some bright blood. Glandular enlargement in the neck was only noticed two days before death. From the general appearances, Dr. Schmidt thought that it was probably a case of cancer of the stomach.

Ulcerative Endocarditis.—Dr. Lafleur exhibited a very typical specimen of this condition The patient, a negro, aged 40, had an attack of rheumatism (the first attack) six months before, and had been in the hospital for three months. Clinically there could be detected signs of an endocarditis with insufficiency of both aortic and mitral valves. At the autopsy there was found hypertrophy and dilatation of both ventricles and left auricle, the hypertrophy about compensating dilatation. There was old disease of the mitral valve, while on the ventral flap there was a large vegetation, having a hole in the centre, and to it was attached a large fibrinous clot, which was divided into threads at the end, caused by its flapping backwards and forwards in the blood-stream. There is an erosion and rupture of the tendinous cordinous cords attached to one of the papillary muscles, which is very characteristic of malignant endocarditis. There is general thickening of the aortic valves, with vegetations where the valves touch each other. There is a distinct loss of substance, which is encircled by a rim of vegetations. There were no septic emboli found in any part of the body. This is rather unusal, as the proportion of non-embolic to embolic cases is small. Other lesions in the body were those of caronic heart disease. The immediate cause of death was a lobular pneumonia.

Dr Mills asked if the pneumonia could be traced to the condition of the heart.

The President said that it is not an infrequent occurrence to come across an embolus of the central artery of the retina, and he could not think that this vessel could be the only one singled out. He had seen cases which had been so diagnosed when no changes could be found in the heart or vessels, and thought if the diagnosis was correct there must be some further explanation of the occurrence of these emboli.

Dr. Lafleur, in reply to Dr. Mils, said that there was no evidence connecting the pneumonia with the heart lesion In answer to Dr. Buller, he said that the only explanation he could give was that the ophthalmologist takes much greater notice of minutiæ than the general practitioner. There may be many emboli all over the body which could not be diagnosed except by such direct examination as by the use of the ophthalmoscope.

Multilocular Ovarian Cyst containing Bone and Cartilage.—Dr. E. A. McGannon of Brockville exhibited the specimens, which he had removed from a girl of 16 on Dec. 30th, 1891, and gave the following history of the case:

The patient had always been healthy, though somewhat anæmic for the last two years. Menstruation began at 14½ years, had always been regular and of the twenty-eight day type, flow lasting for three days, being scanty and without pain. She first came under my notice complaining of lancinating pains in the left inguinal region. On examination, an abdominal tumour was found, which I diagnosed as ovarian. Consent was withheld until a short time previous to the date of the operation. The patient was then put into the St. Vincent de Paul Hospital and subjected to the usual preparation for abdominal section. On Dec. 30th, assisted by Drs. M. C. McGannon, T. F. Robertson and J. W. Lane, I opened the abdomen and removed the specimens now presented. The pedicles were ligated with silk and the stumps carefully covered with peritoneum, catgut being used in this procedure, and the dropped. The abdominal wall, as a whole, was taken up by silkworm gut sutures, but before tying them each layer of the wall was brought together with catgut. The patien made an uninterrupted recovery, the temperature reaching on one day only 99½°.

I must ask your pardon for thus going into some of the details of this operation when presenting a specimen; but I desire to invite discussion on some points of interest other than those presented by the specimen. First as to the specimen. The larger of these tumours was taken from the right side, and, as you see, is a mixed tumour, being a multilocular cyst containing cartilage and bone—a rather rare variety of tumour, and one that I believe occurs oftenest in women of from 15 to 25 years. The smaller tumour, taken from the left side, is simply a cystic ovary showing well the marke of ovulation. This patient began to menstruate only eighteen months ago, yet these ovaries have been active and these tumours have been developing much longer than eighteen months, which is, in my opinion, strong, evidence in support of the theory that ovulation has little to do with menstruation, and goes on long before that function is established. Second, I would invite criticism on the utility of carefully covering the stumps with peritoneum, thereby avoiding adhesions. Third, as to the closing of the abdominal wound. Hernia following laparotomy or abdominal section is, unfortunately, not rare, and is a very embarassing sequela. It is no doubt frequently, if not always, due to some particles of fat or muscle getting between the fibrous layers of the abdominal wall and preventing their union. Primary union may occur in the skin. but the skin is an elastic tissue and plays no part in supporting or keeping *in situ* the abdominal contents. It is very essential that good union shohld be had between the fibrous layers, and to this end they should be brought together. The time is coming, if it has not already arrived, when hernia following abdominal section will be charged (and properly