

duced extensive laceration of the inner and anterior part of temporal lobe and hæmorrhage into the meninges at the base. The arteries were atheromatous, and from the exceedingly thin structure of the wall of the aneurism it is probable that it originated in an atheromatous ulcer, exposing the middle and outer coats which had yielded to the pressure. There was no heart disease and no special change in the other organs. Dr. Osler remarked that this was the sixth specimen of cerebral aneurism he had exhibited to the Society.

(b). *Verminous Aneurism in Horse*. The animal had been admitted to the infirmary of the Montreal Veterinary College with colic, and had died in about 36 hours. The post-mortem shewed intense engorgement, with great distension of the small intestines. The aneurism was from one of the mesenteric branches, and contained thrombi among which were numerous examples of the palisade worm, *Sclerostomum Armatum*. The so-called colic of horses is very frequently produced by these aneurisms, portions of the thrombi become dislodged and plug the terminal branches of the mesenteric arteries and cause infarction of the portion of the bowel supplied by the plugged vessel. In reply to a question by Dr. Gurd, Dr. Osler stated he did not think these cases could be distinguished from those of ordinary colic; Indeed Prof. Bollinger of Munich held that colic in horses was in the majority of cases of embolic origin and due to those verminous aneurisms.

(c). *Cancer of Stomach with enormous Secondary Cancer of Liver*. This case was also under the care of Dr. Molson, who gave the following clinical history:

L. P., æt. 52, healthy up to two months ago, when he began to lose flesh and get weak, with pain after eating and eructation of wind. On admission, November 3rd, 1882, was decidedly cachectic; great prominence with evidence of a tumor occupying the whole of the upper zone of the abdomen. Commencing on the right side and extending over towards the left in the median line, it extended two inches below the umbilicus and on the right side down as far as the ilium. Œdema of both legs and feet. Urine contained abundance of lithates, a small amount of albumen, and numerous granular and hyaline casts some days after admission. Jaundice set in gradually but this was never deep, and vomiting for the first time occurred. He died November 16th, p.m. The stomach shewed a small, flattened, slightly raised

cancer, situated on the lesser curvature, about $1\frac{1}{2}$ inches from the pylorus; it had an excavated base, puckered and hard on the peritoneal surface, and a chain of enlarged glands extended along the lesser curve to the cardiac. The microscopic examination shewed it to be a cylindrical-celled epithelioma. The liver was enormously enlarged, weighing over thirteen pounds, and presenting innumerable masses of secondary cancer scattered through its substance.

(d). *Erosion of Internal Carotid in Cavernous Sinus* six weeks after a blow on the head. Fatal hæmorrhage from the nose. The patient, æt. 21, had received a blow over the left eye, being one of the victims of the "Beauharnois" boiler explosion. There was a long wound extending the whole length of the eye-brow, but it was not thought he had received any other injury, as he recovered quickly. Some time after, however, he noticed that the sight of that eye was failing, and he consulted Dr. Buller, who diagnosed commencing atrophy of the optic nerve, due probably to extravasation in the sheath. He had had several attacks of epistaxis, but not of an alarming character. One morning, about six weeks after the accident, while washing his face, profuse hæmorrhage took place from the nostrils, and he died before assistance could be procured. At the post-mortem the orbital ridge of the frontal bone was found indented at the site of injury. The orbital plate presented an area of superficial erosion about three lines in width, extending beneath the *dura* from a point corresponding to the external wound, to the body of the sphenoid. The left wing and body of the sphenoid slightly reddened, the surface of the bone eroded, and at one spot in the latter the bone was so soft that it broke on a slight touch. The sphenoidal and ethmoidal cells were filled with coagula. On slit up the internal carotid in the cavernous sinus, just as the vessel turns up to enter the skull, there was seen an opening on its interior part leading directly into the sphenoidal cells. There was a small spot of red softening the size of a *ten cent piece* in the third left temporal convolution. Though no fracture of the sphenoid was evident, yet it was believed that at the time of the accident a slight fracture must have occurred leading to ulceration and erosion of the bone and subsequent perforation of the carotid. Dr. Osler remarked that the case was unique in many respects, but Mr. Prescott Hewitt, in his lectures upon fractures at the base, mentions an instance in