widely astray. There are still a good number of conditions which stand out in large outlines to clinical experience, which are vague and dim to the morbid anatomist. Need I do more than mention acute articular rheumatism, typhus, tetanus, and epilepsy?

We may be sure that the phrase "granular kidneys," as it occurs in *post mortem* records, means something else besides the granular degeneration of Bright's disease, as practically and clinically understood. And, in fact, the kidneys do often show granular surfaces in cases which have no real claims to be classed with genuine Bright's disease. I can only speak with exactness of some of these cases. In my work on *Urinary Diseases* (second edition, p. 350), I have pointed out the confusion into which morbid anatomists have fallen in not distinguishing the granular appearance of the kidneys consequent on long sustained passive congestion of the kidneys, from the granulation due to Bright's disease. The anatomical identity of these two conditions, although generally assumed, has been denied on high authority, and clinically, they are certainly distinct.* A real combination of regurgitant heart-disease, or cirrhosis of the liver, with chronic Bright's disease, is comparatively rare; and when it exists, the renal affection never fails to vindicate its existence by its appropriate symptoms. But, as a rule, the passive renal congestion which accompanies impediments to the circulation is quite a subordinate condition, and has none of the clinical features of chronic Bright's disease. The urine is of high specific gravity and scanty, and it either contains no albumen at all, or only small quantities. The renal disorder has no progressive tendency of its own; it does not produce the special secondary effects of Bright's disease, and it oscillates in its intensity strictly with the activity of the primary disease.

There are also morbid conditions of the kidney of a temporary character, which probably leave behind them certain alterations in the cortex of the organs much resembling granulations. When we reflect how many middle-aged persons have suffered in earlier years from scarlatinal and other forms of acute renal disease—from syphilitic tubercles of the kidney, from renal gravel—how many women have suffered from renal congestion during repeated pregnancies, and yet how recovered with practically sound kidneys from all these ailments—it is scarcely a matter for wonder that the organs should, years afterwards, bear upon their surfaces irregularities, depressions, and even more or less granulation with thickening and adhesion of the capsules—not as indicating any existing disease, but, like a scar on the skin, as footprints of a bygone disorder.

LONDON DRINKING WATER.

By J. ALFRED WANKLYN, Esq., Corresponding Member of the Royal Bavarian Academy of Sciences.

THE following, which is the second of a series of monthly analyses of the London waters, is intended as a substitute for the analyses published by the Registrar-General.

COMPANIES.	Free Ammonia.*	Albuminoid Ammon.*
Kent Water Company.—Deptford Railway Station, Nov. 20..	0.01	0.02
New River.—Cab Rank, Tottenham Court Road, Nov. 21....	0.01	0.05
East London.—Cambridge Heath Gate, Dec. 3	0.01	0.18
THAMES COMPANIES.		
Chelsea Company.—Cab Rank, Horse Guards, Dec. 2.....	0.02	0.13
West Middlesex.—Cab Rank, Portland Road, Dec. 3	0.00	0.10
Southwark & Vauxhall.—Cab Rank, St. George's Road, Dec. 4	0.00	0.18
Grand Junction.—Cab Rank, Woodstock Street, Dec. 4	0.00	0.17
Lambeth.—Cab Rank, Palace Road, Dec. 2	0.00	0.16

* Parts in a Million (Milligrammes per litre).

The two first specimens of water were collected on the 20th and 21st of November, and the rest on the 2nd, 3rd, and 4th of December. The analyses have special interest, inasmuch as they exhibit the effect of continued floods on the quality of the metropolitan water-supply. As will be observed, only two of the companies have maintained the quality of their water; viz., the Kent and the New River. All the other companies have suffered in a greater or less degree. The West Middlesex has suffered only slightly. The Chelsea comes next; whilst the East London and Grand Junction Companies (which usually supply excellent water) have, during these floods, sunk to the ordinary level of the Southwark and Vauxhall and of the Lambeth Companies.

* Ferichs has pointed out that a similar confusion has arisen with regard to granulation of the liver in true cirrhosis, and granulation from congestion and other causes.

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS OF GREAT BRITAIN.

THE LONDON HOSPITAL.

SPECIAL KINDS OF FRACTURES.

(Under the care of Mr. RIVINGTON.)

Oblique Fracture of the Lower Ends of the Humerus.—Two cases of oblique fracture of the lower end of the humerus have come under Mr. Rivington's care. Each case occurred in an old man over seventy years of age. One of these patients had been shut up in a cupboard for two days before his admission into the hospital, and his arm was extensively ecchymosed from the shoulder to the elbow. The fracture extended obliquely across the humerus from a point above the inner condyle to another just below the external condyle, and crossed the olecranon fossa. Flexion and extension were not interfered with. The patient died from the effects of the injury and neglect after it, and the specimen is in the London Hospital Museum. In the second case, there was great breadth, especially when the joint was flexed; crepitus was obtainable only on grasping the arm with one hand and the forearm with the other, and moving the two parts of the limb from side to side. Flexion and extension were readily effected, as well as rotation of the radius, without eliciting crepitus. When the two condyles of the humerus were grasped and flexion made, no crepitus could be felt, because the lower fragment was then fixed in apposition with the shaft of the humerus. The inner condyle moved with the forearm, and the outer with the humerus. Hence it was concluded that the fracture extended obliquely across the humerus from above the inner condyle to a point below the external, as in the previous case.

Fracture of the External Tuberosity of the Tibia.—Mr. Evan Llewellyn, of Mile End, asked Mr. Rivington to see a patient of his who had met with an accident. She was a housekeeper, sixty years of age, had slipped off a chair while cleaning a window, and had fallen on her right knee. There was a good deal of swelling below the knee, due to effusion of blood. When the joint was extended nothing could be made out, and the fibula appeared to be uninjured. On flexing the knee-joint, however, and grasping the outer tuberosity, crepitus became apparent, that part of the tibia being moved with comparative ease. Ice was recommended to be applied in the extended position of the joint, and the patient did well. The joint swelled considerably after the first twenty-four hours, as had been predicted; but no unfavourable symptoms presented themselves throughout the progress of the case.

Compound Fracture of Frontal Bone: Recovery.—Charles Moss, aged 33, was admitted into the London Hospital, under the care of Mr. Rivington, on December 23rd, 1871. He had been kicked by a horse on the forehead, and there was a lacerated wound extending transversely from the right side above the right eyebrow to the middle of the left eyebrow. The frontal sinus was laid open on the left side, and a fracture extended upwards from that point through both tables of the bone. The finger introduced could feel the dura mater. Some loose fragments could be felt in the wound, and a piece of the orbital portion of the bone was detached. The loose pieces of the bone were removed, but the portion which formed an integral part of the orbit, and had the tendon of the superior oblique muscle attached to it, was retained. The edges of the wound were brought together with sutures for the greater part of its extent, and a piece of lint dipped in carbolic oil inserted at its left extremity. Ice was applied to the head. The temperature had risen next day to 104.5 deg. On the 25th, it was 103.5 deg., and did not fall again till the 31st, when it went down to 101 deg. There was some delirium at first, especially at night, and a great deal of purulent discharge. The eyelids both became infiltrated, so as to close the eyes completely, and the conjunctivæ became inflamed and oedematous. There were no rigors at any time. There was occasional headache. By the 2nd of January, 1872, he was much better, the eyelids were much less swollen, and the eyes had begun to clear. By the 4th, the wound had quite healed on the right side, and the eyes were nearly well. He continued to improve, and was soon able to sit up. By the end of January, he was able to leave the hospital cured.