was the relief of the pain and hyperæsthesia, but the patellar reflexes are still absent. He had last summer met with a similar case, in which, on failing to reduce the deformity, he had cut down, but found a fracture with injury to the cord. Shede has reported a number of cases, and recommends cutting down and finding out the exact condition; if the cord is much injured nothing can be done, but if spicules of bone are removed, a better result may be expected than if they were allowed to remain.

DR. JAMES BELL emphasized the necessity of early operation in such cases. Experience has shown that not infrequently pressure may be removed and the integrity of the cord restored, while, if left alone, softening would follow. He does not even despair of cases in which there is extensive injury. He had operated upon dogs, and found that the cord can be stretched, but suturing is almost impossible on account of the soft structure. Prof. Maydl, of Vienna, has been making similar experiments, but his reports are not favorable. He (Dr. Bell) thought that it is just as bad surgery to leave such a case to nature as it would be to leave a case of intestinal obstruction.

Excision of the Wrist.—DR. ARMSTRONG presented a man from whom he had removed the wrist joint for tubercular disease. The case was instructive as illustrating the amount of motion that can be obtained, flexion and extension are well performed, and the hand is not in the least œdematous. All the carpus, except the pisiform bone, the ends of the radius and metacarpal bones were removed, but unfortunately the disease has gone on in the pisiform bone and it will have to be removed.

Multiple Aneurism; Aneurism of Superior Mesenteric; Abdominal Aorta; Right Subclavian and dissecting Aneurism of Aorta; Cirrhotic Kidneys.—DR. FINLEY exhibited the specimens from a case of multiple aneurism. The subject was a female, aged 48 years, rather thin, much blanched, and with slight œdema of the lower extremities. A considerable quantity of partially clotted blood was found in the peritoneal cavity. There was an aneurism of the superior mesenteric artery about an inch from its origin, lying behind the pancreas, third portion of the duodenum and the mesentery. On section, the wall of the vessel was surrounded by recently clotted blood, bounded by the above named structures and communicating with the peritoneal cavity by a small opening on the right side of the mesentery. A true aneurism of the superior mesenteric artery was thus formed which had evidently recently ruptured: first, into the surrounding structures, and later, into the peritoneal cavity. A small sacculated aneurism of the abdominal aorta arose just to the left of the cœliac axis, and was lined with laminated decolorized fibrin. A dissecting aneurism forming a firm, solid mass in front of the thoracic aorta and alongside the œsophagus arose an inch above the cœliac axis and passed up as far as the bifurcation of the trachea, where it terminated in a blunt conical end. This mass was traversed by an irregular channel containing blood; its wall was formed of a distinct layer formed by the outer coat of the aorta, and was lined with a reddish-colored thick adherent layer of fibrin. A fourth aneurism was found on the anterior wall of the subclavian artery, an inch in diameter, and lined with a thick layer of laminated decolorized clot.

The aorta presented a few gelatinous raised plaques, but no calcareous change. Both kidneys were small, the right weighing 110 grams and the left 100, and presented the microscopic and macroscopic appearances of fibroid change. The heart weighed 350 grams. The left ventricle was thickened, the anterior papillary muscles transformed into a fibroid mass, and the coronary arteries showed a few irregular areas of atheroma. The other organs were normal. The brain was not examined.

DR. SHEPHERD, who had had the patient under observation, gave the following history: For two years she had been troubled with dyspeptic symptoms, with gradual weakness and emaciation. Six weeks before admission she began to suffer from abdominal pain of a continuous gnawing character, and occasionally referred to the back. Three weeks later she suffered from persistent vomiting.

On admission, August 15th, somewhat emaciated, muscles small and flabby. Vomits frequently without any relation to taking of food, and with relief to pain. A pulsating tender mass about the size of a hen's egg is felt two inches above the umbilicus and half an inch to the right of the median line, and readily moved from side to side. Urine normal.

There was a clear history of syphilis, alcoholism and rheumatism.

An exploratory incision was made by Dr. Shepherd on August 17th, and, on pushing the finger well down toward the vertebral column, a pulsating sessile aneurismal tumor was found in front of the aorta, and evidently connected with the superior mesenteric artery. The abdomen was closed and good union took place on September 5th, the pain which continued after the operation greatly increased and the tumor increased in size. Death took place rather suddenly on September 11th, the patient becoming blanched and pulseless.

Dr. Shepherd remarked that he had refrained from tying the artery about the aneurism owing to the probability of causing gangrene of the intestine, as this vessel supplies all the small intestine and half the large. He also remarked on the rarity of aneurism of the superior mesenteric artery, the usual vessel affected being the cœliac axis. The other aneurisms had not been recognized before death.