twelve days after removal of her thyroid. No changes of any apparent import can be detected.

Nothing definite as to the true nature of this remarkable disease was up to the present known.

UREOMETRY.

Dr. T. D. Reed showed Doremus' apparatus for the estimation of urea. This instrument is extremely simple, consisting of but one piece, a bent tube of glass, one arm of which is graduated with lines representing grains per ounce of urea. To use it, it is filled to the bend with the usual hypobromite solution (experiment shown), and a measured quantity of the urine to be tested is introduced, by means of a pipette, beyond the bend; by the separation of the nitrogen, the result is read off at once. Dr. Reed had tested the instrument with a solution of pure urea, and found the readings correct.

The price of the apparatus is two dollars, and of each test under three cents.

Specific gravity beads, as supplied by Parke, Davis & Co., were also shown and recommended as being more convenient, simple, and portable than the usual urinometers.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

REGULAR MEETING, JUNE 2ND, 1885.

The Vice-President in the chair.

Dr. McCargow exhibited a pathological specimen, the lower end of the femur of a man whose thigh had been amputated in the hospital by Dr. White. The patient had been admitted to the hospital with the following history:—At 14 years of age received a slight injury on the inner side of the thigh, while sleigh riding, since then has had pain in the knee with swelling, chiefly during changes in the weather and in cold weather. Although knee has pained since the first with the exception of slight intermissions of a few weeks, he has never been confined to bed, and the only treatment has been in the form of external applications. Four months ago incisions were made and a large quantity of pus removed. When admitted, the man who is now 36 years of age, was found to have the lower half of the right femur enlarged and hard. The swelling extended to the lower half of the right knee, and the patella was fixed. two openings had been made one on the outer and lower part of the enlargement, the other higher up on the inner side of the thigh; the openings had partially closed, but there remained small sinuses from which pus discharged pretty freely. Patient was able to move about on crutches and was not confined to his bed in the ward. Family and personal history were both good, there being no record of anything specific about him to account for the condition of the knee. The specimen showed the end of the femur after a longitudinal section had been made, there being an abscess cavity in the centre, with thickening and enlargement of the bone. The cavity was six inches long, one half inch wide, but irregular; in the recent state the bone was injected. The cartilage of the knee was intact. The diseased bone was twelve inches long altogether. Dr. Malloch said that when the section of the bone was made there was a piece of necrosed bone in the cavity which would account for the inflammation of the bone; others, though, had not noticed the sequestrum.

Dr. R. R. Wallace then read his paper on Incisions in Whitlow — a subject which had been partly discussed at the previous meeting when Dr. McCargow's specimen was shown. The paper began by giving the definition of whitlow, and showed the different pathological states involved, with the various names more or less indiscriminately applied. Different authorities were then quoted to show the site of incision preferred by them, of these Erichsen recommending an incision on each side of the finger, while Fairlie Clarke advocated incision on one side, the others quoted prefe ring the median palmar, Keetley advising two palmar incisions. The essayist thought that incision in the median line over the ungual phalanx would be likely to divide the digital arteries as they there cross to form an arch, while the great argument in favour of the medial incision had always been that it avoided such accident. He therefore believed that in whitlows confined to the ungual phalanx, incision along the side, carried to the bone if necessary, is the best one to practise, for it affords exit to all pus and sloughs, and effectually relieves tension, thus removing the great cause of the agonizing pain,