Nor are they necessarily disease-producing from their mere presence; for example, on skin, in the mouth, or in the intestinal canal.

But, given the suitable conditions, namely, diminished resistance on the part of the tissues, or increase of dose on the side of the organisms, they are disease-producing. These are precisely the conditions brought about in long-continued necrotic and septic conditions of the mouth.

It is probably impossible to keep pus organisms out of the mouth, just as it is impossible to prevent occasional access of tubercle, typhoid, and other infective organisms. But that fact does not deter us from taking the most exhaustive precautions to keep typhoid contamination out of our water and getting into our houses; or from initiating—as is at last happily the case—measures for preventing access of tubercle bacilli, whether through air or through milk.

I confess I think it urgent, in the interests of the many sufferers from gastritis as well as in the interests of those suffering from pyogenic conditions generally, that some similar steps be taken with regard to the mouth—the chief channel of access, in my judgment, of all pyogenic infections.

We may not be able to prevent their access into the mouth any more than we can prevent them adhering to the skin. But, knowing as we now do their potential qualities, there is not the slightest reason why the mouth, so easily accessible as it is to local measures, should be made into a perfect hot-bed for their development and propagation.

In relation to the whole group of internal conditions caused by pyogenic organisms, I consider there is a wide field of preventive medicine open by the exercise of oral antisepsis, a field that can be worked in, with the most surprisingly satisfactory results, alike by the physician, surgeon, dental surgeon, and patient. And by oral antisepsis I mean no mere rinsing of the mouth with mildly astringent and antiseptic mouth washes, but (1) the direct application to the diseased tooth or inflamed gum of carbolic acid (1 in 20), repeated daily for just so long a period as the patient will persist in keeping his necrosed tooth or fang, still better (2) the removal of all diseased useless stumps (3) the most scrupulous daily sterilising by boiling of every tooth plate worn, and (4) on the part of dentists the avoidance of too much conservative dentistry and the use of contrivances like “bridges” which cannot possibly be kept aseptic.

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A CASE OF ANEURYSM OF THE ABDOMINAL AORTA POINTING POSTERIORLY IN WHICH THE INITIAL SYMPTOMS WERE THOSE OF CHRONIC COLITIS.

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THE following case, which I will first give the history of before passing any comments upon it, was a peculiarly interesting and puzzling one. The patient was under the care of Dr. Shiels, of Glasgow, to whom he had been sent for special treatment, more particularly of a dietary kind, it being supposed that he was suffering from some irritative or inflammatory disorder of the alimentary canal. Dr. Shiels, however, finding that no permanent improvement seemed to follow purely medical treatment and careful attention to diet, asked me to see him with a view to some possible surgical treatment. Our attention was drawn one morning to the appearance of a marked pulsating swelling in the back close to the spine. It was apparently quite sudden in its appearance, and a very cursory examination on our part left no doubt as to its true nature. Sudden death a few hours later, with immediate collapse of the tumour, equally left no doubt in our minds as to what had taken place.

History of Illness.—Mr. D., aged 35, an engineer by profession, had for the last eighteen months suffered from a troublesome bowel complaint. He was unable to ascribe the commencement of his illness to any par-

ticular cause. He believed he once suffered from dysentery when in Egypt. His trouble had consisted mostly in obstinate constipation, with the occasional passage of mucus in the motions. It was stated that on one occasion a mucous cast of the bowel had been passed. The small flakes of lymph that passed were on more than one occasion submitted to microscopical examination. They were found to consist of merely mucous shreds in which were entangled *débris* of granular material; neither blood nor pus cells were ever observed. Pain became in the later stages of his illness a very trying symptom. He stated that he suffered most pain in his bowels prior to the passage of accumulated masses of lymph. The administration of an enema always produced a sense of considerable soreness in the left lumbar region, if the amount introduced exceeded two pints. He further complained of more or less constant “nipping, burning pain” about the eleventh and twelfth ribs in the left axillary line, with tenderness when digital pressure was exercised over this area. His most severe pain, however, was in the region of the epigastrium, which at night so distressed him that morphine had to be given. He always felt pain if he attempted to move or sit up, and selected the almost complete prone position as that which afforded him most ease and comfort.

About twelve days after he had been under my observation, my attention was directed by Dr. Shiels to a pulsating swelling which had more or less suddenly appeared in the left lowest dorsal region close to the spine. It was about 4 inches in length and 3 inches in breadth, occupying a position in the region of the vertebral ends of the ninth, tenth, and eleventh ribs. The pulsation was as marked as if the aorta itself were exposed. The patient complained of a throbbing sensation in the swelling, and also of much discomfort from flatulence. The “wind,” he said, collected on the left side and bulged his abdomen there. This was quite evident on inspection; palpation elicited an unduly flaccid condition of the abdominal parietes, and percussion a highly tympanitic state of the bowel beneath. He now complained of pains radiating from the region of the swelling round to the front of the abdomen, and of a loss of tactile sensation. He remained in much the same condition for about twenty-four hours, when, on the nurse returning to his room after an absence for about ten minutes, she found him dead, in the same position as she left him.

The condition of the bowel supposed originally to be present was one of chronic ulceration or membranous colitis, and the surgical treatment under consideration the performance of right inguinal colostomy in order to give temporary rest to the bowel. I had, however, advised against operation on the ground that for some inexplicable reason in the contents of the bowel as removed by the daily use of water enemata no signs of bowel casts, or, indeed, of any inflammatory exudates were present.

A flood of light seemed at once to fall upon the whole history of the case when the aneurysmal swelling appeared in the back. To read the symptoms in the light of this new revelation was to make perfectly clear what had been previously most puzzling. His varied pains and complaints so mystifying to us, and sufficiently delusive to cause some of his previous medical attendants to believe he was unduly complaining, became now all perfectly explicable, as the probable results of the pressure of the aneurysm upon the various nerves, sympathetic and spinal. His obscure bowel condition, also, now seemed to receive its explanation. Pressure had been exercised by the aneurysm upon the mesenteric vessels, and so led to a chronically congested condition of the mucous membrane. When at a later stage, that is to say about the time he was under my observation, this internal pressure was beginning to be lessened by the gradual extension of the aneurysm backwards, some of the more prominent symptoms, such as the passage of flakes of lymph and mucous casts, disappeared.

The case doubtless has an interest from the point of view of an aneurysm of the abdominal aorta presenting posteriorly. Sir William Gairdner, a recognised authority on the subject of aneurysm, in reply to a question of mine on the subject, was kind enough to inform me that he could only recall one case, and that very many years ago, at all presenting features similar to the above. Let alone, therefore, the very puzzling and almost misleading character of the early symptoms, the case seems well worthy of record. It is to be regretted that there was no *post-mortem* examination, but neither Dr. Shiels nor I could persuade the friends into giving their consent. An investigation might have settled more definitely the relation of the aneurysm to the bowel and mesenteric vessels, and also the actual seat and nature of it. There was but one explanation of the sudden death, and that the internal rupture of the aneurysm. Whether this occurred into the bowel or into the general peritoneal cavity it is not possible to say.

DR. PIETRO GROCCO, Professor of Clinical Medicine in the Reale Istituto di Studi Superiori di Florence, has given 5,000 lire (£200) towards the establishment of a provincial sanatorium for poor consumptive patients belonging to Florence.