urine diminished in quantity, no sugar, albumen nor casts. Ten days after admission she had a severe vomiting spell and at once lapsed into a profound stupor which continued for about six hours. From this time the mental obscuration seemed to be more marked. She answered questions intelligently but was unable to follow any conversation. At this stage the grating of the teeth at night was distressing. The temperature, which up to the present, had not exceeded 100 F., now ranged from 101 F. to 103 F. Three days later another peri[illegible] of unconsciousness followed lasting about the same time as the former and differing only in the additional discomfort—involuntary movements of the bowels. These apoplectic attacks recurred at intervals until her death.

Dr. J. C. Connell examined the eyes July 27th and reported as fo[illegible]ws:—Right eye, anaesthesia of the cornea, pupil reacts slightly to light. With ophthalmoscope cornea hazy and fundus seen with difficulty, disc choked, retinal arteries almost invisible, retinal hæmorrhage irregular in outline, covering the upper part of the disc and curving in a crescent downwards towards temporal side. Considerable lachrymation during examination.

Left eye—Pupil normal in size with slight reaction. On touching cornea with finger there is reflex closure of eyelids. With ophthalmoscope media hazy, disc choked: infiltration from papillitis extends over considerable part of the retina, arteries not visible, veins large and tortuous, no hæmorrhage.

Diagnosis—The prolonged headache gradually getting worse, the vomiting, optic neuritis, involvement of the 3rd nerve, the mental obscuration and general failure in health left no doubt of the presence of a cerebral tumor. Localization was not more difficult. The continued occipital pain suggested the posterior fossa as the seat of lesion. Sequin advises basing localization of the lesion on the first symptom of paralysis, which in this case was the drooping of the right upper eyelid, supplied by the superior division of the 3rd nerve. The nerve has its deep origin in the floor of the aqueduct of Sylvius. The pressure symptoms enumerated chiefly cerebellor indicated that the lesion was at or near the origin of the nerve.

Treatment—Increasing doses of Pot. iodid without effect, otherwise palliative.

PATHOLOGICAL REPORT (DR. W. T. CONNELL.)

On removing dura, surface veins full, no bulging of substance. Sections made from above downwards. Substance very soft and