Among English observers, up to the time that our own case occurred, this subject had received little or no attention. Saundby (2) has a brief reference to one case of bronzed diabetes observed by him, while a case of a peculiar pigmentation of the skin described by Galloway (3) may be possibly another example of this condition. But further than this we have been unable to come across any reference, either in English or American literature. Recently, however, the literature has been enriched by an article of E. L. Opie (4), in which an able discussion of the subject is added to the report of a case occurring in the practice of Dr. T. Opie of Baltimore. In this, and in a recent article by Anschütz (5), the literature and the possible etiology are so fully discussed that it will be necessary for me to do little more than to add the few facts observed by us to those already upon record. It will be seen that a study of these facts leads up to conclusions a little different from those reached by Opie, in that we cannot feel assured that hæmochromatosis is to be regarded as a morbid entity.

Clinical History.

Mary G., æt. 50, unmarried; was first admitted to the Royal Victoria Hospital, under Dr. Stewart, in July 1897. Her present illness began two years previously with symptoms pointing to gastric irritation. Gastric pain and vomiting were complained of at intervals up to the time of her admission. For upwards of ten years she had been in the habit of taking an undiluted glass or two of gin daily. Some few months previous to her admission this gin had been replaced by beer. For years also she had been in the habit of drinking a mixture of vinegar and soda, two or three times daily. She had a tuberculous family history, although she herself showed no signs of tuberculosis.

On admission she was found to be poorly nourished, with yellowish conjunctivæ, while the face, neck, and hands presented a marked discoloration. The skin of these regions had a dark bluish or slaty colour. Similar changes but less marked in degree were present, generally over the skin of the unexposed parts of the body.

There was visible pulsation in the superficial arteries, and a fairly well marked degree of general arterio-sclerosis. At the apex and over the aortic area could be heard a soft blowing systolic murmur.

There were physical signs pointing to effusion into both pleural cavities, more marked on the right side. She was troubled with cough, accompanied by the expectoration of scanty brown sputum, which under the microscope showed epithelial cells, granular material, and a few brownish flakes.

She complained of a sense of weight in the epigastrium and frequently vomited after meals. A test breakfast given showed the presence of hydrochloric and lactic acids, but not of butyric acid. The abdomen was fuller than normal, and in the epigastrium was a firm hard mass, having a rough and convex surface with well-defined borders. The movements of this mass during respiration were synchronous with those of the liver. The gall bladder could not be palpated. The spleen was found considerably enlarged, reaching to within $2\frac{1}{2}$ in. of the anterior-superior spine.

A few weeks after admission she was transferred to the surgical department of the hospital for treatment of a suppurative otitis media and mastoid abscess. Upon her return to the medical side her general nutrition was found to be considerably improved, there being a definite gain in weight and strength.