the history obtained was as follows: Patient's health record is good. He states that he has had intermittent fever several different times; was treated for this malady by several physicians. Like the other patient whose case has been just detailed, J. M. attributed his present troubles entirely to the results of ague. Some six months ago he was specially treated for ague; has never been in good health since then; his own account of his present illness is very vague indeed; however, about eight weeks ago he was obliged to take to bed. At that time he was feeble; had diarrhœa, chills, and cough of late. He cannot say whether the chills were of periodic occurrence or not; appetite rather poor; the tongue is red and glazed; no diarrhœa just at present; cough is slight; very little expectoration. The patient is of a sallow hue, though this is very much more marked on some days than on others; indeed, occasionally the aspect is tolerably healthy; the emaciation is considerable. The notes on the physical examination were as follows:

Lungs—Relative dulness in right side; most marked at angle of scapula behind.

V. R. and V. F. augmented on right side.

Respiration harsh and feeble; but râles are absent during ordinary respiratory efforts.

Heart—Sounds weak, but free from murmur; apex beat not defined.

Hepatic dulness extends from upper border of 6th rib, for 3 to 4 finger-breadths below the lower margin of the ribs. There seems to be a *tumour* of considerable size extending as low as umbilicus, and to the left of this point, in the form of a curve, with the convexity downwards. This tumour cannot be well defined, from the extreme rigidity of the abdominal walls; however, there is dulness over the whole right hypochondrium, epigastrium, and left hypochondrium, as indicated by the curved line referred to above. Below these points the abdomen yields a highly resonant note on percussion.

Subsequent examinations confirmed the first impressions. Flatus interfered with the percussion of the spleen. Veins of the abdomen distinct. The abdomen over the area of dulness is very tender, even on superficial examination; but deep palpitation reveals tenderness in other parts of the abdomen also.

As the course of Case 1 was given in some detail, it may suffice to outline the symptoms, with their variations, less minutely in this case. The patient was in the ward and under observation from December 18th, 1879, up to the date of his death, March 17th, 1880—three months.

The *Temperature* varied from 104° to 96½°, having been subnormal on several occasions. He had, on not a few occasions, chills, during and immediately after which the temperature rose, generally falling within twelve hours either to normal or two or three degrees. The patient was under the impression that these were fits of ague. There was, of course, the absence of the characteristic sweating and other symptoms of intermittent fever.

The *Pulse* ranged from 72 to 120 per minute, and varied with the temperature.

The patient vomited on several occasions, but *vomiting* never had been a marked symptom, nor was it such as to attract very much attention at any time. He did not vomit in all a dozen times during his three months' stay in the hospital.

Constipation, a very decided symptom in this case, was constant, yet overcome with moderate purgative doses. The stools were often scybalous, sometimes clay-coloured. The *Appetite*, till within three weeks of his death, was tolerably good, though very variable.

On admission, the *Urine* contained a trace of albumen; different examinations failed to establish the presence of casts. February 8th there was a trace of bile pigment, and an unusual amount of colouring matter.

Pain was frequently complained of in the abdomen, especially over the tumour; but this was invariably relieved by hot applications, without the use of opiates. The night before the patient expired he was thought by the nurse to be dying, and the resident physician, on going to him, found him in a state of partial collapse, from which he rallied on being given some stimulant. He died on March 17th, in clonic spasms.

During his residence in the hospital he was under the care successively of Drs. Locke, Mackelcan, Malloch, and Woolverton.

The treatment was largely expectant. Throughout the patient was given a nourishing