

At the beginning of October she began to be depressed, and suffered from a violent attack of abdominal pain, with frequent vomiting after meals. The attack passed off, to recur again a fortnight later; there was a third attack the next week, and since then there have been several others. A fortnight before admission, the seizures became very frequent and violent, two or three daily. The vomiting did not recur after the first attack.

During the last two months the emaciation had been most rapid, until upon admission, on December 7th, the little patient was little more than skin and bone. The abdomen was full and slightly distended and painless upon entrance into hospital, later there was diffuse tenderness upon palpation. The bowels were regular, but slightly loose.

A diagnosis was made of tubercular peritonitis. It was worthy of note that the family history in this case was good. The father had died of a "tumor in the neck," the mother and three children were alive and healthy. While in hospital the child stated that a cow at the house had become sick some few months before, and at last ceased to give milk.

The child became weaker and yet more emaciated, and died upon the 22nd instant.

At the autopsy, the body presented the most extreme emaciation, with a petechial eruption upon the lower part of the thorax and upper half of the abdomen, and upon examination presented advanced tuberculosis. Upon opening the abdomen there were abundant signs of dry tubercular peritonitis. The omentum was adherent in several places to the walls. Scattered through it were several small hæmorrhagic spots and occasional large tubercles. In the centre of the hæmorrhagic spots miliary tubercles could frequently be detected. The coils of the small intestines were dotted over with similar petechiæ. In the serous coat of the stomach also were at least four whitish tubercular masses. In the small intestines were typical transverse tubercular ulcers which had broken down, exposing irregularly the muscular coat. The mesenteric glands were enlarged and caseous, as were also the retro-peritoneal glands.

Before passing to the consideration of the state of the stomach, Dr. Adami concluded, describing the general post-mortem appearance.

Dissecting out the thoracic duct, a tubercular mass was found in its walls opposite to the body of the sixth dorsal vertebra.

The bronchial glands were found enlarged, and some of them entirely caseous. There were small cavities, the largest the size of a brown bean, in the upper lobes of both lungs, with tubercular broncho-pneumonia, and further a condition of fairly recent dry tubercular pleurisy, the membranous adhesions being not

pale and bloodless, but of a reddish color, and removable with moderate ease. Tubercles were present in both visceral and parietal pleuræ.

There was then a condition of advanced and very generalized tuberculosis, which, from the extremely caseous state of the mesenteric glands, he was inclined to regard as having first manifested itself in connection with the alimentary tract, although it would certainly be possible to urge that the disease began in the lungs. It was easier to explain intestinal tuberculosis succeeding pulmonary than *vice versa*. It must, however, be remembered that in this case the earliest symptoms were abdominal.

The petechial eruption and hæmorrhagic condition of the omentum and the serosa of the small intestines gained an explanation by the discovery of growths of the pyococcus aureus in cultures, made from the spleen and other organs. There had been secondary infection on the day immediately preceding death.

Turning to the stomach, this was found fairly full of curdled, milky matter, and upon examination of the walls there was found, as shown by the specimen, a certain amount of post-mortem digestion, so that in one place the wall was almost eroded through. In addition, in the centre of the great curvature was an ulcer 13 mm. in diameter, with raised and irregularly thickened edges, and with a comparatively smooth base, formed of the muscular coat of the viscus. The smoothness of the base might have caused doubt as to the tubercular nature of the ulcer, but that this was truly tubercular was shown by the fact that corresponding to it in position upon the serous coat was an area of confluent tubercles.

Tuberculosis of the inner coats of the stomach was a rare condition. Why this should be when the affection was so common in the intestines it was difficult to explain, unless it was that the acid excretion of the cells of the mucosa hindered the proliferation of the tubercle bacilli, just as acids are known to hinder the growth of the microbes outside the body. This theory would help to explain the rarity of tuberculosis within the brain substance and in muscle-tissues, which also are characterized by their active development of acid substances. That there was no great lack of production of acid on the part of the gastric mucosa, as a whole, in this case was evidenced by the post-mortem digestion.

*Multiple Intestinal Anastomosis of Tubercular Origin.*—The same case exhibited no less than four fistulous communications between different portions of the gut. The uppermost of these was in the lower part of the jejunum where the opening passed between the floors of two ulcers at points distant, the one four