of to-day; and how so many people deceive themselves, mistake structural and functional changes for supernatural cause of effect.

Stated Meeting, Dec. 19th, 1884.

T. G. RODDICK, M.D., President, in the Chair.

PATHOLOGICAL SPECIMENS.

Dr. KENNEDY exhibited some inky black sputum expectorated by a middle-aged man, a painter, who enjoys good health. He has been expectorating this black sputum for about seven years; never much at a time, but lately is rather worse. It comes just after a slight cough, and is at first viscid. He has never inhaled carbon. There are over his body several melanotic spots. Dr. Kennedy suggested that he may be eliminating pigmentary matter from the lungs. It was not chemically examined. Dr. Kennedy promised to further investigate this case, and bring it again before the Society in the form of a paper.

Malignant Disease of the Œsophagus, causing stricture.—Dr. Ross exhibited the specimen and related the case:

J. W., aged 54, was admitted to Hospital Dec. 10th, 1884, suffering from a severe attack of acute pleurisy, with effusion, commencing twelve days before. *Previous history*—Difficulty in swallowing for six months previously, beginning with sudden obstruction in swallowing glass of hot spirits; since then was unable to swallow solids, but could readily take liquids; was a hard drinker, and a subject of constitutional syphilis; no family history of cancer. Owing to patient's serious condition, no examination by bougies was made, but he stated that three months before admission Dr. Perrigo had treated him for stricture of gullet, with some benefit; he stated also that he had lost weight rapidly since beginning of illness. Patient, from the first, was very weak, gradually sank, and died on Dec. 17th. *Autopsy*—Right pleura contained 40 ozs. thick, yellow, very turbid serum. Right lung collapsed; surface covered with a thick sheeting of lymph; no pneumonia. Left lung normal. Heart normal. Œsophagus, at level of bifurcation of trachea, presented a large, deep ulcer with shreddy bases measuring three-quarters of an inch by one-and-a-half inches; edges not indurated, but rather excavated, although base is thickened and a small lump of glands beneath base were enlarged and firm, and projected into left bronchus, shewing beneath the mucosa (which is intact) as a firm mass the size of a large bean. No secondary nodules elsewhere. No signs of syphilis. On microscopical examination, base of ulcer showed an epitheliomatous growth, the cells being arranged in columns and nests.

Dr. PERRIGO said he had passed a bougie down this man's œsophagus on two or three occasions, with relief to the dysphagia for a time.

Dr. MILLS said that German investigators had proved by experiments that a band of muscles of the œsophagus or intestines may be excited into contraction and remain so for a long time, like a tetanic spasm of a voluntary muscle.

Dr. SMITH said this patient came to see him about three or four months ago, complaining of difficulty in swallowing and cough. He diagnosed malignant disease, and sent him to Dr. Perrigo.

Dr. MIGNAULT said he had a patient, a nun, who has periodic attacks of dysphagia, which he was always able to relieve by a hypodermic of morphia. His patient, ten years ago, drank by mistake a strong solution of potash. He believes there is an old cicatrix in her œsophagus, which becomes irritated and sets up spasm.

Dr. CAMPBELL said that a duodenal ulcer will at times allow food to pass over it and at other times will not. He related briefly the history of a patient of his who died from hæmorrhage of an ulcer in the duodenum, in whose case these symptoms existed.

Dr. R. L. MACDONNELL read a paper entitled "*A Year's Medical Work in the Out-patient Room of the Montreal General Hospital,*" in the course of which he read very many reports in brief of some of the more instructive cases he had met with during the year ending May 31st, 1884, together with remarks upon the clinical features peculiar to the cases noted, as well as to those met with in out-patient practice generally. The paper included more particularly remarks upon three cases of lead palsy, in two of which no distinct history of metallic poisoning could be traced, while in the third, colic and wrist-drop had followed the prolonged use of tinned vegetables. Two patients with locomotor ataxia had presented themselves, and one of tabes in its pre-ataxic stage, symptoms present being recurring gastric attacks, one with hæmatemesis, at first supposed to be caused by alcoholism, followed by temporary derangement of vision (Argyll-Robertson