Further Experimentation on Animals with a Monilia commonly found in Sprue. By Bailey K. Ashford (American Journal of Medical Sciences, April, 1916).—The author makes the following observations on the results of his experimental work:—

1. The species of monilia recovered by him from nearly one hundred cases of sprue is apparently new, and is pathogenic for laboratory animals (guinea-pig, white rat, rabbit, monkey) by hypodermic inoculation.

2. The species, which he calls for the present monilia $x$, is ordinarily a low virulence organism.

3. When recovered from a patient with sprue and promptly injected into certain laboratory animals, it generally produces their death from a mycotic septicemia.

4. When grown for a long time, and frequently transplanted, it seems partially or completely to lose its virulence.

5. This virulence may be recovered by passage through susceptible animals, and even reach such a point as to sicken or kill these animals by continued feeding.

6. Usually an animal may not be killed by feeding on monilia $x$ until its virulence has been increased by passage.

7. In such animals the symptoms depend on the part of the intestinal tube most affected.

8. A certain number of animals exposed by feeding rapidly die of a monilia septicemia believed by the author to be due to a sudden primary pneumonia and secondary septicemia.

9. Other animals die more slowly from what seems to be a toxin developed in the intestinal canal by a localisation of these monilia.

10. Feeding experiments have produced stomatitis on two occasions, and severe and long-continued diarrhoea on several occasions.

11. Monilia septicæmia causes the necrotic areas in organs described macroscopically as "white spots." Such organs are highly congested, dark red, and friable.

12. Localised in the skin, typical blastomycotic ulcers are formed. If an
internal organ be attacked, large colonies of monilia are seen which look like emboli. The author has never seen pus produced by monilia.

13. In one guinea-pig with severe stomatitis sections of the affected zone showed monilia in the midst of the muscular bundles below the sub-epithelial connective tissue. This may explain the tendency for sprue to recur after an apparent dietetic cure.

14. In experimental animals in which mycotic septicæmia is induced by intraperitoneal injection, the lungs are most grossly affected, and after them the kidneys.—Archd. W. Harrington.

Congenital and Acquired Enuresis from Spinal Lesion—
(a) Myelodysplasia, (b) Stretching of the Cauda Equina. By William G. Spiller, M.D. (American Journal of the Medical Sciences, April, 1916).—Under the name of myelodysplasia, Fuchs, in 1909, described anomalies of development and enuresis nocturna, associated often with spina bifida occulta, and depending on imperfect development of the lower part of the cord. The important features of this condition are:

1. Weakness of the sphincters, and especially enuresis nocturna, persisting after puberty.
2. Syndactylism between the second and third toes; more rarely between the second, third, and fourth toes; still more rarely between the other toes; usually bilateral.
3. Disturbances of sensation, chiefly of temperature sensation, not strictly radicular in type, especially in the feet, and more frequently only in the toes.
4. Defect of the sacral canal recognised by the Roentgen rays.
5. Anomalies of cutaneous and tendon reflexes in the abdomen and lower limbs.
6. Defects in the feet in many cases (pes planus, varus, valgus), sometimes with peroneus weakness; also, trophic and vasomotor disturbances in the toes.

Other anomalies to be looked for are hypertrichosis of the sacral region, lipoma in the coccygeal region, asymmetry of the rima ani, forca coccygea or fistula-like depression of the sacro-coccygeal region.

Saenger, since the report made by Fuchs, has examined every case of enuresis nocturna by x-rays, but has found only one in which myelodysplasia existed. Three cases recently reported by Bonorino-Udaondo and Castex all showed nocturnal enuresis, skeletal malformations, infantilism, ogival palate, cephalo-facial hypertrichosis, syndactylism, and sensory disturbances in the big toes.

It is important to remember that the enuresis of older children and adults, not necessarily merely nocturnal, may be a sign of spina bifida occulta, and may exist with but few signs of this defect. If such a defect be discovered by x-rays, it should warrant the physician in assuming that much exercise of the lower limbs might be followed by paralysis in the peroneal nerve supply.

Spiller describes three cases in this paper. The first was a case of pronounced spina bifida, aged 18, with enuresis and other symptoms increased by violent exercise. The second was a boy of 14 years who had spina bifida occulta, with enuresis and other symptoms developing after moderate exercise. The third case illustrates how disturbance of micturition may be acquired by stretching the cauda equina in bending the trunk far forward on the lower limbs. In such a position the lower roots are severely stretched. The patient was injured by an elevator descending upon him while he was working in a stooping position.
Difficulty in retaining the urine and faeces began soon after the accident, and persisted one year. The condition is now much improved. There is some sexual disturbance, the Achilles jerks are lost, the right knee-jerk is impaired, and the left a little exaggerated. Sensation is normal.

—Archd. W. Harrington.

OBSTETRICS AND GYNAECOLOGY.

Viscera from a Fatal Case of Eclampsia. By W. Gilliat (Proc. Roy. Soc. Med., 6th May, 1915).—The patient was a young primigravida at the twenty-eighth week. On admission to hospital she had had twenty-eight fits, and had received chloroform and saline injections. The urine, which was scanty, solidified on boiling. The chloroform was stopped and morphia was administered without any improvement in the patient's condition. Two hours later she was still unconscious, the fits now numbered about forty, and there was no sign of labour; Cesarean section was accordingly performed, and the uterine wound was allowed to bleed freely; two pints of saline solution were left in the abdomen. The patient never regained consciousness nor did she secrete urine, though diuretin was administered per rectum, and she died fifty hours later. At the autopsy, sixteen hours after death, the liver was found markedly affected; there were numerous small subcapsular haemorrhages throughout, and a larger one on the under surface; there were similar haemorrhages throughout the organ, and microscopic examination showed that almost as much of the liver substance was degenerate as remained normal. The changes in the cells varied from irregularity of shape to absolute necrosis and disappearance of the nuclei; the vessels were not thrombosed. Both kidneys were slightly enlarged and congested, and the epithelium of the convoluted tubules was found microscopically to be swollen. In the brain a large subarachnoid haemorrhage was found over the whole left frontal lobe and a small one over the right pre-Rolandic convolution. There were extensive perforations on both walls of the stomach; these were of large size without thickening of the edges, and in some places the ulceration did not extend through all the coats. This is characteristic of post-mortem digestion, first described by John Hunter, but it is unusual to find so extensive a digestion of the anterior wall of the stomach, and Dr. Gilliat has been unable to find any such case recorded.—E. H. Lawrence Oliphant.

Condition of the Larynx and Trachea in Still-born Infants and its Bearing on Artificial Respiration. By E. A. Barton (Proc. Roy. Soc. Med., 1st July, 1915).—Examinations of the bodies of still-born children show that, in the majority of cases, the glottis is closed, and for about one-third of an inch below it the trachea is funnel-shaped, narrowing downwards till a point is reached where the points of the cartilaginous rings are bent forward so as to close the lumen. The structure is such that with the folding in of the muscular wall any muscular contraction tends to open the trachea. In the cases where this flattening of the lumen of the trachea does not obtain, it is probable that the infant has made an attempt at inspiration. If this description be accurate it is obvious that artificial respiration as usually carried out is useless. Intubation entails a very real risk of lacerating the cords, and Dr. Barton has