that the ulcerative process was most intense in the large bowel as far down as the rectum. The ileum showed early infiltration of the Peyer's patches. All the ulcers were cleared except two or three in the ileum.

Hypertrophic Cirrhosis of the Liver.—Dr. Lafleur exhibited the specimen and gave the following account of the conditions found at the autopsy. The body was intensly jaundiced; there was moderate abdominal distension and emaciation. The liver projected far beyond the normal limits in all directions, the surface was roughened and covered with numerous adhesions, many being organized and traversed by large veins, which were connected with those of the abdominal wall and diaphragm. The organ was rough, uniformly enlarged, of a pale reddish-brown colour, and very firm. The cut section showed here and there prominent bright yellow spots, which were found to correspond to unaltered liver tissue. The rest of the organ was of a grayish-yellow colour and much firmer than the light yellow patches. On microscopic examination there was seen a very general development of fibrous tissue which was not restricted to the periphery of the lobules, but penetrated between the individual liver cells to the centre of the lobule. There was marked atrophy and degeneration of the liver cells. In many places there were collections of small round cells among the strands of fully formed fibrous tissue (probably tuberculous tissue.) It was extremely difficult to make out the lobular arrangement in many sections. No increase in the number of bile ducts could be made out. The case illustrates that variety of cirrhosis called "intercellular" as distinguished from the more common "lobular" cirrhosis. The jaundice was not due to the obstruction of the common duct or any of its larger divisions, as the bile could be easily pressed out. The immediate cause of death was an acute miliary tuberculosis, the lungs, the retro peritoneal glands, which were very large, and spleen being stuffed with minute miliary tubercles. The kidneys also contained them in lesser quantities. There was no meningeal tuberculosis. No old tuberculous focus was discovered to account for the acute infection.

In connection with this case Dr. Lafleur exhibited a specimen of the atrophic form of cirrhosis. There had been no history of cirrhosis, but one of obscure lung disease. There was found a chronic bilateral pulmonary tuberculosis upon which had been grafted an acute attack. There was no ascites. The surface of the liver was roughened with small elevations and corresponding depressions. It was softer than the other specimen, and friable. The internal appearance was the same as that on the surface, the elevations corresponding to the lobules and the depressions to the portal spaces. It is an example of atrophic changes involving the portal circulation, induced probably by a calculous obstruction of the duct, for the common duct and all its branches are enormously dilated. A calculus did probably pass down at some time, as a small one is seen in the gall-bladder, but none in the common duct. The terminal feature in this case was also pulmonary tuberculosis. In the other organs there were no special changes.

Dr. James Stewart said that the man from whom the first specimen was taken was 40 years of age, and had passed the greater part of the last two years in the hospital. The case was of special interest, being the one on which the late Dr. R. L. McDonnell had written his article on "Cirrhosis of the Liver" in the first volume of "International Clinics." The marked feature of the case was the enlargement of the liver and spleen; it was impossible to distinguish between the two, as the splenic dulness merged into the hepatic. There was constant persistent jaundice and absence of effusion into the abdomen. He had had a severe attack of erysipelas and of peripheral neuritis. Two weeks before death he had passed a large quantity of chylous urine, the source of which could not be traced at the autopsy.

Chronic Myocarditis.—Dr. Lafleur exhibited the specimen and gave the following notes on the autopsy. There was general arterial sclerosis of the larger and medium sized arteries, which was seen in all the organs. The chief changes were seen in the heart, at the base; there was hypertrophy and dilatation of both ventricles. At the apex of the left ventricle there was great thinning of the wall, and in which two well-marked zones could be distinguished—an outer one, like normal muscle, and an inner one, from which all traces of muscular structure had disappeared. In this situation there was distin[illegible] bulging of the apex of the ventricle and a large clot adhered to the endocardium. Microscopically the internal zone is necrotic, all the muscular structure being replaced by a granular amorphous substance. As to the cause, there was no thrombus or embolus of the coronary arteries discovered, but there was probably clogging of some of the minute vessels. Higher up in the ventricle there is a fibroid change, appearing as pearly glistening patches, offering great resistance to the knife and alternating with areas of normal muscle. The valves were competent and showed slight fibroid changes. Thus there was in this case a commencing cardiac aneurism, and had the man lived he would have had a distinct sacculation of the left ventricle.

Dr. Jas. Stewart related the clinical history. The patient had been only two days in the hospital, and the cardiac condition had not been diagnosed. The main clincal features were the constant dyspnœa and the marked difference in the respiratory sounds on the two sides of the chest,