degree of macroglossia. The tongue projected about two inches from the mouth, and great difficulty was experienced in feeding the infant. He proposed to remove the tongue with the écraseur.

Poisoning by Sulphate of Copper.—Dr. WYATT JOHNSTON exhibited the stomach of a man, aged 28, who had committed suicide by drinking nearly a quart of a saturated solution of sulphate of copper from a battery jar in the electric works, where he was employed as a night watchman. Death occurred in an hour and a half. The stomach and intestines had externally a leaden-blue color, and contained a large amount of pale grayish-green flocculent fluid. The mucosa had the appearance of having been tanned, and was stained a deep green color. Chemically, the contents of the stomach were found to consist of basic or subsulphate of copper. Heart muscle and liver parenchyma looked opaque and grayish. No examination for copper was made of these organs.

Dr. W. F. HAMILTON said that the patient had been admitted to the General Hospital shortly before death. Large quantities of warm water and mustard failed to produce emesis. He seemed to suffer from extreme pain and difficulty of respiration, owing to a quantity of mucus in the throat. Extremities were cyanotic; superficial capillaries were markedly dilated. There were some mucous and watery stools.

Dr. MILLS asked if there was any evidence along the course of the vessels and lacteals to indicate whether the salt had been absorbed into the blood.

Dr. JOHNSTON replied that there were no signs to indicate that absorption had taken place; no naked-eye changes in the blood.

Localized Tuberculosis of Ascending Frontal Convolution.—Tuberculosis of one Suprarenal.—Dr. ADAMI exhibited the drawing of a brain recently removed by him, presenting a peculiarly rare localized tubercular lesion, affecting the centres for the movements of the upper limb and neck of the left side.

The patient, a woman of 28, phthisical and a morphine maniac, a patient of Dr. Stewart at the General Hospital, had, for two days before death, suffered from repeated attacks of an epileptic nature, in which there were convulsive movements of the left upper extremity and the neck, so that the head became pulled down to the left, and the face turned partly to that side. These movements were executed with great rapidity, as many as 145 contractions of the extremity being recorded per minute.

At the autopsy, there was found old phthisis of both apices, and, extending from there, a condition of acute tubercular broncho-pneumonia, miliary tubercles of relatively large size being scattered all over both lungs. Both the kidneys and the liver presented similar tubercles, while the medullary substance of the right suprarenal contained caseous tubercular foci of large size. The left suprarenal had a gray softened medulla, but was not tubercular.

A condition of great interest was exhibited in this brain. Careful examination and section revealed no tubercular affection save at one spot—an area a little over half an inch in diameter, situated upon the right ascending frontal convolution, at either apposed side of a fold forwards in that convolution, at the level of the sulcus which separates the superior from the middle frontal region of the brain. Here miliary tubercles surrounded the surface vessels, and the tubercular process extended along the sheaths of the branches given off from these, and formed small wedge-like masses, passing through the gray to the outer service of the white matter. Dr. Adami pointed out that a tubercular lesion of such small dimensions affecting so distinctly one group of associated movements was almost, if not quite unique. He called attention to the fact that this case supports Ferrier's conclusion, reached by experimental research, that the area for the movements of the neck passes backward to the ascending frontal, and overlies or intermingles with the areas for movements of the upper extremity.

Recto-ovarian Fistula.—The same case presented another rarely recorded condition. Upon removal of the pelvic organs *en masse*, it was found that both ovaries were situated low down in the cavity, and were there bound to the vaginal end of the uterus by firm old inflammatory adhesions. They were fibroid and contracted. The Fallopian tubes curved downwards to them, and did not present such extensive evidence of inflammatory disturbance. It is to be noted that the left tube was not at its extremity in close attachment to the ovary.

Upon attempting to cut away the left ovary, a fistulous track, containing foul-smelling contents, was opened, and upon passing a sound into this, it emerged into the rectum at a point about 3½ inches above the anal orifice. The ovary lay curved over the blind end of this fistula, which was 1½ inches in length. There had been so much inflammatory change all around the fistula, that it was not possible to recognize microscopically anything but firm, fibrous tissue in this region; however, macroscopically, the rather thin upper wall of the fistula, seen from above, was in direct connection with, and indistinguishable from, the rest of the ovary, while, clinically, there was the history of acute ovarian disturbance several years previously. Hence, it may safely be inferred that this was a true recto-ovarian fistula.

Not a few cases of tubo-ovarian abscess