Oct. 23, temperature was 103°, pulse rapid and weak, joints still greatly swollen, pain in back no better; estimated the patient had passed more than a gallon of urine during the twenty-four hours; vomiting; pain in feet and legs worse.

Oct. 24, temperature 103½°, pulse weak; pain in back better, but feet and legs more swollen and painful; still passing unusual quantity of urine; vomiting every half hour.

Oct. 25, I first saw the patient. Temperature was 101°, pulse 140, respiration 26; anxious and wasted countenance; vomiting every twenty minutes; had retained nothing on stomach for two days. Mind was perfectly clear, although the patient had not slept for forty-eight hours. The joints of the upper extremities were red, swollen and very tender. The legs were cold, black and dead from the knees down. Mortification had attacked the right foot twenty hours before my visit, the left foot eight hours. There was no appearance of the line of demarcation; it was evident the process of mortification was still continuing higher up the limbs.

Examination of the heart showed slight increase of the normal area of dullness; apex beat normal in location. There was a loud systolic murmur heard at the apex, denoting mitral insufficiency. A musical (systolic murmur was heard at the base, pointing to aortic obstruction. The heart's action was so rapid it was with considerable difficulty that these sounds could be properly located in the cardiac revolution. There had been great dyspnœa for two days and some pain beneath the ensiform cartilage. There was plainly a serious endocarditis; whether it dated from the beginning of this attack or was a legacy of a preceding one, I had no means of determining. The patient died the next day, Oct. 26, less than a week from th date of attack.

I regret an autopsy could not be secured. It is on account of the mortification of the legs and for the purpose of finding a reasonable explanation for such an occurrence in the course of acute rheumatism that the case appears to me worth recording. Without being able to verify my diagnosis by post-mortem examination, I venture to submit that which I made at the bed-side: rheumatic endocarditis with embolism at the bifurication of the abdominal aorta.

Embolism at this point alone would explain bilateral mortification of the extremities. It may explain the deep-seated pain in the sacral region, as also the remarkable polyuria, the whole force of the heart being directed against the kidneys in consequence of the obstruction below. —Medical Sentinel.

A CASE OF IMPOTENCE—LIGATION OF THE DORSAL VEIN OF THE PENIS—FAILURE.

By Bransford Lewis, M.D., St. Louis.

X. Y. Z., American, aet. 41; married eight years. General health good: weight 175 pounds; occupation an active one, requiring out-door exercise. Never had venereal disease of any sort; never habitually dallied with women.

From his eighth to sixteenth year he practised masturbation almost daily. Between this and his twenty-first year he had pleasurable intercourse after satisfactory erection, a number of times. After that, although he often had nightly erections and emissions, he noticed that intercourse did not seem to be as completely accomplished as formerly; it was somehow a failure. But as he did not care much about it, one way or another, he simply let women alone thereafter, until he began to think of matrimony. Then he consulted a physician, who told him it would be all right after he married. This he did in 1887. So far as he was concerned, marriage proved a disastrous failure—and has been so ever since. At his first attempt at intercourse, erections were feeble and emissions premature. As this kept up, he consulted Dr. Gill, of St. Louis, who treated him comprehensively with cold douches and injections; electrical applications to th posterior urethra and the spine and tonics internally. Erec-