changes which, I think, take place when the abdominal cavity has been filled with fluid or an ovarian tumour.

The result of my treatment in this case will encourage me to attempt, at some future date, a repetition of the operation. I may mention that I have under my care several patients who are troubled with symptoms of displaced cartilage or growth in the joint, which are constantly slipping or getting pinched between the ends of the bone, thus causing pain and crippling them. I intend, therefore, if I find no improvement after a fair trial, say six months, to open their joints, and remove a fringe or fix a cartilage; and, by so doing, I shall hope to rid them of pain, discomfort, and inability to use the limb.

P.S.—The patient wrote to me on April 16th, 1888 (seven months after the operation), saying he continued quite well.

AN UNUSUAL CASE OF HÆMATURIA.

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THE following case is so unique in my experience that I venture to place it before the profession.

On September 11th, 1887, I was asked to see, in consultation with Dr. Campbell, of Newcastle-upon-Tyne, Miss L. B., aged 11, a pale, emaciated young lady, who for a month had been suffering from hæmaturia, accompanied by high temperature. I was told that when an infant she had suffered from some illness, which had been followed by general desquamation, but whether it was scarlet fever the parents could not say. A few years after this she had measles, and soon after this whooping-cough. A year ago she had a slight attack of hæmaturia, the cause of which was never properly understood. Her recovery was slow, and although the temperature was not taken by the medical gentleman then in attendance, the mother states that the patient was decidedly feverish, particularly towards evening. Ultimately she made a good recovery.

Whilst spending last summer at Cullercoats along with her family, her brother took ill and was brought home only to develop and pass through a very severe attack of typhoid fever. When Dr. Campbell and I met in consultation the boy was convalescent; it was the thirty-second day of the fever. Five days after the illness of this brother was distinctly recognised as typhoid fever our patient had become feverish, and hæmaturia suddenly made its appearance. The temperature ranged from 101° to 103°. Hæmaturia had persisted without any intermission from the commencement of the feverish attack. At times the urine was deep black in colour; it was always plentiful, had a specific gravity about the normal, and was acid in reaction. It was passed without pain, never contained clot, never pus cells or tube casts, but numerous blood cells. A few days before I saw her, vomiting had set in, always coming on immediately after eating, and without pain. Bowels were natural; there was slight cough, no expectoration.

When I saw her she was very ill, much reduced from the fever and vomiting; her tongue was moist and creamy; she was sleepy and seemed heavy and apathetic; pulse from 120 to 124, and it had remained at this all through her illness. Small moist musical *râles* were heard all over the lower part of the chest; the base of the right lung was rather dull on percussion. The heart's sounds were healthy; liver dulness normal; splenic dulness slightly increased. There was no tumour or increased dulness detected over the region of either kidney, but a degree of pain was experienced when the right kidney was tilted forward. The abdomen was flat, no spots were seen in the skin, no fluid was detected in the peritoneal cavity, no œdema of face, feet, or hands existed. A record of the temperature was unfortunately not kept at first, but on the evening before I saw her it was 104°. From September 2nd to the 18th, the evening temperature generally registered 1° to 3° higher than the morning; the evening temperature being 103° or 104°, whilst the morning was 101° or 102°.

On September 19th the morning temperature suddenly fell from 103° to 99.2°, and whilst on this evening the temperature rose to 100.2°, it never again did so. The morning and evening temperatures were for the future pretty nearly equal, never being higher than 99°.

All sorts of medicines had been tried, iron, gallic acid, quinine, ergot, ergotin, in the view that the hæmaturia might be in some way or other associated with a specific fever. Sulphur, carbonate of soda, and quinine were given, but all without avail.

After the sudden fall of the temperature on September 19th, blood never appeared in the urine, and the patient had a convalescence which was quite uninterrupted.

Now here was a case of hæmaturia which began with high temperature quite suddenly; both continued for thirty-five days, the high temperature and the hæmaturia each being quite uninfluenced by drugs; then a sudden fall of the temperature occurred, also a cessation of the hæmorrhage, both followed by cure. What was the hæmaturia symptomatic of? There was nothing to suggest stone in the kidney or in the bladder, no enlargement of the kidney pointing to cancer, no history of hæmophilia, no purpura hæmorrhagica, no Bright's disease. The diagnosis, in my opinion, lay between tubercular disease and some peculiar blood condition; and we eliminated the former partly by the good family history we obtained, and the absence of any diseased condition of the lung which we could definitely regard as tubercular; the few *râles* which we heard in the chest had not been of two days' duration. From the sudden onset of the illness and the high temperature, the continuation of the high temperature and hæmaturia as associated conditions of thirty-five days, the distinct evening exacerbations, their refusal to be influenced by medicines, the enlargement of the spleen, the contemporaneous illness of the brother, and that illness unmistakably typhoid fever, and the fact that brother and sister had been living under identical conditions at Cullercoats, the one taking ill five days before the other; all these led us to regard the hæmaturia as specific, or, in other words, that our patient was also suffering from typhoid fever. Am I right in even suggesting this? All our textbooks speak of the relationship. In scarlet fever we have an illustration of how a poison known to act principally upon the skin and the tonsils may yet attack the glands in the wall of the intestine and the kidney; for as early as the second or third day of the fever the kidney *post mortem* has been found to be the seat of an interstitial or a glomerulo-nephritis. Besides, in typhoid fever itself, is it not the case that while the glands in the lower part of the wall of the ileum are the seats usually selected by the poison, there yet occurs every now and then an inflammation of the lungs with all the physical signs of a pneumonia, a pneumonia difficult to explain as regards its causation and relationship to the typhoid fever, and yet at other times so acute and so severe as to mask the other signs of typhoid fever, of which it is after all but the local expression? I am inclined to think that in our case the kidneys had to bear the brunt of the poison, or as the result of the poisoned condition of the blood, the walls of the renal vessels allowed the blood to escape. If so, then I trust I have made good my claim to this case of hæmaturia being regarded as quite an unusual one.

WOLFFBERG'S COLOUR-TEST.

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BY the employment of this test Dr. Wolffberg (*Klin. Monatsbl.*, p. 359, 1886) claims to have discovered a simple method of telling in a given case whether defective vision is caused by refractive errors or by defect of the light-sense. He employs two discs placed on a background of black velvet; the one is red, 2 millimètres in diameter (R^2), and the other blue, and 7 millimètres in diameter (Bl^7); if the vision is less than $\frac{1}{5}$ larger, red and blue discs are used. By comparing the distances at which these discs are recognised by the eye under examination, with the degree of visual defect, as ascertained by Snellen's types, Wolffberg believes that he is able to tell whether the defective vision is due to an error of refraction. An eye which reads $\frac{1}{5}$ should see the discs at 5.5 mètres; if this be not the case, he concludes that it is suffering from some affection, other than a refractive error, which is likely to affect the light-sense.

If vision be impaired by simple ametropia, the discs should be seen with each degree of vision at a certain constant distance from the eye. Wolffberg believes that he has ascertained these distances by experiment, and he has constructed a table from which can be seen at a glance the distance at which the discs ought to be recognised with each degree of vision. If the defective vision be caused by defect of the light-sense—which is supposed to influence colour-vision more than form-sense—the distances at which the discs will be seen will correspond to constant distances,