quality of blood. In the exhaustive lectures on transfusion by Dr. William Hunter, delivered before the Royal College of Surgeons and published in the *British Medical Journal* for April last, it is clearly shown that the distressing disturbances, sometimes seen to follow transfusion, are due to capillary thrombosis, and not to any over-filling of the system with blood or too rapid injection, which are usually considered the producing causes. Why this capillary thrombosis should occur in one case or experiment and not in another is as yet not clearly understood, but everything points to the condition of the recipient's blood at the time of operation as the main factor. It is much more likely to follow the injection of blood than of saline solution, Defibrinated blood is more dangerous than ordinary blood because the proportion of the white corpuscles is much higher, and the disintegration of these and the blood plasma seems to be the immediate cause of thrombosis. Dr. Hunter lays stress on the fact that the chief value of transfusion is physical, restoring a volume of fluid to the vascular system sufficient to enable the circulation to be carried on. Blood possesses, in addition, a physiological value in its greater power of stimulating the vasomotor centres, but this advantage is more than counterbalanced by the greater difficulty and danger attending its use. Great care should be taken to see that the temperature of the solution should not be above that of the body.—*R. Worrall in Austral. Med Gaz.*

A PHENOMENAL CASE OF GASTRIC ULCER.—F. T., æt. 34, Swede laborer, good family history, enjoyed very good health until Nov. 15; from that date until the 25th he was attended by Dr. A., who diagnosed typhoid fever. For a few days he had had general malaise, then repeated chills and attacks of vomiting; a week later severe abdominal pain and tenderness, with some tympanitis. The least pressure upon the abdomen caused pain, and at the end of the second week a cough came on which caused great pain in the epigastrium.

On the 25th he fell under Dr. B's care, who diagnosed typhoid fever with a complicating right pneumonia. For a few days, until the pneumonia resolved, the fever was pretty steady and high, 104° to 104½°. There was rusty sputum, cough, and pain in side. Dec. 14th the patient was so far convalescent that the physician ceased to call. Patient was taking nourishment and gaining strength, but not out of bed, and there was no enlargement in the left side. Dec. 19th the doctor was again called, and found what he thought was an enlarged spleen. The tumor then filled the left side from the fifth rib to near the iliac crest, and across to near the mesial line, even beyond the middle line at a point above the umbilicus. The tumor, hard and non-fluctuating, projected very prominently in the left hypochondrium. It must have arisen very quickly, as the doctor was absent but four days, and the friends called him as soon as they noticed it. From Dec. 19 to Jan. 4 a pretty steady temperature of from 100 to 101, bowels constipated, and a good deal of vomiting.

Jan. 4 the patient was taken to the hospital. A prominent tumor occupied the left side, extending from the fifth rib to near the iliac crest, felt hard, but gave indistinct fluctuation. When patient lay on his back there was flatness in the axillary line from the fourth rib downwards, and the respiratory murmur, bronchial in character, was distinctly heard over the dull area, while on the right side the flatness disappeared and was replaced by hyper-resonance to near the ninth rib; bronchophony. Over the right lung vocal fremitus, bronchial breathing and bronchophony.

Diagnosis.—Enlarged spleen, with abscess and left pleurisy with effusion. The tumor became more flat under the ribs, softer, and distinctly fluctuating. On Jan. 18 he was aspirated in the 8th interspace, axillary line. First came a quantity of apparently pure blood, followed by 24 oz. of most foul pus with a fæcal odor. The patient died the following night.

Autopsy—Body moderately emaciated. A large pus cavity, with walls ¼ inch thick, was found to occupy the left side of the abdomen cavity. It was wholly infra-diaphragmatic, that organ being crowded upwards, and extending from the fourth rib to near the iliac crest. It was somewhat cone shaped, with the base directed upwards, and extended from a little past the mesial line, in the epigastric region, around to the left to near the spinal column, and still contained three quarts of dark, thin,