On consideration of the whole facts of this case, especially when read in the light of my experiences with the former case, it seemed to me extremely probable that the symptoms were almost, if not quite entirely, due to reflex disturbances from the renal mobility. My opinion was, therefore, communicated to Dr. Askew with the suggestion that the patient should enter my ward for closer observation, and, if it should seem advisable, for operative intervention. He accordingly returned shortly afterwards and was carefully watched for two or three weeks. Full consideration of the whole condition confirmed me in my opinion, and after consultation with Mr. Cotterill, the patient was transferred to his care and underwent the operation of fixation of the right kidney. In this case the result of the operation was as satisfactorily as in the previous instance: since the date of the operation the patient has manifested none of the Raynaud symptoms, and the gastric condition has very considerably improved. This is all the more gratifying inasmuch as, since being allowed to rise after the operation, the patient has gone through extremely cold weather, such as would previously have caused him very great suffering.

These two cases seem to me excellent illustrations of a variety of Raynaud's Disease having its origin in reflex disturbances, and falling into the same category as the angina pectoris vasomotoria of Landois (*) and Nothnagel (†). It may possibly be objected that mobility of the kidney is, in itself, scarcely sufficient to produce such widespread disturbances, but clinical experience has taught me that movable kidney is a fertile source of palpitation and of tachycardia, and it seems to me that there can be no doubt of its power to bring about all the vasomotor changes which are summed up under the title of Raynaud's Disease.

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*Correspondenz-Blatt der deutschen Gesettchaft fur Psychiatrie, 1866, Bd. XIII., S. 2.

†Deutsches Archy fur klinische Medizin, 1867, Bd. III., S 309.