operation the patient became somewhat childish, mania appeared, and death occurred on the twelfth day after castration.

CASE IV.—About this time my attention was called to a case in one of the large Glasgow hospitals. It had been decided to perform orchectomy for enlarged prostate with consequent distress. The operator was a surgeon of large experience, for whose skill I have the highest admiration. A few days after castration the patient exhibited acute mania and died.

CASE V.—A. M., pensioner, had suffered all the distress attending an enlarged prostate for four years, for which he had undergone much unsuccessful treatment at various hospitals. I proposed castration, explaining the dangers such an operation would incur. I castrated, and though I have noted no psychical phenomena as in former cases, thirty days have passed without appreciable mitigation of the urinary trouble.

CASE VI.—My friend and teacher Mr. H. E. Clark, of the Glasgow Royal Infirmary, having taken into account the foregoing cases, determined to try a single orchectomy on the next case that presented, to the end that he might get such partial atrophy as would alleviate symptoms at a minimum risk. The patient died, however, in a few days in a state of mental aberration.

Moreover, I am permitted to refer to a private case of Mr. Clark in which perineal section had been performed to ensure rest and drainage for the bladder. The removal of one testicle was followed by distinct mental weakness and death.

Now in all these cases the patients had been brought to the best possible state of health; some had been relieved, so far, of bladder and kidney disturbance by perineal section, all with the object of minimising the immediate and remote effects of the operation.

I know that in operations other than castration the manic condition may supervene, as, for instance, in a debilitated patient with disordered kidneys after undergoing oöphorectomy. I acknowledge what was known years ago that in some animals castration was followed by prostatic atrophy, but the subjects of such experiments were young and sex not matured. I have good reason for saying that the result—that is, dwindling of the prostate, in part or general—does not invariably follow castration. I have castrated young men for tuberculous disease of the testicle. One case I can recall in which the second testicle was removed one year after the first. This case resulted neither in prostatic atrophy nor in psychical change. Nay, but a few days since a *post-mortem* examination was held in the Glasgow Royal Infirmary on the body of a man who had been castrated five years ago; the prostate was that of unchecked virility.

Now, I consider that in the present state of our knowledge we are not justified in removing the testicles at the risk of precipitating mania or dotage. To my mind, the *post-mortem* appearances of some of the prostates have been more of a cirrhosis than a true glandular enlargement, and this would explain how the muscular fibres could not contract during micturition, and therefore failed to assist the detrusor at the end of micturition. Thus residual urine accumulated. Until the physiologists can more accurately explain the relation between prostate and testicle, show, in fact, wherein their functions become common or most nearly approximate, and until they can show the relationship between the functional group and the higher and lower nervous centres, we are not, in my opinion, justified in operating thus.

ON THE FREQUENCY OF MOVABLE KIDNEY.

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I HAVE read with much interest the successive records of the operative treatment for movable kidney. That the condition is frequently overlooked I infer from the fact that several of my cases had sought advice repeatedly for the associated symptoms and had been treated for intestinal or nervous disorders. I can call to mind 7 cases of movable kidney, of which 1 only had been previously recognised. Of the 7 cases, 1 was a male, the remainder female patients.

The male patient was 33 years of age. He was a keen otter hunter, and had been subject to frequent and prolonged immersion in water, and had also done a good deal of rough pony riding. The symptoms were mental depression and languor, flatulence, and tendency to diarrhoea. The urine contained a small quantity of albumen, varying from $\frac{1}{4}$ to $\frac{1}{5}$. The left kidney descended considerably below its normal position, and slid away in the characteristic manner when the lower end was compressed between the fingers of the two hands. The question naturally arose whether this was a case of incipient Bright's disease or of mechanically-produced albuminuria. An eminent London authority on renal (and many other) diseases decided in favour of the second alternative, and advised the continuance of the pad and belt which the patient was wearing. The symptoms generally improved; albumen was frequently absent from the urine, and the patient was mentally relieved by the knowledge that the indefinite symptoms were due to a mechanical condition and not to some mysterious disease. It is now three years and a-half since I first saw him, and I gather from his letters that the mental and bodily conditions are both more satisfactory now than then.

My first female case was an ayah travelling in Europe. She was seized with renal colic, and the attack was followed by a copious discharge of gravel. She had had one or two similar attacks previously, and the kidney was very movable. I attributed the accumulation of gravel and consequent colic to dislocation of the kidney. A pad was applied, but I have no further record of the patient. I met with another case in a young lady travelling with a trusted maid as companion. The maid had been instructed to pay as little attention as possible to the young lady's complaints. The latter called on me one day complaining of pain in the right iliac region. She had a history of recent gastric catarrh. I examined the abdomen thinking there might be some chronic perityphlitis, but instead of this I found a movable right kidney. I explained the state of things, and here again the knowledge of a mechanical cause for the train of symptoms was a source of great relief to the patient.

Recently I have met with two cases of movable kidney, both in young women and both associated with localised pain, neuralgia, and derangement of bowels. One patient has a strong family history of malignant disease, and was much relieved when I explained the cause of her symptoms. The second had vague ideas of incipient something, and was glad to know that even if the symptoms were progressive there was a fairly certain means of permanent cure.

The following considerations seem to me worthy of attention: 1. That though the individual symptoms, namely, localised pain, mental depression, neuralgia, and intestinal irregularity are indefinite, yet, when associated, they form a fairly characteristic clinical picture. 2. That the pain is often not in the kidney itself, but in the structures irritated by its abnormal mobility, of which the genito-crural nerve appears to be an important one, and may possibly be the afferent tract where reflex neuralgia is a prominent symptom. 3. All my female cases (possibly excepting the ayah) were nulliparous women, and I have been unable to trace any causal relationship with tight lacing. On the other hand, four of the cases occurred in patients who had indulged in violent exercise, such as running down the Righi to Viznau, donkey-riding, pony-riding, and pedestrianism generally. 4. What treatment short of operative interference is likely to lead to permanent relief or cure? The prospect of wearing a pad indefinitely is not satisfactory; to forbid exercise is paving the way to troubles innumerable, and to treat symptoms is to beg the question of treatment altogether. Recently, I have prescribed exercises with a view to strengthening the lumbar and abdominal muscles, together with a liberal diet and appropriate treatment of the digestive organs.

PRESENTATION.—Dr. Tomory has been presented with a purse of sovereigns as a mark of the great respect and esteem in which he is held as a medical officer in Halkirk and the surrounding districts.

A LABORATORY for the preparation of antitoxin is being fitted up in the Willard Parker Hospital by the New York City Board of Health at a cost of 5,000 dollars (£1,000).