bladder in contra-distinction to other diseases of the bladder, such as diphtheria and cystitis, which are also a kind of necrosis.

Stated Meeting, May 1st, 1891.

F. J. SHEPHERD, M. D., PRESIDENT, IN THE CHAIR.

Dr. G. G. Campbell was elected a member of the Society.

Multiple Epithelioma of Œsophagus and Stomach.—Dr. Johnston exhibited this specimen, which had been obtained at the autopsy from a patient who had recently died in the hospital. It was a very unusual condition. Two epitheliomata were found high up in the œsophagus, whilst within the stomach, close to the œsophageal opening, was another tumor. The liver contained two large tumor masses and two smaller ones; the former were broken down in the centre. They differ in their microscopical appearances from those found in the œsophagus and stomach. The cells were not arranged in nests, but in alveoli. It was very difficult to say which was the primary tumor. But few of these cases had been reported.

Brain Tumor.—Dr. Johnston showed this specimen for Dr. Stewart. The growth was situated at the base of the brain, and occupied the position of the pituitary body, involving the optic nerves and optic commissure. The lateral ventricles were considerably distended, and covered with minute granulations produced by a thickening of the lining membrane from chronic distension. The tumor extended into the third ventricle. There were considerable areas of necrosis and fatty degeneration. From the microscopical appearance, the growth was pronounced a teratoid tumor, not uncommon in that region.

Dr. James Stewart remarked that the patient, whom he had seen, had been admitted to the hospital under Dr. Buller. He complained of failing vision, severe headaches, vertigo, and vomiting. There was double optic neuritis, which went on to complete blindness. He had ptosis of the right lid, and the head inclined to the right side. There was no history of syphilis. The symptoms were those of a gross lesion in the brain. Nothing pointed to the localization or nature of the tumor.

Cardiac Thrombus in a Case of Pneumonia.—Dr. Finley related that the patient from whom this specimen had been obtained was a man, 46 years of age, who, in 1889, had had a pleurisy which had lasted six weeks. On the 7th of February of this year the patient was taken ill with pneumonia. The fever disappeared on the tenth day, and he was apparently progressing favorably. A week later the patient was seized with a malarial-like attack. The chills were of a marked intermittent type, recurring at intervals of twenty-five hours. He had never had malaria, and had not lived in a malarial district. Dr. Finley was at a loss to explain their causes. The patient died from heart failure on 23rd March. At the post-mortem examination the right pleura was found greatly thickened. There was a localized pleurisy, with some effusion at the base of the right lung; the lung itself was in a condition of resolving pneumonia. Fraenkel's micrococcus of pneumonia was found. The examination of the heart was interesting from the presence of a large thrombus in the right side of the heart, which projected upward into the auricle; the valves beneath were perfectly healthy. Sections of the thrombus were made, but no bacteria were found.

Dr. Geo. Ross remarked that he had seen the patient on two occasions. At his first visit he had found him in one of those rigors mentioned by Dr. Finley, which was very violent, and very much like the chill of ague. At his next visit the patient was apparently well, pulse quiet, and temperature normal. There were physical signs of consolidation at the base of the right lung. The appearance of the ague-like attacks at a time when the patient should be recovering from pneumonia was very perplexing. The possibility of its being accounted for by septicæmia was negatived by his good condition in the intervals. Malignant or ulcerative endocarditis, which has often been mistaken for ague, could also be excluded from the absence of a heart murmur It was difficult to offer an explanation.

Ulcerative Endocarditis.—Dr. F. R England, who reported the case, remarked that the patient, a man aged 36, employed as a locomotive engineer, had been in good health until two and a half years ago, when he suffered from an attack of articular rheumatism with endocarditis, which kept him in bed for four weeks. There was at that time a soft blowing murmur transmitted down the sternum and upwards along the vessels into the neck. He recovered and remained well until the winter of 1890, when he suffered from a dry, harsh cough, which disappeared in the spring. The cough returned again last winter, and impaired his health considerably; he lost weight and complained of night sweats. The loss of a child about this time preyed heavily upon his mind. He persisted in going to his work until the 10th of March, when Dr. E. was called to see him. He complained of cough, great weakness, and pain in the left lumbar region on deep inspiration or movement. His temperature was 101°F.; pulse quickened. There was no evidences of disease in the heart or lungs. For six days of the illness the temperature ranged between 100° and 101°. The nervous prostration, the profuse sweats, together with the persistence and severity of the lumbar pain, lead Dr. England to believe that the trouble was probably