saggital suture, just behind its junction with the coronal suture. The wound was surrounded by cicatricial tissue, and presented a few weak granulations. In the floor of the wound, firmly embedded in the skull, was a piece of lead about a quarter of an inch in diameter. This could be scratched with a knife, and gave the characteristic mark to Nelaton's probe. There was a slight purulent discharge from the wound, but otherwise he suffered no inconvenience from it. Venous oozing accompanied by giddiness and faintness occurred on the patient making any extraordinary effort, especially if made in the stooping posture. As any pressure on the lead caused considerable oozing, and as the patient was averse to any operation, no further attempts at removal were made. From this time till his death, which occurred in 1888 from an abdominal complaint, there was little change in the above condition, except that the cicatrix became slightly more depressed from absorption of the surrounding bone. Evidently the bullet had struck the right parietal bone obliquely, about three-quarters of an inch from the coronal and half an inch from the sagittal suture. It had passed backwards and to the left, grooving the bone until it reached the saggital suture, where it had produced a depressed fracture, the portion displaced being about the size of a shilling. In the posterior and deepest part of the depression, firmly embedded in the bone, and exactly above the superior longitudinal sinus, was a piece of lead four-tenths of an inch long, and one-tenth broad. Close to the piece of lead was a small foramen, which allowed the passage of a small vein to the longitudinal sinus. Probably after producing the fracture the bullet had split, and the smaller portion had remained embedded in the bone. Originally the piece of lead must have been considerably larger, as on many occasions small pieces had been removed by scraping with a knife. The sagittal suture in the neighborhood of the fracture had been considerably obliterated.

The inner surface of the skull presented a prominent irregularity, corresponding to the depression seen on the external surface.—*Edin. Med. Jour.*

EXCESSIVE VOMITING DURING PREGNANCY.—B. C. McDougall, M.D., in *Mass. Medical Journal.*—I was requested to see Mrs. P., who was in the sixth month of pregnancy and could not retain anything on her stomach—no food and no drink. She had consulted two medical gentlemen, one of whom had advised purgation, which was tried, as were also the various remedies recommended in such cases, but all had been of no avail. The other physician, who was subsequently called in, concurred in the opinion that she was in great danger; advised a certain course, but would not consent to the procuring of abortion, as the fœtus was not viable, and he was a zealous adherent of the Roman Catholic church.

I prepared to do whatever was necessary to save the mother, or both fœtus and mother, if it could be done. I found the pulse 96; incessant nausea; vomiting whenever anything was taken into the stomach; sleepless at night and also during the day; no delirium, no tinnitus aurium; no dimness of vision. I claimed a delay of twenty-four hours to try two remedies. One was the hypodermic injection of morphia over the region of the stomach, and the other was the injection of beef essence and brandy into the rectum. On the next day I found that the remedies had done no good. She vomited, as ever, the little ice-water she took, and the injections could not be retained at all.

My mind was now made up as to the course to be pursued, and I examined the neck of the womb with my finger. I could readily introduce the index finger into the os tincæ and carry it up to the internal os, and the examination convinced me there was granular erosion of the cervix. Nothing effective could now be done, short of abortion; the method of procedure was the only question. To dilatation by means of tents, there were these objections: it is slow in its operation; and in this particular case, the pathological condition would lead to a metro-peritonitis, or to a pelvic cellulitis. I have seen these arise after dilatation, even when there was no granular erosion of the cervix, nor any other lesion of that part of the womb, and when dilatation was practised for other objects. The detachment of the membranes according to the method of Kiwisch is also objectionable on account of its slowness and uncertainty.

I determined to puncture the membranes, and for the following reasons: the child was not viable and could not be saved. I have