face, chest and lower limbs, appearance typical of chronic and very advanced valvular disease. No kidney lesion, urine normal; no cardiac lesion, but sounds loud and ringing; no murmurs; pulse regular though small; heart displaced upwards very decidedly. Liver pushed up to nipple line on right side. Tapping of abdomen done November 9th, and 130 ounces fluid removed, clear, greenish-yellow, no fibrin or flakes in it, quite non-inflammatory in character. On the 13th a second tapping withdrew 96 ounces of a similar fluid. This child was taken from the Hospital for Sick Children, and on the advice of an outside man, who is reported to have said that it was peritoneal tuberculosis, was sent in to the General Hospital, where an exploratory incision was made, and the diagnosis of cirrhosis of the liver confirmed. The omentum was anastomosed; and though the fluid at first returned I was informed some weeks after from her home that she was then doing very well, and had very little ascites, having apparently largely recovered her circulatory balance, though no one would, of course, call this a complete cure, for the organic change in the liver has gone beyond full restoration. As some one has said, we might as well say that chronic valvular lesion is cured when ruptured compensation has been temporarily restored by rest and digitalis.

Points of similarity of all these cases are: 1. Age—childhood and early adult life. 2. Sex—all three female, contrary to usual experience, 22 of a series of 26 quoted by Osler from Schachmann being males. 3. Etiology—extreme indefiniteness, also frequently seen in such cases. Alcoholism, syphilis, malaria and chronic lead or other similar intoxication can be reasonably excluded with certainty in each case, as well as valvular lesion, a very common cause of the hepatic enlargement known as mixed "nutmegging" and cirrhosis. I freely admit that in the absence of histological examination an element of uncertainty prevails, not as to the gross anatomy of the organ, but as to exact histological condition. One point in which Case 3 presents a striking difference from the other two, is in the presence of ascites and other evidence of extreme portal obstruction. Ascites is rare in such cases, but of course the rule in ordinary "portal" cirrhosis.

To turn aside for a few moments to an academical discussion of this disease, one need scarcely remind one's self of that most useful modern distinction of cirrhosis of the liver into (*a*) portal cirrhosis, (*b*) biliary cirrhosis, and (*c*) mixed cases. In portal cirrhosis the irritant, usually alcohol, reaches the organ by the vein and sets up the well known changes, development of scar tissue along the larger vessels so as to produce the multilobular or hobnailed type, or around the finer portal