By carrying out the above recommendations with regard to the treatment of male and female inebriates the cost of treatment would be reduced to a minimum, and the number to be provided for at the Mercer Reformatory for women and on the farm colony for men would be reduced to small proportions.

Clinical Reports.—Cases in Practice.

CASE NO. I.

(From the Case-Book of R. J. DWYER, M.B.)

H. P., admitted to St. Michael's Hospital February 24th, at midnight. She was unconscious, but got history from brother. Aged nineteen. Has always been rather delicate, but never had any illness of note.

Father killed seven years ago by train. Mother died two years ago with apoplectic convulsions. One brother and six sisters living and well; none dead.

Brother says she had complained of headache for three days before admission. She was at service, and went to see Dr. Heggie, of Brampton, who attended her. The day before admission she became very restless and delirious, complained of pain in head and neck. The evening before became unconscious.

CONDITION ON ADMISSION.

Patient is a well-nourished, stout girl, cheeks faintly flushed, but prolabia quite pallid. Dark areola under eyes. Pupils contracted and divergent squint. Neck somewhat rigid. Pulse 56, quick and regular. Soft booming sound at apex; heard just over apex and slightly upward. Systolic in rhythm. Respiration 20, very quiet, but varying in depth; though not distinctly Cheyne Stokes, they suggest it. Inspection shows supra-clavicular spaces well marked, the left slightly more than the right.

Owing to condition of patient, no complete inspection could be made. The percussion note seemed to have a slightly higher pitched resonance over upper left front, *i.e.*, down to the second intercostal. Ausculation did not show anything conclusive, though at times there seemed to be a click, and the strength of sounds varied with the energy of breathing. There was no distinct difference on the two sides. Abdomen concave and slightly hard. No other sign of abnormal condition of any organ. Bladder empty. Knee jerks and plantar reflexes are equally increased.

Patient for the most part lies very quiet, in fact, unusually so, either on the back or the side. On any attempt being made to examine her, or in any way to disturb, she is apt to (though not invariably so) become very noisy, groaning and half opening the eyes, and resisting. These attacks soon subside, however, and she apparently sinks to sleep. At times she has slight starting fits or jerks. Temperature per rectum, $101\frac{2}{5}$. Surface quite cold, with goose flesh manifestations.

Diagnosis. Though there has been so short an antecedent history of illness given, I think that she has been ill for some time, and conclude, from the headache, the rigidity of the neck, concave abdomen, slow pulse and increased reflexes, along with eye conditions, that this is a case of meningitis of the base, owing to absence of any other apparent cause such as injury, suppuration, or tubercle. The signs of lung disease are too vague to demand much consideration, and the murmur at apex seems to be due to modification of the normal first sound, not to an adventitious sound.