under surface of the organ to within 2 cm. of the upper and outer surface of the lobe; its breadth from side to side was 12 cm., and from above downwards it was 15 cm. (6 inches) across. Throughout the rest of the right lobe there were scattered a few other secondary abscesses; the largest of these was 15 mm. in diameter.

The intestines were markedly congested. In the jejunum were a few subcutaneous hæmorrhages. Upon examination of the large intestine no signs could be made out of any dysenteric lesions. Close to the ileo-cæcal valve was a small whitish patch, which gave rise to the suspicion that there was a ciacatrix, but upon closer examination the most that could be discovered was that here the mucous membrane was softened and thin, with no ulcerous or old inflammatory conditions. Here, then, as not unfrequently occurs, the amœbic abscesses of the liver were present, without any indication of dysenteric intestinal lesions, either during life or at the autopsy. It is to be noted, however, that the hepatic flexure of the colon was in close contact with, and, in fact, adherent to, that portion of the under-surface of the right lobe of the liver, which was undergoing necrosis.

Beyond that the heart presented the condition of early pericarditis, and that the kidneys showed some acute parenchymatous nephritis, the condition of the other organs does not call for remark.

Stained sections of the liver and slough showed the presence of amœbæ; these were best shown by staining with methyl blue, and were faintly stained by hæmatoxylin. In the abscess cavity and its walls were numerous masses of streptococci. These were evidently of secondary growth, for the abscess contents were singularly free from pus cells, being mainly formed of broken down cheesy matter. Microscopic examination of the walls of the colon showed no evidence of necrosis.

In this case, therefore, the presence of fever, of hepatic enlargement, pain and tenderness, suggested the presence of purulent inflammation in the neighborhood of the liver. That this was so was confirmed by the result of aspiration. Whether the abscess was sub-diaphragmatic or in the liver substance was determined by the discovery of the amœbæ in the removed fluid. These indicated clearly that the origin of the disease was in the liver itself.

The failure to find amœbæ in fæces was explained at the autopsy by the absence of any dysenteric ulcers or necrosis in the colon.

This case gains an additional interest from the fact that, so far as we know, it is the first recorded in Canada in which the amœbæ coli have been demonstrated in an hepatic abscess, if not in the living body generally.

Dr. LAFLEUR stated that this was the first case of the kind reported in Canada. The presence of abscess without dysentery is not at all unusual. He had seen three cases in Baltimore, which began as abscess of the liver, and in which it was only secondarily discovered that the patient suffered from dysentery, and, in fact, this was so slight that it did not form an important part of the disease, the lesions in the bowel being very secondary and unimportant compared with those in the liver. The anatomical picture in this case was exactly like that he had observed in a good many fatal cases of liver abscess, in which the amœbæ seemed to be the cause of the disease, and he had no doubt that the microscopical examination would be found to correspond. The pus of the abscess really consists of masses of softened necrosed material, and, as a rule, unless there has been a coincident infection by pyogenic organisms, the leucocytes are very few in number. He added that since he had written his share to the contribution on "Amœba in Dysentery," there have appeared in Germany and Austria a number of works upon the subject, which seem to favor the existence of a distinct form of dysentery caused by the amœba coli, and which confirm the work done in Baltimore.

Stated Meeting, March 9th, 1894.

A. D. BLACKADER, FIRST VICE-PRESIDENT, IN THE CHAIR.

Dr. O. F. Mercier was elected a member of this Society.

Xanthoma Tuberosum.—Dr. SHEPHERD showed a case and gave the history as follows:—The patient was a woman, aged fifty, who had suffered severely from jaundice, and was at present jaundiced. Three weeks before, she had noticed some yellowish-looking tubercles under the skin, which were of the size varying from that of millet seeds to that of peas. These grew larger, and others appeared in the normal lines and folds of hand, and often on the surfaces of phalangeal joints; here the tubercles were fused together into a raised yellowish band, which were subepithelial. These growths looked as if they contained fluid, but on pricking them it was seen that they were dense and fibroid in character. Latterly, tubercles of same character had appeared on the elbows and knees and also on the lips and side of nose. They were excessively painful when touched and pressed, and itched a great deal. The hands were continually perspiring. Dr. Shepherd said this was a somewhat rare disease, and was more common in women than men, being often but not constantly associated with jaundice. The tubercles are not connected with the sebaceous glands, as seen by