THE CANADA MEDICAL RECORD.

VOL. XI. MONTREAL, MAY, 1883. No. 8

CONTENTS.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, March 16th, 1883.

T. G. RODDICK, M.D., VICE-PRESIDENT, IN THE CHAIR.

Dr. Osler exhibited the following pathological specimens:—

Membranous cast of Windpipe and Bronchi.—An unusually extensive cast of the air passages taken from a patient of Dr. Blackader's who died of diphtheria. Tracheotomy had been performed, but death took place from the gradual filling of the bronchi with the exudation. The glottis was completely occluded, and the membrane was so firm and consistent that it was removed entire from the rima to the tubes of the 3rd dimension, the tracheotomy orifice perforating it about 1½ inches below the rima.

Chronic Bright's Disease.—The patient had been ill for six weeks with dropsy and other signs of chronic renal trouble. The fluid in the peritoneum and pleural sacs was milky, and a specimen of it was shown by Dr. Ross at a former meeting. The kidneys were large, pale and smooth; cortices swollen, and presented many opaque areas of fatty degeneration. Examination showed the interstitial tissue to be also somewhat increased, and many of the Malpighian bodies were atrophied.

Aneurism of Pulmonary Artery in small cavity.—Taken from patient with chronic phthisis, who had had profuse hæmoptypsis, which had been checked, but death followed in 48 hours from exhaustion. In the upper part of the right lower lobe there was a small cavity filled with clots, and projecting from the wall was an aneurism the size of a large pea. This had ruptured, and was filled with pretty firm clots.

Dr. Osler called attention to the frequency of these small aneurisms, and to the fact that the fatal hæmoptysis in chronic phthisis is very often due to their rupture.

Acute Tuberculosis of Lung and Spleen.—A. M., aged 26, under care of Dr. Geo. Ross, admitted into hospital with symptoms suggestive of some low form of blood poisoning, with severe pain and tenderness in right side of abdomen. No physical signs of lung or heart trouble. A year before, had symptoms of chest trouble, apparently recovered from, with exception of loss of weight and night sweats. While in hospital he failed rapidly, with irregular temperatures. One week before death, physical signs began to develop over front of left chest, slight dullness, feeble breathing, and fine râles; this condition soon extended over the whole of both lungs, increasing rapidly in intensity. At autopsy, lungs crepitant, except at apices, where they are firm; both organs universally stuffed with miliary tubercles, largest in upper lobes, making small caseous nodules size of