weaker the patient becomes, the more rapidly the disease progresses.

Now to consider the condition of gout proper as contrasted with rheumatic affections. Gout, or as it is generally considered the "gouty diathesis," most commonly develops in patients of middle age onwards, although it is not unknown to occur even in young adults. It is most common in males, and is undoubtedly an hereditary disease.

There are two forms of gout recognised :—

(*a*) *Typical gout* (*podagra*), in which sudden attacks occur with very severe and acute symptoms, and

(*b*) *Atypical gout*, a more or less chronic condition, with swellings around various joints containing deposits of uric acid in the form of urates accompanied with pains of a fleeting nature, and often complicated with a tendency to gall-stones, gravel in the urine, stone in the kidney and general liathiasis.

In all these cases, *i.e.*, in both typical and atypical gout, the patients have an excess of uric acid in the blood, but before we consider the pathology of the condition I will describe the two classes more fully.

(*a*) Podagra is the name given to an acute attack of typical gout. A patient, usually a male over 40 years of age, will suddenly be seized with a very severe pain in the big toe joint of one (generally) or in both feet. The attack usually comes on early in the morning, the patient waking up with a most exquisite pain. Previous to the attack he may have been in perfect health, going to bed quite well, so that these attacks are, you will gather, very sudden in their onset.

The patient may or may not have been indulging too freely in over-eating, or possibly it may come on after taking a large amount of rich wine—port or champagne.

The big toe joint becomes rapidly very tender, red, swollen, and the skin over the joint glossy and shining. If the patient will allow you to touch the joint, pressure, even slight, will cause paleness which immediately shows up pink or red when the pressure is released.

The whole foot may, and probably will, become swollen, and the pain in the big toe joint is extremely severe.

During the day the pain usually subsides somewhat, only to recur the following night, and even with prompt treatment the attack will last for several days, gradually subsiding and leaving the patient as well, if not better, than he felt before the attack. During such an attack there is some pyrexia, the temperature rising generally over 100 degrees at night, the tongue is furred, there is constipation, and the urine is thick, scanty and red in colour—loaded with urates and uric acid. The patient is irritable, depressed, and cannot even bear the bedclothes on the affected foot.

When mentioning the actual condition of the blood and urine later on I will draw your attention to the fact that the urine during an acute attack of podagra, as described, is loaded with urates, so that the patient loses a great deal of uric acid while suffering from his febrile and painful condition.

Before passing on to the consideration of the more chronic forms of *atypical gout*, it may be well to mention the treatment for such an attack as described. The patient should be kept in bed, with the painful foot elevated and a cradle around the limb to keep off the weight of the bedclothes. A free purge is given such as calomel, low diet free from proteids, while diuresis is induced by copious drinks of water, barley water and piperazine—the latter, I believe, certainly helps to eliminate uric acid, as it appears to act as a solvent. Colchicum in large doses for the first few days relieves the pain and helps greatly to minimise the symptoms. It is a very old but still reliable drug treatment. The pain is so severe for the first night or two that opiates are generally necessary to combat the insomnia and restlessness.

Now such an attack of gout is very easy to recognise, especially when it occurs in a man over middle age, who appears to be an individual who has always fed himself well, and who is not a teetotaler. There is generally a history of previous attacks, and the appearance of the big toe joint is so typical that there is no doubt you are dealing with the true typical podagra or gout.

When we come, however, to consider the more chronic cases of atypical gout the diagnosis is not so easy, and unfortunately numerous vague symptoms of varying character—as fleeting pains in the legs, in the body, the head, attacks of neuralgia and migraine, and gastric disturbances—are often called gout, simply because no other diagnosis can be made.

Very serious diagnostic errors in this direction are of common occurrence. The great majority of symptoms that are frequently grouped under the name of gout are really due to the rheumatic disease.

They are really masked forms of articular rheumatism, and like the latter can be relieved or cured by salicylates and by the removal, if known, of the septic focus.

Now, you will understand how very important it is for one to endeavour to make a correct diagnosis, for if the diagnosis of gout is made in error the patient is put on a rigid and strict diet, is given treatment both depressing and weakening, so that his general health must suffer, while at the same time the best period for proper treatment is sacrificed.

A rheumatic neuritis, or fibrositis—*i.e.*, a rheumatic inflammation of the fibrous tissue around a joint or in the tendons of muscles—which could have been relieved within a few days by salicylates, may drag on for weeks or even months if such a case be treated by an anti-gout diet, by exhausting baths, and by massage. I need hardly warn you that massage, which we all consider of such enormous benefit in chronic a-febrile cases, may do a great deal of harm if misapplied to acute inflammatory lesions.

(*To be concluded.*)

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