The patient looked very ill and was evidently suffering from profound toxæmia. The diagnosis was *septicæmia of doubtful* nature; broncho-pneumonia; delirium tremens. The sputum was examined for tubercle bacilli, but none were found.

The delirium continued, incontinence of urine appeared, and he died three days after admission from syncope, on the 25th of November, 1891.

SUMMARY OF THE AUTOPSY.

Lungs, œdematous. *Bronchi* down to their finest branches filled with muco-pus. At the apex of the left upper lobe some ill-defined patches of reddish consolidation and a few similar areas in the right upper lobe. At the base of the right lower lobe a hæmorrhagic mass of the size of a plum.

Larynx. Three or four small, roundish superficial ulcers with yellowish base on the internal surface of the arytenoid cartilages. *heart*, 12 oz., uncontracted. Aortic valve thickened. Aorta slightly atheromotous. *Spleen* 12 oz., large, soft and diffluent. *Kidneys*, 14 oz.; one contained a small yellow infarct. *Liver* 4 lbs. 8 oz., large, soft and slightly nutmeg. Peyer's patches in lower part of ileum swollen and the mucous membrane much injected. Four or five small superficial ulcers with yellowish base, close to the ileocaecal valve. Pericolic glands and some of the mesenteric glands enlarged, soft and red.

Brain, with its membranes and vessels, healthy.

Case 3.—Albert B. Æt. 8. Admitted into the London Hospital 26th May, 1904.

The history was that he had been ailing for two weeks, with headache, feverishness, cough, wasting and loss of appetite.

On admission, no rash, coryza, whooping, cyanosis, or glandular enlargement. Pulse 120; respiration 48; temperature 103°. The thorax was rickety, respiratory recession of the intercostal spaces was present, and small bubbling rales and rhonchi were scattered over both lungs.

Heart, normal.

Abdomen slightly distended. No spots. No tenderness. Spleen palpable. Stools constipated.

Diagnosis—broncho-pneumonia.