

per cent. by volume; sulphuric acid 100 cc.), and allowed to remain there for one minute. It was then examined directly in water, or could be dried and mounted in balsam if desired. In most cases this examination could be made in less than five minutes.

*Stated Meeting, February 6th, 1891.*

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

*Hæmatoma of the Ovary.*—Dr. T. J. Alloway exhibited two interesting specimens of hæmatoma of the ovary. In one ovary, the larger of the two, a cavity existed in the oöphoron portion of the ovary which contained about three drachms of dark, tarry blood. This cyst ruptured on the ovary being brought to the surface for ligature. In the second specimen the cavity of the ovary contained a hard, dried, coffee-colored blood-clot about the size of a marble. Dr Alloway said that the ladies from whom these ovaries had been removed were young women between the ages of 25 and 30, one married and the mother of one child. They were chronic invalids, and had been so for some years. The first case was operated on ten months ago; she was now in robust health and acting in the capacity of trained nurse. The other case had been but recently operated upon, and was improving. He said that he had now exhibited three cases of this rare pathological condition before the Society. He thought the condition more common than was generally supposed. The symptoms were the same as those seen in hyperæmia of the ovary and chronic ovaritis unless rupture takes place, when alarming shock and collapse will follow, according to the amount of blood lost. He had no doubt that follicular hemorrhage was a frequent cause of intra-peritoneal hæmatocele. It was due to excessive ovarian congestion and escape of blood from the larger deep-lying veins into one or more ruptured vesicles. The number and size of the hæmatocele sacs were in direct proportion to the extent of congestion.

*Contortion of the Fallopian Tubes.*—Dr. Alloway also exhibited this specimen. He explained that this is a twisting or bending of the tube upon itself irrespective of inflammatory adhesions. He said that Dr. Haultain of Edinburgh had recently drawn attention to this peculiar condition saying that it was in his experience, the most frequent morbid condition of the tube met with, and that it gave rise to very distressing symptoms. Sterility and dysmenorrhœa are the two principal associated conditions found in connection with *contortion* of the Fallopian tubes. In regard to the ætiology of this lesion, he said it was very difficult to offer an explanation, but it was thought that it had something to do with developmental irregularity. Before birth the Fallopian tube is in a state of contor-

tion similar to the specimen exhibited, and it is not till puberty that, by a gradual process of straightening, it has acquired its normal undulating form, so that this condition may really be a continuance of the foetal state. This, however, would not explain cases that occurred after pregnancy had taken place, but under such circumstances it is thought there was an inherent tendency on the part of the tube to return to its foetal state.

*Aneurysm of the Aorta simulating Aneurysm of the Innominate.*—Dr. R. L. MacDonnell related the history of the case, which was briefly as follows: W. H. (colored), aged 33, barber, was admitted to the hospital in October last with an apparent pulsating tumor over the innominate artery. The patient had formerly been a Pullman car conductor. There was no history of syphilis or intemperance. In August last he began to suffer with severe pain in the right side of the neck, and behind the right ear; subsequently pain was felt in the upper axillary region of the chest, and in the right shoulder, which he believed to be rheumatism. He then came under the notice of Dr. J. A. MacDonald, who advised him to enter the hospital. On admission there was slight bulging of the chest, and dulness on percussion over an area of two and a half inches in diameter, occupying the space between the clavicle and the sternum. The pulse was not perceptible in the right radial, brachial, carotid or temporal arteries. There was tracheal stridor and weak breathing at the left pulmonary base; no tracheal tugging; no laryngeal paralysis. The diagnosis was aneurysm of considerable size involving the innominate artery, and possibly the ascending arch. The absence of tracheal tugging and laryngeal paralysis, together with weak breathing at the base of the left lung, rendered an involvement of the transverse arch highly improbable. No symptoms pointed to the third part of the arch or the thoracic aorta. In Dr. MacDonnell's experience, the tracheal tugging was met with when the transverse arch was enlarged and rested on the left bronchus against the angle which that tube forms with the trachea. When the aneurysm occupied a point on the transverse arch beyond the crossing of the left bronchus, the tracheal tug was not perceptible; since the tumor dragging down the loop formed by the vagus and the left recurrent nerves (which bend around the aorta behind the root of the left lung) produced pressure upon the left bronchus from behind, this pressure was incapable of making a pulsatile impression on the left bronchus such as to be transmitted to the larynx. The patient was put to bed and 10 grains of the iodide of potassium ordered daily. He left the hospital Dec. 6th, feeling much better, almost free from pain, and no apparent increase in the size of the tumor. He was readmitted Jan. 23rd with great dyspnoea;