwise, it was difficult to recognize the individual lobules. The capillaries contained an undue number of leucocytes—in fact, certain of them were completely injected with these corpuscles. In addition, the organ was markedly cirrhotic, but the cirrhosis was not of the common type. There was not anything approaching to a framework of increased fibrous tissue, but here and there were isolated patches of fibrous overgrowth, many perilobular, while some were within the lobules. The growth was of various periods; some of the patches were of well formed fibrous tissue, but there were occasional areas of recent cirrhosis with small cell infiltration.

Certain capillaries in the heart muscle showed also this injection with leucocytes; otherwise the heart muscle was normal, save that it showed, where the fibres were cut transversely, peculiarly well marked vacuolation. This vacuolation is frequently to be no-