the right, ophthalmoscope shows atrophy of optic disc on left side and commencing atrophy on right. Treatment, direct galvanism.

Drs. Oldright, Wilson, Powell and others reported cases in practice.

Dr. N. A. Powell presented a specimen of sero-fibrinous fluid removed by aspiration from the left pleural cavity of a lady 30 years old. The entire axillary and infra-axillary region was flat upon percussion while marked dulness extended up to the third rib in front. The upper limit of this dulness was a level line. After the removal of six ounces of fluid the curved line of dulness regarding which Peter, of Paris, Garland, of Boston, McPhedran, of Toronto, and other physicians have written, became well marked. As usual, this rose highest toward the axilla, reaching there a point three inches higher than it did near the spine. Only a small quantity of fluid was removed, the object being to reduce the intra-thoracic pressure and promote absorption. In the practice of one large hospital, not situated in Toronto, in nearly every case when aspiration was resorted to in the treatment of sub-acute pleurisy with effusion, empyema subsequently developed. After a time the plan of purchasing a new needle for each operation was adopted, and the series of cases of empyema came suddenly to an end. The speaker had not himself seen empyema follow thoracentesis. He was in the habit of sterilizing his aspirator needles by scrubbing them in hot water with green soap, boiling them in a *closely-covered* vessel after each use and also before they were used again, and finally just as aspiration was about to be done, the needle selected was dipped into alcohol and flashed in the flame of a spirit-lamp. So treated they were reliably aseptic, inside as well as outside, would stand any gelatine culture test, and could be depended upon not to convey germs into or cause purulent decomposition in fluids contained within any of the serous cavities of the body.

Gastric Ulcer with Perforation.—Dr. Alex. Davidson presented stomach showing ulceration and perforation, with following remarks: Mr. N., aged forty, mariner; had often suffered from severe attacks of pain in the region of stomach, which had induced a worn expression of the face. He was a spare, ill-nourished man, and a great lover of acid articles of diet, to wit, cider, pickles, and the like. On June 30th, he was taken with sudden and severe pain in the epigastric region, the abdominal muscles were intensely rigid, being of board-like hardness. Subsequently the abdominal muscles became relaxed; pain greatly abated. Abdomen now became distended somewhat, and coils of inflated intestine could be mapped out on its surface. Liver dulness could be obtained, but high up and diminished. Patient vomited, also passed, per rectum, large quantities of greenish-colored fluid. In the vomit were found pieces of broken cherry stones and undigested potato. Death took place July 5th. Autopsy showed distention due solely to distended intestines. Perforation of stomach found at its upper and anterior surface, near pylorus. The stomach at seat of perforation was united to the structures above by inflammatory lymph, evidently an effort of nature to heal the rent in the stomach. On endeavoring to break down these bands of lymph, the finger passed into the perforation. After tying both ends of the stomach and removing it, several broken and whole cherry-stones, together with some grape seeds, were found in the back of the abdominal cavity, as it were behind the stomach.

Dr. W. H. B. Aikins presented specimens showing extensive cancerous growth of the œsophagus, with secondary encephaloid deposit involving a portion of the edge of the right lobe of the liver. The notes of the case were furnished him by Dr. McDonagh. J. K., aged 53, by occupation a carpenter. In the family history there was no constitutional trouble. He first noticed a difficulty in swallowing about six months before entering the hospital. During the next four months this difficulty became gradually more and more marked, until he was then able to swallow solids only in the smallest possible quantities. The point of obstruction seemed to him to be just at or below the larynx. He complained of a good deal of cough, and excess of bronchial mucus, but no pain. He also had become considerably emaciated, but attributed this largely to not having had sufficient nourishment. The symptoms became more aggravated during the next two months, when hoarseness set in, and the cough was increased. He entered the hospital about August 1st, 1888. An examination with the laryngoscope proved complete paralysis of the left vocal cord, which was in the cadaveric position. This was thought to be due to pressure on the left recurrent laryngeal nerve. A bulbous