

progressive glandular enlargements, usually starting in the cervical region, without the blood changes of leukaemia.

(2) The growth presents a specific histological picture, not a simple hyperplasia, but changes suggesting a chronic inflammatory process.

(3) The microscopical examination is sufficient for the diagnosis. Animal inoculation may confirm the decision by its negative results.

(4) Eosinophiles are usually present in great numbers in such growths, but not invariably. Their presence strengthens the diagnosis.

(5) The pathological agent is as yet undiscovered. Tuberculosis has no direct relation to the subject.

The second subject is that of diabetes insipidus, which is ably discussed by Dr. T. B. Fletcher, a graduate of Toronto.

His conclusions are: The old classification of diabetes insipidus under the headings of hydruria, azoturia, and anazoturia is no longer tenable, the nitrogenous constituents of the urine being almost entirely dependent on the nature of the food. Diabetes insipidus comes under two classes, the primary or idiopathic, without organic basis; and the secondary or symptomatic, where there is some organic change in the nervous system or abdominal viscera, etc. Tumors involving the medulla and floor of the fourth ventricle, cerebral hæmorrhages, and basilar meningitis are the commonest organic lesions causing the disease. Syphilis appears to be a cause oftener than is supposed, most frequently by a basilar meningitis. Diabetes insipidus is a rare disease, occurring about once in every 100,000 cases of sickness. Four of the five cases gave evidence of cerebral disturbance, and the ages were 44, 32, 25, 36, and 35. They were all males. In all five cases, thirst was the first symptom to attract attention. The nature of the disease is uncertain, but there is some nervous disturbance, causing a vaso-motor derangement of the renal vessels and constant congestion of the kidneys. The most frequent changes found after death are enlargement and congestion of the kidneys. The treatment must be directed to any discoverable causes.

The article on placental transmission by Dr. Frank W. Lynch is of much interest. He concludes that the typhoid bacillus may pass from the mother to the child in utero. The resulting disease in the fetus is a septicæmia. In cases of placental transmission there are usually placental hæmorrhages. The child usually dies in utero or soon after birth. The placental transmission of infection does not always happen in typhoid fever.

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