

granular appearance of the tubercles was recognizable. In the right lung a patch of pneumonic consolidation was seen in the lower part, where liquid râles had been heard; and a cheesy mass of bronchial glands were also found.

In comparing the other case we found some similarity, but many points of contrast also. There was a marked internal squint of the right eye, and also a notable retraction of the head; both of these, with an obvious impairment of the consciousness and a tense fontanelle, at once suggested meningitis. But the diagnostic significance of the squint was largely affected by the history of its having been there for three months, while the brain symptoms were only supposed to be of at most three weeks' duration. Before these symptoms came on there was a history of what was called "congestion of the lungs," taking the illness back for six weeks before admission. But apart from the squint, the partially unconscious state, and the retracted head, pointed to some brain affection; the question, however, arose what kind of affection this might be? The pupils were equal, somewhat contracted at times, but sometimes moderately dilated, and a response to light, in the left pupil especially, could frequently be obtained. The child was fairly well nourished, and the history seemed to suggest some acute febrile illness arising out of the so-called congestion of the lungs. The temperature was high on admission (103.4° F.) and continued so (101° F. to 103° F.) There was a history of diarrhoea, and the bowels were loose on admission and continued so; this is of very unusual occurrence in tubercular meningitis, and although it does happen occasionally, it always makes one hesitate in the diagnosis. The abdomen, far from being retracted, was actually rather tumid. The persistence of high temperatures after comatose symptoms become developed in tubercular meningitis is quite unusual; and the pyrexia, the diarrhoea, and the tumid abdomen made one feel inclined to hope that the brain symptoms might be due to the nervous disturbance of enteric fever, as this frequently resembles tubercular meningitis. Even retraction of the head occurs in this fever, as I witnessed last winter in the case of a girl in my ward who recovered after a severe illness, characterized by diarrhoea and other diagnostic symptoms. In her case the retraction of the head was very marked and persisted for some time. For a few days I actually thought we might see this favorable view of the baby's case confirmed as the temperature came down a little. The diarrhoea moderated; at the same time the nervous symptoms improved, and the retraction of the head became less extreme, and a week after admission the child was conscious enough to play with toys (May 15th). The presence of a *tache cerebrale* in this case did not, as I explained, exclude the diagnosis of enteric fever.

Eight days after admission (May 16th), the hopes of improvement were disappointed by the supervention of sickness and vomiting, and by an increased retraction of the head; this became more and more marked, and for four or five days before death it assumed the feature of a typical opisthotonus, as I pointed out to you. With this aggravation the unconsciousness became more profound, but the temperature still remained high (102° F.) With the disappearance of the partial improvement and the aggravation of the nervous symptoms, one had to give up the hope of the illness being due to the nervous disturbance of enteric fever; but all the points against the diagnosis of tubercular meningitis still remain in force, so I was led to think of some other fever with nervous symptoms as the cause of the illness, and cerebro-spinal fever, as it is sometimes called, or cerebro-spinal meningitis seemed to afford the most likely explanation of the symptoms. When the reaction of the head passed into a regular opisthotonus, the existence of this seemed almost certain. The feeding of the child, as it lay on its side with the head powerfully retracted, was very difficult; and regurgitation of the fluids through the nose repeatedly occurred. The child died on May 22nd, fourteen days after admission. Tremulous movements of the arms occurred four or five days before death, and when the opisthotonus was most marked, some slight spasm of the legs, with pointing downwards of the toes, was recognized. There was no marked spasm of the hands, but the thumbs were often drawn across the palms. No pronounced convulsions occurred. The temperature ran up to 105° F. just before death.

The examination of the brain showed copious exudation of the gelatino-purulent type, over the whole surface, especially abundant on the convexity of the brain in the sulci. In this case a large amount of exudation was seen at the base and especially in the region of the optic chiasma, a region usually little affected in this form of meningitis. The spinal cord showed no exudation on the anterior surface, but the whole of the posterior surface, from the lower end of the cervical enlargement to the upper part of the lumbar enlargement, was coated with a thick layer of the same gelatino-purulent exudation.

Unfortunately permission was not obtained for examination of other parts of the body. It would have been important to see the state of the chest, particularly as there was a recent history of "congestion of the lung." Special interest attaches to this subject as the microbe of cerebro-spinal meningitis is said to be the same as the pneumonic. In my own practice, last winter, a man died in the height of pneumonia with high delirium, and at the *post-mortem* examination we found meningitis of the convexity. In another case I had some years ago, after the crisis of pneumonia seemed to