placed near a door, where there is a very cold draught, and that he woke up the other morning with a sensation of rawness and tickling, which he referred to the larynx, and a sense of chillness and general malaise or soreness of the muscles. This was followed by cough of a coarse, harsh character, and destitute of expectoration. Then the cough got somewhat loose, and now the expectoration is considerable, and of the character of muco-pus. There is often some aphonia, and there was and still is in this case. This peculiarity of the voice is due to swelling of the mucus membrane, and variation in the tension of the vocal cords. The disease is an acute catarrhal inflammation of the mucus membrane of the larynx, and if moderately mild passes through its various stages in a week; more serious cases may take a month or more.

Treatment.—In severe cases confinement to bed and to a room of a uniform temperature; in mild cases confinement in the house and possibly to a room of uniform temperature. It is well to moisten the air by discharging steam into it; tincture of aconite and vinum antimonialis will often loosen the cough, and hasten the production of secretion from the membrane. A solution of morphia sprayed over the throat often relieves cough. A good combination for the same purpose is tartar emetic, camphorated tincture of opium, and syrup of lactucarium. A mustard poultice for a few minutes to the throat followed by the wet compress. Bromide of potash is a good addition to any mixture. Persons are very apt to become subject to it; such persons should sponge the body every morning with cold water, wear flannels, protect the feet from dampness, and keep up the general health. It is said that an impending attack may be abated by the administration of fifteen grains of quinine, and a quarter to half a grain of morphia. Persons subject to this disease, and who have the means, should live in a dry, equable climate.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, December 17th, 1886.

J. C. CAMERON, M.D., PRESIDENT, IN THE CHAIR.

Aneurism of the Innominate Artery.—Dr. W. G. JOHNSTON exhibited a specimen of aneurism of the innominate artery, which had eroded the sternum and first and second ribs on right side. The arch of the aorta was unaffected. The right carotid and right subclavian were given off from the sac. The left carotid and left subclavian pressed upon and pushed over towards the left. The superior vena cava was obliterated through pressure at a point two inches above its origin. Azygos vein enlarged to the size of the ring finger, and communicated by a large branch with the superior intercostal vein. Superficial anastamoses of epigastric and hypogastric veins were prominent Hemorrhoidal veins normal.

Dr. Ross said that the patient had been under his observation for eighteen months, and was never recognized as a case of aneurism of the innominate artery, but the symptoms pointed more to the arch of the aorta. The earliest symptoms were pain at the back or neck and shoulder of a neuralgic nature, accompanied with cough. These were relieved by potassium iodide. The patient got better of his first attack, but was frequently laid up in hospital. Enlargement of the superficial veins of the abdomen and thorax was early evident, but lately the superficial veins were tortuous and as large as a man's finger. The patient also exhibited signs of intra-thoracic pressure—such as paralysis of the right vocal cord, rattle in the larynx, and signs of pressure on the trachea.

Dr. R. L. MACDONNELL had had the case under observation for the last fourteen months, both in his wards in the Montreal General Hospital, as well as during the past summer, when the patient was earning his living as a night watchman. There were two points of clinical interest in the case. In the first place, the results of the use of the sphygmograph were deceptive. The tracings obtained showed very marked interference with the blood current through the left radial, hence he had assumed that the aneurism was situated on the arch at a point beyond the giving off of the innominate artery, the fact being that the great dilatation of the innominate artery caused not an impediment through that channel, but by its bulk had pressed upon the subclavian and disturbed the flow of blood to the left upper extremity. In the second place, the relief afforded by the iodide of potassium had been most effectual. Whenever the drug had been discontinued, or whenever the patient had been unable to obtain it, the pain and dyspnœa had increased. This effect had several times been noted, and particularly by the patient himself.

Dr. WILKINS referred to a case in his practice