

considerable callus; allowed up; passive motion to knee, which is stiff.

Nov. 14th.—Able to run about the ward; very slight motion at knee-joint.

Nov. 28th.—Learning that chloroform was to be administered and the knee-joint loosened, he ran out of the Hospital.

THE MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, December 9th, 1892.

JAMES STEWART, M.D., PRESIDENT, IN THE CHAIR.

Paramyoclonus.—DR. STEWART exhibited a middle-aged patient, who has been affected with a peculiar myoclonic trouble for upwards of fifteen years. The spasms, which are almost constantly present, are partly clonic and partly tonic in character. They affect the muscles of the neck, face and trunk only—the extremities being free.

DR. LAFLEUR asked if there was any hereditary history, and if the case might be one of senile or Huntingdon's chorea.

DR. STEWART replied that as far as he could ascertain there was no neurotic family history. It was not a case of Huntingdon's chorea, which is characterized by the sliding, jerky movements in walking, and which are entirely distinct from the movements in this case.

Acute Hæmorrhagic Pancreatitis with Fat Necrosis—Glycosuria; Symptoms those of Peritonitis.—DR. FINLEY exhibited the specimens, and stated that the case had been looked upon as one of peritonitis. At the autopsy there was no evidence of peritonitis or obstruction. A distinct mass in the position of the pancreas was felt, and on removal the organ was seen to be greatly enlarged, weighing 380 grams. On section the gland was studded with numerous purplish-colored hæmorrhages, varying in size from a small pin head to one-fourth of an inch in diameter. A number of small round opaque white areas, like tallow, representing fat necrosis, were present on the surface of the gland and a few scattered through its substance. None of these were larger than the size of a split pea. There was no fat necrosis in the omentum, but a few small areas in the immediate neighborhood of the pancreas. Some of the fat lobules were surrounded by a fringe of this necrosed fat. There was a small thin patch of lymph lying on the surface of the organ. The mesenteric and splenic veins were normal.

A specimen of the urine analyzed by Dr. Ruttan was found full of mucin, no albumen, sugar 1.66 per cent., no acetone, no diacetic acid, urea 8.5 grs. to fl. oz., bile pigments and bile salts in excess. The usual symptoms of this affection were those of peritonitis. One of the most interesting features of the case was

the presence of sugar in the urine, and, so far as he could ascertain, no previous mention of this was recorded.

In view of recent investigations on pancreatic diabetes, it was not unlikely that sugar might prove to be a constant constituent, and, if so, would be a valuable diagnostic sign. The presence of bile pigment might perhaps be referred to pressure on the common bile duct by the enlarged pancreas.

Fat necrosis has been frequently noticed in hæmorrhagic pancreatitis, but its significance is not altogether clear. It has been explained by some as due to trophic changes from interference with the nerves of the solar plexus, and by others it is regarded as due to pressure interference with the vascular supply.

REPORT BY DR. J. G. ADAMI.

Upon section, the pancreas as a whole was of darker color than usual, and presented several blackish blood-stained areas varying in diameter from 3 to 12 millimetres. That organ was surrounded by a moderate amount of fat, having an abnormal appearance, for scattered over its surface and through its substance were small whiter masses, differing also from the rest of the fat by their opacity. The periphery of the gland was altered, there being no well-defined boundary between the gland and its investing fatty tissue.

Microscopic examination showed that the gland had undergone much chronic degenerative change; it was fibroid, and presented abundant evidence of atrophy of the pancreatic follicles. This was especially marked towards the periphery. Here were numerous small regions in which fat cells replaced the atrophied gland tissue. The hæmorrhages into the gland were of sufficiently long standing to have permitted the staining of the cells of the affected areas with blood pigment. Sections made by the paraffin method and stained with hæmatoxylin showed well the extensive fat necrosis, both within and around the gland. The necrosed fat cells contrasted clearly with the unaffected in that they took on a diffuse cloudy stain.

It was noticeable that, while there was evidence of acute inflammation here and there throughout the fatty tissue, there being slight infiltrations of small round cells between the fat cells, nevertheless, these inflammatory foci were not in direct association with the necrosed areas. Between the necrosed cells no infiltration was discernable. The extravasated leucocytes lay between clear unaffected cells at some little distance from the patches of necrosis. In this the sections resembled those brought recently before the Pathological Society, of London, England, by Dr. Rolleston (*British Med. Journal*, Oct. 22nd, 1892, p. 895), and differed from the description generally given. (*Fitz. Med. News*, Feb. 23rd, 1893.)