nosis was made by Dr. Cochrane, then a resident physician in the hospital. In the other, no diagnosis had been made. In this case there was no history of injury, nor was there any history of a ruptured cyst. Moxon gives the latter as sometimes the cause. The diagnosis of such an obscure case can only be correctly made by an accurate examination of all the organs, of the careful and thoughtful consideration of all the evidence obtained, and by the use of an exploring trocar.

Dr. Scadding had seen this patient on two or occasions, first in July, 1890, when he had diagnosed perihepatitis. He then had an elevated temperature, constipation, and jaundice. He thought his symptoms were due to a chill while bathing.

Dr. W. J. Greig had also seen him last November, and found his temperature 100° F. and pulse 90. He suspected perityphlitis. There was no abdominal distension; resonance was present on the left side, and dulness on the right; there was forcible vomiting of a black material, and a good deal of gastric flatulence. He had been taking capsules containing carbolic acid, which would, perhaps, account for the black vomit.

Dr. John Caven said this looked like a pyæmic abscess. As in man, at any rate, suppuration never takes place unless micro-organisms are present, there must have been some channel for germ infection—perhaps some lesion of the stomach wall, or of the retroperitoneal glands. There must have been an infective focus somewhere. There may be pus without micro-organisms, but it is only rarely and with much difficulty produced as the result of experiment. The dense wall of the abscess would show that it had been in existence for a long time.

Dr. Primrose asked how the gastric dilatation was to be accounted for.

Dr. Peters said: Might not the stomach dilate from peristalsis taking place when the organ was filled?

Dr. Graham replied that he did not think the healthy stomach would dilate from being filled, and peristalsis then take place, but would hypertrophy. It would be otherwise, however, with a stomach the walls of which were in an unhealthy condition. Sub-diaphragmatic abscesses were very difficult of diagnosis. He had seen only two cases before this one, one of which had been accurately diagnosed by Dr. Cochrane when an assistant in the General Hospital.

CEREBRAL HEMORRHAGE.

A case of cerebral hemorrhage, reported by Dr. Barnhart, was presented by Dr. Graham.

G. T., aged forty-four, had always enjoyed good health. He, however, had met with a serious accident when twenty-six years of age, on account of which his leg was amputated in the middle third.

On the afternoon of November 4th, while returning from Little York with a load of lumber, his horses were frightened by some unusual noise and ran away, overturning the wagon, and throwing him to the ground with the lumber. Dr. Walters was quickly summoned, and found him in an unconscious condition, but with no visible injuries except a fracture of the tibia. He put the leg up in temporary splints, and sent the patient to the hospital.

The accident occurred at 5:30 p.m., and the patient was brought to the hospital at 6:45 the same evening. The fractured limb was dressed, and the patient put into bed. There was no sign of injury to the head. The patient was unconscious and utterly helpless: temperature 101; face slightly flushed, hot and moist; pulse rapid but regular, 140 per minute; heart sounds distinct. Both upper and lower extremities were affected with slight spasms, which varied somewhat at different times from greater to lesser degrees of rigidity. The neck was flaccid, the cheeks relaxed, but the jaws were rigidly closed. There appeared to be a condition of hyperalgesia and hyperæsthesia, as the patient would show signs of distress when the catheter was introduced into the bladder, or when the supra-orbital nerve was pressed upon. The conjunctival reflex, at first absent, returned in a few hours after admission. The pupils were very sluggish and slightly unequal, the right being the larger. The breathing was stertorous, the cheeks puffed out at each expiration. After eight or ten hours, Cheyne-Stokes breathing gradually developed in its most typical form. The progress of the case was marked by a great rise of temperature; 103°, 106°, and 107° were registered in the first twenty-four hours, and Dr. Barnhart is of opinion that it