subnormal, she was covered with cold sweat, and almost pulseless. Vomiting had ceased; pain was less. Her mental condition was perfectly clear, and she was able to answer all questions accurately and without hesitation. She was unable to assign any cause for her sudden illness, and was positive that she had never suffered from indigestion or vomiting previously. There was no jaundice. Her bowels had not moved since noon the day before, but up to that time had been regular.

Within two hours of her admission Professors Purser and Ball held a consultation, and decided that her condition was such as to negative operative interference.

She died the following morning at about 6 A.M. Her entire illness had lasted only 42 hours. The *post-mortem* record reads as follows:—"The body was well nourished and fat. The adipose tissue on the abdominal wall was very thick. The great omentum was loaded with fat, and adherent in several places to the pelvic peritoneum. There was slight peritonitis, lymph slightly glueing the coils of small intestine together. The large intestine was intensely injected in places, the descending colon more particularly being, about the splenic flexure, of very dark colour. On its peritoneal surface it showed numerous dark-coloured hæmorrhages. The cæcum and appendix were not involved.

"The chief and most marked focus of inflammation was about the head of the pancreas. The pancreas itself was intensely injected, and enlarged evidently by inflammatory changes. The gall-bladder and common bile-duct contained a large number of whitish faceted gall-stones. One of these was found projecting into the lumen of the duodenum. They were about the size of peas, and contained a dark nucleus.

"The whole gut was distended with gas. There was no perforation or ulceration of the gut, gall-bladder, or ducts, or of the urinary bladder. A very little reddish-coloured fluid was in the peritoneum of the pelvis. The upper surface of the liver only showed signs of old peritonitis. The ovaries and Fallopian tubes were prolapsed into Douglas's pouch; the fimbriated ends of the tubes were closed.

"The rectum opened showed a pucker where an old adhesion had formed between the left Fallopian tube and the rectal wall; the tube was acutely bent in itself. There was no obstruction to the lumen of the gut." The thoracic organs and kidneys were healthy. I have no note or recollection, I am sorry to say, of the condition of the spleen.

The points of similarity between this case and that so fully recorded by Dr. Cayley are so remarkable that, though there are some points of difference, they are so small as to leave no doubt in my mind that this case was also one of acute pancreatitis.

The presence of gall-stones, though no pancreatic calculi were found, is of interest in connection with Dr. Fitz's opinion that the disease is to be regarded as an acute infective inflammation, the "starting-point of which is some inflammation of the stomach and duodenum." The fact that one of the gall-stones protruded into the duodenum in itself suggests that though no gross duodenitis or inflammation of the common bile-duct was present, quite sufficient lesion may have been caused by the stone to allow of the entrance of "infective agents" to the pancreas through its duct.

So far as diagnosis was concerned I did not feel satisfied at the time that the gall-stones alone were sufficient to account for the rapidly fatal illness. Had she given a history of "gall-stone attacks" it might have led to a diagnosis of ruptured gall-bladder or duct; I should certainly not have thought of acute pancreatitis. I have to thank Professor Purser for kind permission to make use of these notes.

A CASE ILLUSTRATING THE RAPID INFLUENCE OF DIETING IN GLYCOSURIA.

By BERTRAM THORNTON, M.R.C.S., L.R.C.P.,
Surgeon, Royal National Hospital for Scrofula, Margate.

THE following notes on a case of glycosuria are, perhaps, worthy of record on account of the amount of sugar in the urine and the unusually rapid improvement by appropriate diet.

On March 5th, 1896, Mrs. T., aged 64, consulted me, complaining of intense thirst, polyuria, muscular weakness, rapid wasting, constipation, and generally of symptoms suggesting diabetes. She was unable to assign any cause for the condition or even to give an approximate date as to the beginning of her indisposition, but I was led to believe that her symptoms had existed in gradually increasing intensity for at least five or six months. Her history and usual diet presented no special features.

On examining her urine I found that the specific gravity was 1045, and that it contained a large quantity of sugar; on submitting it to a skilled analytical chemist, he reported to me that it contained 43 grains of sugar to the ounce. I might add that from careful inquiries of the patient it was clear to me that the urine examined had no accidental addition of sugar.

I ordered a strict diabetic diet (Seegen's and Sir W. Roberts's, as described in Burney Yeo's *Manual of Medical Treatment*); this dietary was at once adopted and intelligently adhered to by the patient.

A week later the urine was examined again, and the chemist reported that the specific gravity was 1020, and that there was no sugar, but that it contained an equivalent of 1 per 1,000 of dried albumin. The general symptoms were better, but the patient complained of symptoms of defective visual accommodation.

A week later (March 19th) the specific gravity of the urine was 1016, and it contained no sugar.

Without going into details it may be stated that the urine has been examined from time to time since this date, and that it has contained no sugar, and has been otherwise normal, with the exception of a steadily diminishing amount of albumin.

The patient's general health has improved in every respect, and it may now be considered normal. The ocular symptoms have practically disappeared.

For the first month the diabetic dietary was strictly adhered to; by degrees sugar-forming foods have been added till at the present time the patient is practically taking ordinary diet. The only drug treatment has been a mixture of bismuth, bicarbonate of potash, and hydrocyanic acid. The amount of urine passed *per diem* as measured by the patient from March 5th onward never exceeded two pints. Time alone will show whether the glycosuria will return; the interest of the cases lies in the fact that a strict diabetic dietary reduced the quantity of sugar in the urine from 43 grains to the ounce to *nil* in one week.

COAL GAS POISONING.

By ARTHUR T. JONES, M.R.C.S.ENG., L.R.C.P.LOND.,
Assistant Surgeon Albion Merthyr Collieries, Ctf. mydd, South Wales.

HAVING read with interest the discussion on the pathology of coal gas poisoning, as I have had two cases recently I thought it would be interesting to record them.

On September 18th I was called to a house about 1 o'clock in the afternoon, where two persons had been found in bed, one apparently dead, and the other in a critical condition. The two persons, one a woman 33 years of age and the other a girl, 11 years of age, had been sleeping together. It being a business establishment, and the shop not being opened, suspicion was aroused, and an entrance was forced, and the two persons found as stated. I was immediately sent for, and on arrival, the first thing observed in the room was a powerful odour of gas. The elder person was dead and lay on the bed with lips somewhat cyanosed, but otherwise the features were calm, as if the person was in a natural sleep.

The girl was at once removed from the room to a larger room on the ground floor, with plenty of fresh air passing through. She was deeply comatose, and could not be roused at all, the lips were cyanosed, the arms and legs quite flaccid, respirations very shallow, pulse very small and rapid (140 to the minute); urine was passed unconsciously. Artificial respiration was at once resorted to, and 5 minims of ether were given hypodermically. After about three-quarters of an hour she could be roused by shouting, but very soon fell off again