

the practice of Mr. Scott of the London Hospital, in which after an injury a pulsating tumor of the orbit occurred, and during an examination profuse hæmorrhage from the nostrils took place, which was controlled by compression of the common carotid, and subsequently cured by ligation of that vessel.

(c). Specimen from a case of diphtheria, showing blocking up of the glottis by false membrane and extension down the trachea into the primary bronchi. Tracheotomy had been performed, but with only temporary relief. A point of interest in this case was the *caking* and hardening of the exudation at a point corresponding to the orifice of the tube, which must have materially interfered with the entrance of air.

Dr. Wilkins exhibited *Tubercle Bacilli* prepared by the *Ehrlich-Gibbes* method, with an important modification, as suggested recently by Balmar & Fraentzel. The sputum after being spread out in a thin layer on cover glass, and dried and passed through the flame of a Bunsen's burner, is now placed in a solution of *fuchsin* in *aniline* water, (one part of *fuchsin* to fifty parts of *aniline* water); it is kept in this for twenty-four hours, after which it is taken out and washed in distilled water, and placed for about half a minute in dilute nitric acid (one of acid to three of water). After being again washed it is placed in a concentrated solution of *methylene blue* for a few minutes. The specimen is then thoroughly dried, passed through a *Bunsen* flame once or twice, and mounted in balsam.

Dr. Wilkins read a paper on a case of *Obliteration of Superior Vena Cava*.

(The specimen was exhibited at a former meeting of the Society.)

The patient was admitted into the Montreal General Hospital on June 27th, complaining of great dyspnœa which condition existed through the whole course of the disease. A year or so before coming into Hospital he felt something give way on lifting a heavy weight, and has suffered more or less ever since.

Shortly after admission he became cyanotic, with an œdematous condition of the head and neck. About six weeks after entrance into Hospital fluid began to collect in the left pleural cavity, and subsequently also in that of the right side: he was tapped a great number of times, but only experienced transient relief—eight hundred and sixty-two ounces in the aggregate was drawn off. Patient's pulse, which previous to this never went above 104, now rose considerably, and the tem-

perature, which hitherto had been normal, rose to 102°. Dyspnœa became very severe; he was again aspirated, withdrawing twenty ounces of bloody fluid from the left side and forty ounces of clear fluid from the right. The patient finally died from exhaustion.

At the autopsy the *superior cava innominate and internal jugular veins* were found obliterated by thrombi; the left pleura was covered with recent lymph; the azygos veins were widely dilated, and the foramen ovale was found to be permanent. Dr. Wilkins exhibited beneath the microscope a number of sections from various parts of the thrombosed vessels, the most interesting being those taken from the cardiac extremity of the superior vena cava, showing cicatricial thickening of a portion of the circumference of the vessel, to the extent of two millimetres, the vessel itself being but six millimetres in diameter, and filled with organized clot. No other lesion could be discovered accounting for its occlusion. Dr. Wilkins considered these changes to have arisen from a primitive phlebitis, commencing in the adventitia, causing changes in the intima, with subsequent thrombosis, this giving rise to secondary phlebitis of the vessels above, resulting in a thrombosed condition of these vessels also. Some of the sections showed fibroid thickening of the septa of the alveoli of the lungs, due to a passively congested condition of these organs. The cyanotic appearance was explained by the blood current being delayed until a collateral circulation was established. In accounting for the dyspnœa, Dr. Wilkins stated that the blood of the left bronchial vein reached the heart through the superior vena cava, and consequently when that channel closed it would necessarily return to a great extent by way of the pulmonary veins, thus distending them and helping to cause thickening of their walls; he considered the permanency of the foramen ovale an important factor in causing the dyspnœa, and the remarkably slight relief obtained by aspirating the pleura. As soon as the blood current from above was shut off by closure of the superior cava the current from the inferior cava, meeting with no opposed current, must lift up the upper segment of the *annulus ovalis*, and get into the left auricle, and so block up the blood returning from the lung.

Dr. Wilkins accounted for the larger quantity of fluid in the left side, from the fact that on that side the blood from the four superior intercostals reaches the heart by the superior vena cava, while