and begins before the flow and lasts until it ceases. In some cases there is vicarims menstruation. It appears that in these women miscarriages are very apt to occur. The most interesting point is the treatment. Rigid diet he says is *de rigeur*. Hydrocarbons and alcohol must be interdicted. Exercise, either active or passive, cannot be neglected. General and local faradization are of value. Laxatives are useful, but strong purgatives are bad because they cause anæmia. I must confess that these cases give me a great deal of trouble.

TENDON REFLEXES.

Dr. Sternberg, of Vienna, read a paper on this subject, based on observations made on 1,500 patients in the clinics of Professor Meynert and Dr. Redtenbacker. The object of the experiment was to determine the "components" constituting the tendon reflexes, that is, the effects produced by shaking of the muscle, the tendons, the bone, etc., and to separate these various phenomena from each other. In this way he succeeded in showing that the so-called tendon reflexes consist of two phenomena, namely, a bone reflex and a pure muscle phenomenon, which, most probably, is also a reflex. The bone reflex consists in the fact that a shock to the bone, particularly in the direction of its longitudinal axis, irritates the nerves of the periosteum and the articular surfaces, and this produces a contraction of all the muscles belonging to the bone. The muscle-reflex consists in the fact that a stretched muscle becomes contracted when a shock is transmitted to it in the longitudinal direction. The tendon only plays a mechanical part. No reflexes originate from the nerves of the tendon. The existence of reflexes of the fascia cannot be proved. In contractures occurring after localized cerebral affections in various diseases of the spinal cord and in articular processes, the tendon reflexes are invariably increased. In contractures which occur in large cerebral hemorrhages, cerebral tumors and abscesses, uræmia and meningitis, and paralysis agitans, the tendon reflexes are never increased, and very frequently are diminished. These two forms of contracture can occasionally be distinguished by the tendon reflexes. In conclusion Dr. Sternberg pointed out that when all the precautions recommended by Schreiber and Jendràssik for the examination of the tendon reflexes were observed, complete absence of the tendon reflexes was much more seldom found than on less careful examination. —*British Med. Journal.*

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, December 19th, 1890.

F. J. Shepherd, M. D., President, in the Chair.

A Large Aneurysm of the Aorta.—Dr. Johnston exhibited this specimen, which had been sent by Dr. Tunstall of Kamloops, B. C. The specimen showed a diffuse dilatation of the ascending and transverse portions of the arch of the aorta. Springing from the right side of the arch, immediately above the aortic ring, was a sacculated aneurysm rather larger than the fist. The orifice of the sack was about 2½ inches in diameter, and the sinus of valsalva was involved in the dilatation, so that the segment of the aortic valves, which were thick and stretched out laterally, lay across the edge of this space. The sac lay in close connection with the posterior wall of the right ventricle, which was very thin in places, the muscle apparently being atrophied from pressure. Between the muscle fibres the whitish fibrous wall of the sack could be seen in places. Dr. Johnston wished to know if any set of symptoms or physical signs were known to be associated with aneurysm in this unusual situation.

Chronic Calcifying Pericarditis.—Dr. Johnston exhibited this specimen for Dr. MacDonnell. The autopsy showed considerable dilatation and hypertrophy of both chambers with universal adhesive pericarditis. Extending almost entirely round the base of the heart, in the auriculo-ventricular sulcus, was a calcified plate lying within the adhesion, evidently due to unabsorbed exudation. At one spot about a teaspoonful of thick, whitish, purulent fluid lay encapsuled between the adhesion and the heart wall. The calcareous plate was not firmly attached to the heart, but rather to the mediastinal tissue. It was evident, however, that it prevented the mitral and tricuspid muscular rings from properly contracting. The valve segments themselves were almost normal.

Dr. R. L. MacDonnell gave an outline of the history of the case. The patient had had scarlet fever in childhood. There were no heart symptoms until he had arrived to the age of 40, when he had begun to suffer from dyspnœa, præcordial pain, and dropsy of the feet. During his illness there had been severe attacks of epistaxis. In one of these, the posterior nares on the left side had been plugged. This operation had been followed immediately by acute otitis media ending in rupture of the drum membrane. There had subsequently been an attack of acute renal congestion with the passage of bloody urine.