The movement was wavy and slow. There was a tendency to aggregate in intertwined clusters. Prof. Roberts of Manchester, Eng., describes something like this and also gives the appropriate treatment-salicylate of sodium gr. x x ter. i. d. This was accordingly followed and for three days the symptoms rapidly abated. Contrary to directions the medicine was discontinued at the end of that time when the symptoms re-appeared. The same treatment again caused them to disappear and for 9 months the patient has been comparatively well, the only persisting symptom being a somewhat abnormal frequency of micturition.

Case 2.—Mrs. M, act. 35, married, 5 children, a pretty ruddy and strong but over-worked woman. Had suffered for some 6 weeks from very frequent and painful micturition; she had been treated with the ordinary cystic sedatives, &c. Urine on examination showed the following characteristics:

Clear, pale.
Faintly acid.
Sp. Grav. 1018.
No albumen or casts.

A small sediment of epithelium mostly from urethra. The first mentioned strepto-cocci were abundant. The salicylate of sodium caused an entire disappearance of the symptoms. This was nearly two years ago and there has been no re-appearance.

This latter is plainly a case of primary bacteruria. The epithelial sediment was insignificant. The first is not so clear but I have reason to think that the cystitis which existed at the time of my visit was secondary. In both cases the urine was acid and did not readily decompose, in fact the latter specimen remained on my table for over two weeks without signs of decomposition. In neither case had a catheter ever been introduced. As regards albumen, in one case there was a trace, in the other none. In three others in which I diagnosticated bacteruria but was not able to follow them up, there was no albumen.

SURGICAL CASES IN PRACTICE.

1. *Case of acute intestinal obstruction; death within 22 hours immediately before intended operation.*
2. *Strangulated femoral hernia in a woman; operation; recovery.*
3. *Diphtheritic laryngeal obstruction; laryngotomy; recovery.*

BY ARTHUR MORROW, M. B.

I.—ACUTE INTESTINAL OBSTRUCTION.

ON Jan. 27th. (6 a. m.), I was called to see Mr. W., a well built man of about 30 years. I found him in agonizing cramp which involved not only the abdominal walls and intestinal canal but also the legs. The abdominal wall would at times become intensely hard and his legs doubled up. The abdomen was very tympanitic. His countenance betokened extreme distress and anxiety. He vomited at short intervals chiefly bile.

I obtained the following history,—About 2½ years ago in Gibraltar (he was attached to the Engineer corps), he had suffered from a rather bad attack of abdominal cramps, which was relieved after the successful use of an enema. Since then he had enjoyed good health up to the time of the present attack, having had very little trouble with his bowels. The day before I saw him he had eaten heartily of beef and pork, had with his dinner drunk more freely than usual of beer and had then lain down to nap on the sofa. In the course of the evening he began to have cramp like pains which increased in severity, and about midnight became associated with vomiting. He had had a most distressing night and when I saw him at 6 a. m., begged for something to relieve the muscular cramps which he said he could not stand. I injected Atropine and Morphine hypodermically and gave him a dose of castor oil. When he was somewhat relieved I left him. Four hours later I saw him again, and again felt bound to relieve his pain by a hypodermic injection. I gave an enema of Turpentine, Soap and water with little effect in removing fœces and none as affecting the pain. I began seriously to suspect intestinal obstruction and my suspicion became a positive diagnosis when about the middle of the afternoon the vomited matter began to have a foecal odour. It seemed clearly a case of intestinal obstruction somewhere high up in the canal—high up because of the rapid course of the symptoms. Soon after 6 p. m. I called in Dr. Lindsay for consultation, who agreed that an early operation offered the only chance of recovery. The temperature had not risen to any extent throughout, but the pulse was fast getting increasingly unsatisfactory. A most obvious circumstance at this point was the dyspnœa caused apparently mechanically by the extreme tympanitis which interfered with the play of the diaphragm. For this reason we attempted to lessen the tympanitic distension by puncturing with an aspirating needle. We carefully punctured at several points, but little gas escaped and no benefit resulted. I decided to perform laparotomy as soon as I could procure my instruments, and Dr. Lindsay kindly consented to meet me at ½ past 8 (it was now about 7:30) to assist me. When we left him the dyspnœa was so marked and so great as to lead Mr. W. to ask that the window should be raised, which will be recognized as a significant and ominous sign of a sense of impending suffocation. When I got back at about 8:20 I found that he had died a few minutes after eight.

I may say here that the *severe* cramps had not been so noticeable after about 2 p. m., and he did not vomit much during the last three or four hours, the dyspnœa, so to speak, displacing them as the most prominent feature of his distress.

Post Mortem.—The examination (at which Dr. Lindsay was present), revealed a most interesting and not common condition. Many prominent coils of intestine were tensely stretched with gas. Some others were empty and flaccid. There was a strong firm adhesion between the small intestine (at a point about six feet below the commencement of the duodenum) and the abdominal wall at the umbilicus. It was evidently the outcome of an infantile umbilical