the farm, where she had been occupied for two or three weeks (I have not my original paper at hand). I asked her if when she came to the farm she had any diarrhoea, but this she denied. She assured me that during these intervening weeks she had been in good health.

At this point arose a further remarkable problem. She had fallen ill at another remote farm, where she had been working; so that unless there had been fever there our difficulty was but thrown one step backward. At this farm accordingly I had full inquiries made, and with the parallel result that there, too, typhoid fever had been unknown till this woman fell ill (whether other cases had arisen there I forget, but I think it was so). Thus, as I say, our difficulties were not solved, only pushed back a step. To cut a long story short, it turned out that to this second isolated farm, then and always before free from typhoid, had come a kinsman of the occupier, who was convalescent from the disease contracted in Liverpool. He came to the farm for country air after, as was supposed, a perfect recovery had been made.

On the basis of these observations of mine I begged Dr. Dreschfeld, when engaged upon the article on Enteric Fever for my *System of Medicine*,² to go closely into this matter, urging upon him that the bacilli survived for indefinite terms in the stools—in the stools, there was my error. Dr. Dreschfeld, with unwearied kindness, examined again and again the stools of convalescents from typhoid, but with no success in this respect. With the help of Dr. Richmond the fullest investigation was made into the alleged survival, but in vain. In the stools the bacilli certainly do not survive long into convalescence, even if until convalescence. To suspect the urine never occurred to me. The victims of the arrows of Apollo fell at our feet but we failed to see whence they came.

Dr. Hugh Walsham has been so good as to demonstrate to me that tubercle bacilli are usually excreted by the kidney without the formation of "tubercle" in the organ; and Dr. Horton-Smith and others assure us that typhoid bacilli thus excreted may come through in millions, and for a period long enough to poison a county. I repeat, then, that upon all practitioners, and medical officers of health especially, it is incumbent to see that the disinfection of the urine urged by Dr. Walker is carried out systematically in every case before the patient is allowed to mix again freely with his kind.

REFERENCE.

¹ Richardson, *Journal of Experimental Medicine*, January, 1899. ² *System of Medicine*, vol. 1, 1896, pp. 799 and 800.

ON THE EVOLUTION OF MYELOPATHIC ALBUMOSURIA.

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It is now more than three years since I first brought the subject of myelopathic albumosuria to the notice of the Royal Medical and Chirurgical Society. The disease was then unknown to the profession in this country, and only 8 clear cases were to be found recorded in the medical literature of Europe.

Since that time 7 more cases have been published, more or less fully, bringing the total up to 16. Of these I have personally examined 2, and in a third case I have been enabled to make a thorough investigation of the urine. There is one point in the clinical history of the disease which has never been determined—namely, the manner in which the albumose appears first in the urine. In all recorded cases it has been present in massive quantities, but it has never been ascertained whether it begins to appear in minimal quantities and gradually increases, or whether the onset is sudden, the maximal amount appearing almost from the first. The possibility of the latter mode of onset is suggested by what we know of the onset of pancreatic diabetes.

I have lately been consulted by a physician of eminence practising on the Continent of Europe, who is the subject of myelopathic albumosuria, and owing to exceptional circumstances it was possible to detect the abnormal condition of the urine at an early stage. As this is the first case of the disease which has been recognised as such in a country with a population of more than 50 millions, it is not surprising that the exact

condition of the urine was at first apparently not understood, the albumose being mistaken for albumen; but at the present time the reactions are highly characteristic, and apart from the symptoms which have recently become prominent, they leave no possibility of doubt as to the nature of the case.

The albumose was first observed in December, 1899, when the patient, who was then 53 years of age, had an attack of mild pneumonia. The quantity was at that time minute, but it has subsequently gone on continually increasing, and has reached a maximum of 10 parts per 1,000. Until the middle of May in the present year the patient felt no inconvenience and was able to follow his profession, but since then he has grown pale and lost flesh and strength. He has also found a soft tumour about the size of a hen's egg, in connection with one of his ribs.

The foregoing account of the case does not claim to be in any way complete, but it illustrates two important points, one of which is new.

1. The presence of the albumose in the urine is the earliest symptom of the disease, and may be observed for many months before there are any other indications of failing health, or any local signs of alterations in the skeleton.

2. If we may be permitted to generalise from the only case in which the point has been investigated, the albumose is first excreted in small amounts; but, owing to the fact that at this stage the subject of the disease does not suffer any inconvenience from it, he is not likely to consult a medical practitioner, and so the urine is generally not examined until the albumose has risen to a large amount. Its early discovery in the present instance was doubtless due to the fact that its onset closely coincided in time with an acute illness, and that the subject of it a member of our own profession.

ON SOME CASES OF HÆMORRHAGE INTO THE SKIN AND SUPRARENAL CAPSULES.

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The following four cases are apparently of sufficient rarity to justify us in putting them on record; at all events they are the first cases that have ever been noted in this hospital.

CASE I.

G. F., a male child, aged 11 months, was admitted to the East London Hospital for Children, Shadwell, on February 4th, 1901.

History.—On the day previous to admission the child was running about and playing, apparently quite well. At 9 p.m. he went to sleep, but a quarter of an hour later he woke up and vomited slightly. He was very restless all night, and on waking in the morning he did not seem at all well, and the mother noticed one or two dark spots on the back. At 7 a.m. violent diarrhoea began, the stools being very frequent, watery, and yellow-green. He did not again vomit. From this time he got rapidly worse, and at 9 a.m. was brought to the hospital. The child was a breast-fed baby, but on the day before admission he had had in addition some potato, some bread and butter, and a little toast. He had had no previous illness of any kind, and had never been vaccinated. The family history was good, but there was a slight history of rheumatism.

Condition on Admission.—The patient, who was extremely well nourished, was moribund; his eyes were half open, respirations were slow and shallow, and the pulse rapid, but scarcely perceptible. The face and lips were cyanosed and the extremities cold, though the body felt hot. All over the surface of the body there were numerous subcutaneous hæmorrhages, irregular in shape and of various sizes from a pin's head to a threepenny piece. These were most numerous on the back, where they were of a larger size than elsewhere. On the face they were small and not very numerous, and were distributed for the most part on the forehead and behind the ears. There were a few on the scalp, and they were very numerous on the upper and lower extremities. All over the chest coarse rhonchi were heard; the heart sounds were feeble; the abdomen was natural to palpation.

Death.—The patient died at 11.15 A.M., having been ill fourteen hours altogether.

Post-mortem Examination.—The body was extremely well nourished. Subcutaneous hæmorrhages were present as above described. The lungs showed some areas of emphysema and collapse, but there were no subpleural hæmorrhages. The heart was natural. The thymus was very large and natural. The stomach was natural. The Peyer's patches throughout the whole length of the small intestines were very much swollen and prominent, as in the early stage of typhoid fever, but there was no ulceration. There were a few minute petechial spots on the peritoneal surface of the bowel. The mucous membrane of the large intestine