It is somewhat singular that the cases of hæmorrhagic enteric fever published during the past four or five years have been regarded chiefly as clinical curiosities and no attempt has been made to study the condition fully or to ascertain its cause. Indeed, in most even the clinical features are very inadequately described, and in a very few where a post-mortem examination has been made the investigation has been, to say the least, very superficial. After a careful study of the recorded cases we have been obliged to conclude that they are of little scientific value and do not materially advance our knowledge of the intimate nature of this process. In the case herewith presented we have endeavoured to make a minute examination of the various organs in the hope of arriving at a more adequate conception of the processes involved. The case was as follows.

A female, unmarried, aged 21 years, a school-teacher, was admitted to the Royal Victoria Hospital under the care of Dr. W. F. Hamilton on June 19th, 1900, with headache, anorexia, and pain in the back. Her history was as follows. She was born in Canada. She had had measles eight or nine years previously, but no other illness; her habits were regular and her food and clothing were satisfactory. Her father was subject to asthma; her mother was weakly and "bothered with her kidneys"; and two sisters were dead (one from diphtheria). Careful questioning failed to elicit any evidence of hæmophilia or rheumatism. The patient first felt ill six days before admission, but kept at work for two days. The illness began with chill, pains in the back, and following this some fever. The condition persisted and gradually got worse until she applied for admission to the hospital. On admission the patient was a well-nourished girl of medium size. Her face was flushed, her eyes were dull, and her lips were dry and sore. The temperature was 100° F., the pulse was 98, and the respirations were 22; the mucous membranes were pale. The pulse was regular and of good volume; tension was slightly *plus*. The apex beat was visible in the fifth intercostal space, two and three-quarter inches from the mid-sternal line. Cardiac dulness was normal. On auscultation the first sound at the apex was rather muffled; at the base the pulmonary second sound was extremely accentuated. With regard to the respiratory system expansion was good; a few fine crackling râles could be heard over the base of the right lung posteriorly; the lungs otherwise were normal. The tongue was dry and caked; it was moist at the edges.