be separated easily from the surrounding brain substance. The latter is not invaded. The third and lateral ventricles of the brain are very much distended from the pressure of accumulated cerebro-spinal fluid. On microscopic examination the tumour showed the characteristics of a cliosarcoma which had undergone cystic degeneration. Very little infiltration of the surrounding brain substance was seen. In a section stained by Van Giesen's method the fibrous tissue of the tumour was seen to be rather scanty in amount, and the walls of the blood-vessels showed signs of degeneration.

The following seem to be the points of interest exhibited by the above case :—At one time there was a suspicion that the true explanation might be general paralysis of the insane. This was based on the presence of slurring speech, sluggish pupils, seizures and stertor, coupled with bladder and rectal troubles. The absence of any specific history of any tremor of the tongue or lips, and the presence of well-marked papillitis, caused the abandonment of this idea. The classical features of brain tremor, headache, vomiting and optic neuritis, all appeared during the course of the case, though they were not all present at the same time. Attention was directed to the cerebellum as the site of disease by the following considerations. There was absolute inability to stand, and yet coordinated movements were tolerably carried out when the patient was prone. Nystagmus was present and the knee jerks retained, both signs described in pure cerebellar lesions, while the cerebral cortex was apparently sound, as there was no actual paralysis except of the sphincters, and the patient's intellect, though usually dulled, was fairly good at intervals. This condition could hardly have occurred in the presence of any gross lesion of the intellectual or motor areas of the cerebellum. Two points which might have been expected to occur never actually did so: Glycosuria and hyperpyrexia, due to injury to the medulla. Other signs of injury in that locality, presumably due to pressure, did occur. These were: The speech affection due to the involvement of the hypoglossal nucleus, and the paresis of palate and pharynx, and the stertor.

AN UNUSUAL CASE OF FEVER.

By Major T. B. BEACH.
Royal Army Medical Corps.

Corporal M., Army Service Corps, aged 23, service five years, was admitted to the Military Hospital, Chatham, on December 11th, 1906.

On admission he complained of slight headache and muscular pains, and his temperature was 100·6° F., rising to 105° F. the same evening. At this time a good many cases of influenza were being admitted, and it was thought that he was probably suffering from that disease, as he showed no symptoms of pneumonia or other acute illness. But the course

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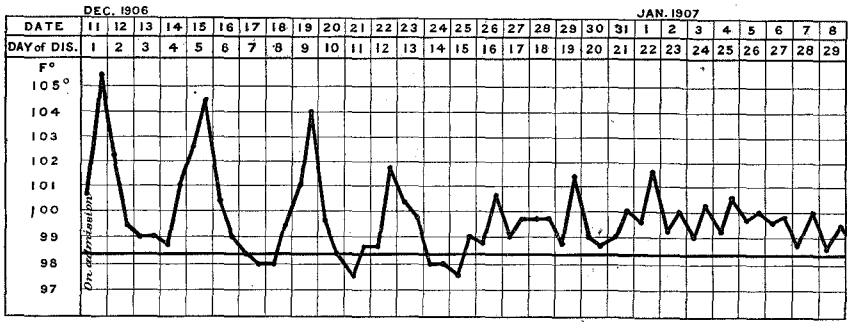
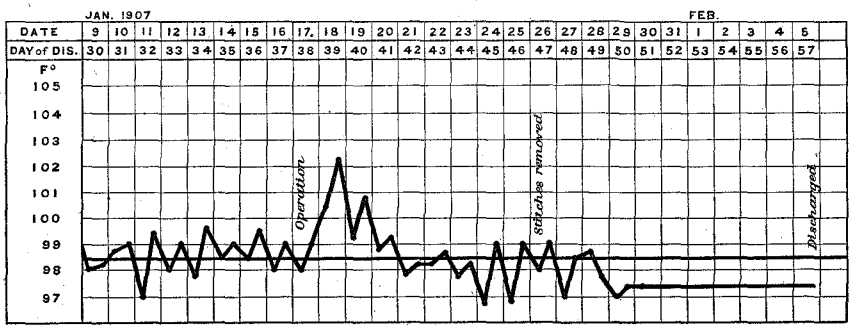
of the temperature soon showed that he was not suffering from influenza. As may be seen in the chart, it ran a markedly periodic course, with an interval of three days between the gradually decreasing exacerbations of fever. Malarial infection was naturally thought of, but the man had never been abroad, and it could not be made out that he had been brought in contact with mosquitoes at home. Moreover, his blood, on examination, was found to be quite free from malarial parasites. On further examination the blood serum was not found to react to enteric or Malta fever. As the leucocytes were relatively increased, search was made for any source of suppuration, but none could be found in the liver or elsewhere.





Except for ordinary febrile malaise during the exacerbations, the man seemed in perfect health, with a clean tongue and a good appetite. Thoughout the illness he remained strong and well nourished.

He was given quinine in large doses, and also arsenic and iron, but none of these drugs appeared to have any marked effect on the disease.

It had been noticed that there was a mass of enlarged glands in the left groin. The enlargement was quite indolent and painless. He denied any venereal disease, and there was no record of any on his medical history sheet, nor any signs of such about him. He attributed the glandular enlargement to a strain while riding. In the absence of any

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other visible cause for his fever, it was decided to remove these glands, although they were not suppurating or giving rise to any discomfort. Two large glands were accordingly enucleated. They were both hard and fibrous, and each about the size of a pigeon's egg. One was very deeply seated near the external abdominal ring, and was removed with some difficulty. The wound was stitched up and healed by first intention. The little operation was done under local anæsthesia with eucaine and adrenalin, with absolute freedom from pain. On section the glands were found to be hard and fibrous, and there were no signs of breaking down of tissue in them. There was a rise of temperature on the day following the operation; this soon subsided, and he was sent on a month's sick furlough on February 5th quite free from all fever.

Apparently the two enlarged glands were the cause of the unusual type of fever in this case, as no other cause could be found, and the fever ceased soon after their removal. This case seems to be of interest, as such a type of fever is not often seen in cases of non-suppurating lymphatic glands.

The blood examinations were very kindly carried out for me by Lieutenant-Colonel Cecil Birt, R.A.M.C., at Millbank.

A CASE OF ACUTE GENERAL PERITONITIS FOLLOWING ENTERIC FEVER; OPERATION; RECOVERY.

By Major F. E. GUNTER and Captain G. F. SHEEHAN.
Royal Army Medical Corps.

Private D., 19th Hussars, aged 19, service one year and three months, was admitted into the Military Hospital, Curragh Camp, August 21st, 1906, with symptoms pointing to enteric fever. The diagnosis was subsequently confirmed by Widal's test. He had a very severe attack followed by a relapse in November, from which he had more or less recovered by the end of the month, and he continued to do well until December 27th, his temperature having been normal for nearly a month. That day his morning temperature was 99° F., and his evening temperature 100·2° F. Pulse full and strong. He was constipated, so he was given a simple enema, as a result of which he passed a large motion.

Next morning, December 28th, his temperature was normal, and he felt much better. On that evening, at 7 p.m., he complained of acute pain all over the abdomen. Tongue slightly coated; knees drawn up; temperature 101·4° F.; pulse 104, regular and strong. On examining the abdomen it was found to be tense and tender, the tenderness being more marked about the right iliac fossa. Fomentations were applied to the abdomen. No morphia was given. At 11.30 p.m. the orderly officer, Lieutenant C. J. Wyatt, R.A.M.C., came over to the mess and told us that Private D. was suffering from signs of general peritonitis, and that

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