history of the case. He attributed its cause to a strain during a tug of war.

Dr. T. F. MacMahon then reported a number of cases under the heading of "Obstetrical Worries." See page 182.

Dr. Carveth said he had heard of a number of cases lately. He emphasized the importance of examination of the urine. There was more danger of sepsis if the kidneys were not functioning well. There were many cases of auto-infection, he believed, in which the medical man unjustly blamed himself.

Dr. Greig, referring to the bowel lesions in the case of pyonephrosis reported by Dr. Nevitt, said enlargement of Pytre's patches had been noted in nephritis and also in serious septic cases.

Dr. Parsons also referred to the enlargement of these glands in septic conditions. He asked if it was possible that this might have been a case complicated with intestinal lymphatic leukæmia. He thought sections through the enlargements would be of interest.

Drs. C. J. Hastings, Webster and Greig briefly discussed Dr. MacMahon's cases.

Dr. MacMahon closed the discussion.

The Society then adjourned.

TORONTO CLINICAL SOCIETY.

A meeting was held on April 15th.

Dr. Albert A. Macdonald, President of the Society, was the chairman.

The minutes of the March meeting were read and adopted.

The following fellows were present: Dr. Nichol, of Baden; George Elliot, William Thistle, William Aikens, Charles Trow, Graham Chambers, Elliott Brown, Geoffrey Boyd, Herbert Hamilton, Frederick Fenton, William Oldright, J. Algernon Temple, Herbert Bruce, William Pepler, F. LeM. Grasett, Albert A. Macdonald, and George Bingham.

Dr. Bruce read a paper on "The Surgical Treatment of Osseus Ankylosis of the Temporo-Maxillary Articulation."

Four years ago the patient fell down stairs, striking her chin forcibly on the lower step. Dr. Stevenson, who saw her immediately afterward, says there was no dislocation of the jaw, but that the alveolar process of the upper and lower jaw in part was broken, causing part of the teeth of both jaws to be loosened. Some of the teeth penetrated the lower lip, the scars of which remain. She could remove the jaw freely after the injury, and continued to do so for about a year. The movement gradually diminished until one and a half years after the injury the jaw became fixed. Then a wedge-shaped screw gag was used on eight or nine occasions under chloroform. This was followed by temporary movement. Soon, however, all movement was lost and the jaw became absolutely fixed. On examination, August 9th, 1897, the jaw was quite fixed, neither lateral nor up and down movements being possible, and was said to have been in this condition for two and a half years. The jaw was displaced laterally to the right side about one-sixteenth of an inch, indicated by noting the relation of the middle line for the two jaws, as shown by the incisor teeth. From this I concluded that the disease involved the right joint and advised excision of the condyle. On September 9th the transverse incision was made three-quarters of an inch long, one quarter of an inch below the zygoma, beginning just in front of the ear. The parotid fascia was divided along the zygoma, the parotid gland displaced downwards, the joint exposed, the neck of the condyle was chiselled through and an attempt made to separate the jaws. This was found impossible. The coronoid process seemed to be held firmly to the skull. As the