VERMIFORM APPENDIX REMOVED DURING OVARIOTOMY.

There were dense adhesions and ascitic fluid present in the abdomen; the ovarian cyst, for which the operation was undertaken, was multilocular and suppurating. The vermiform appendix was brought up into the wound, and it bled so profusely and persistently that it was deemed advisable to pass a ligature around it and to remove it. The peritoneal surfaces were brought together, as mucous surfaces will not unite.

Dr. Ross also exhibited a specimen of

INTESTINAL ANASTOMOSIS IN A DOG.

An operation had been performed in which six inches of intestine were first removed, and then an operation for the establishment of intestinal anastomosis performed. The dog died after three weeks, and the specimen exhibited shows the establishment of the anastomosis.

Dr. Macdonald reported a case of

CYSTIC SARCOCELE—SECONDARY GROWTH IN THE LIVER.

A man came to Dr. Macdonald eight years ago (the patient was twenty-five years old at the time); there was no history of syphilis, and he had a good family record. About a year before coming to Dr. Macdonald, he had received an injury to the testicle while riding. Pain resulted, which continued for a year and then a swelling appeared; there was fluctuation in one or two points in the testicle and in the cord. Dr. Macdonald removed the testicle and a good recovery followed. Subsequently he strained his back whilst lifting a heavy weight; this was followed by fever, thought at the time to be malarial; others thought he had spinal disease, but the case was obscure. During the middle of last summer Dr. Macdonald was called to see him, and detected a tumor on the left lobe of the liver, hard, and to a certain extent movable. Dr. Macdonald made an incision and found a tumor involving the left lobe and the under surface of the liver, removal was impossible. An unfavorable prognosis was given, and the man died. A *post mortem* examination could not be obtained.

April 30th, 1891.

The Vice-President, Dr. A. A. Macdonald, in the chair.

Dr. J. E. Graham showed a patient suffering from

RIGHT FACIAL PARALYSIS, WITH PARALYSIS OF THE RIGHT ARM AND LEG.

The following history was given: Miss B., æt. 23, one night three weeks ago went to bed well, and on the following morning she found that the right side of the face was paralysed, as were also the right arm and leg. This kept getting gradually worse for a week, and she then consulted a doctor, who referred her to Dr. Graham. It was noted that the patient had not the ordinary paralysis of the face of hemiplegia, because in her case the orbicularis palpebrarum is paralysed and she cannot wrinkle the brow on the affected side. She also has complete hemi-anæsthesia of the right side of the face; the anæsthetic area extends beyond the distribution of the fifth nerve, and includes the back and upper part of the head. There is absence of smell and taste on the right side; partial paralysis of the right arm and leg. Increased knee-jerk on both sides, but perhaps more marked on the left. There is complete anæsthesia of the right side. The sensations of heat and cold have not yet been tested. The Faradic current produced little or no effect on the paralysed side of face. With the galvanic current the qualitative reactions on the affected side were abnormal—acc. > ccc. The reactions normal in the right arm and leg. The uvula does not appear to be affected. There is right-sided deafness, without any organic ear disease. Tactile sensation is lost in the hand; there is no dysæsthesia and no optic neuritis. For the first few days after the onset of symptoms the temperature was slightly elevated. The case is somewhat obscure. 1. It is not an ordinary lesion of the internal capsule of the opposite side, because if it were so the orbicularis palpebrarum and the muscles of the forehead would not be paralysed, nor would there be anæsthesia. 2. A lesion in the anterior and upper part of the pons on the left side, if sufficiently extensive, might account for the anæsthesia and paralysis of the face and side, but would not account for the paralysis of the orbicularis palpebrarum, and of the occipito-frontalis muscle. 3. The only explanation seems to be that of a lesion in the facial nerve as it passes through the aqueduct of Fallopius, and the neuritis passing back so as to involve