the symptoms were marked from the first, there being marked collapse, restlessness, a pulse of 120, abdominal wall hard and moving little on respiration. In the latter, it was 12 hours before there was evidence of any serious injury, when the pulse became accelerated and the abdomen was distended and rigid and especially tender to the right of the umbilicus. Laparotomy was performed in both, the one with the acute onset showed laceration and pulping of the spleen, the other two fissures on the diaphragmatic surface, one just below the middle extending completely across the organ and a much smaller one at the upper pole. Excision was performed in both cases with success. The peritoneal cavity was washed out with saline solution, some of which was left in, and intravenous injection was employed in both cases. Blood examinations were made by W. d'Este Emery, extending over a period of three years, during which the patient remained in perfect health and underwent the normal physiological growth of this period. The absence of the spleen did not appear to influence the blood counts from those in an ordinary healthy child about puberty. Those counts immediately following the operation gave the same general results as are found after any operation in which hæmorrhage is a feature. Both cases are now three years after operation, in perfect health; the first has some enlargement of the glands in the axillæ, groin, and both sides of the neck.

CUTHBERT WALLACE, M.B., B.S. Lond., F.R.C.S. Eng. "Diabetic Gangrene." *Practitioner*, July, 1907.

This article is one of twenty dealing with the subject of diabetes in general appearing in the present volume. A very good clinical picture is given of the onset and progress of this special form of gangrene, and the general lines of treatment advocated are those now applied in cases of senile gangrene. These may be palliative or radical. If the dorsum of the part is involved the only treatment is amputation above the knee as recommended by Jonathan Hutchison. So long as the gangrene remains dry, as it does until the more fleshy part of a limb is involved, the condition is not grave, but when it has become moist and septic absorption once begun we are dealing with a very serious condition. In such cases ablation of the entire limb may be called for. The diminution or disappearance of the sugar, after the removal of the limb, and the septic absorption produced by it, is a remarkable feature in a certain number of cases, and suggests that the glycosuria may itself depend upon, or be aggravated by, the septic lesion. Septic conditions in non-diabetics sometimes produce glycosuria, and it has been shown that a patient with active septic absorption cannot dispose of as much glucose at a meal as