ing and removing the tube, together with this fibroma of the right ovary. Fortunately here the operation was in time, before the inflamatory process had extended very far, that is, while it was yet localized and before paresis of the intestinal wall had occurred, and the result was all that could be desired.

These cases are primarily in the hands of general practitioners, and I believe it to be the duty of the family physician to thoroughly inform himself of the natural history of this disease, and not to discharge a patient suffering from salpingitis as soon a she can sit up and join her family at dinner, but to watch carefully over her for months and years if necsessry, and to keep informed of the condition of the tubes, and thus discharge one of the highest functions of the family physician. And I believe that in recurrent cases of salpingitis, as in recurrent cases of appendicitis, the question of operation is a legitimate one for serious consideration.

Discussion.—Dr. W. Gardner agreed with all the reader of the paper had said. The danger of delay in such cases is obvious. He had seen the last case mentioned in consultation, and as her symptoms had improved he advised delay. Those who see many of these cases come across some of which have all the symptoms and physical signs of the disease which recover and remain well for years, while others with exactly the same symptoms do badly. It is a very difficult question to know exactly what to do; and for this reason he sounded a note of warning against the too frequent resort to surgical treatment.

Dr. Alloway spoke of the extreme difficulty of diagnosing salpingitis beforehand, of determining whether the patient has pus-tubes or not. He had operated on cases where the whole pelvis was one matted mass, with hæmatoma or abcess of the ovariess but tubes healthy. In the case of a healthy woman, whose history Dr. Armstrong gives, who, after making a good recovery after confinement, takes suddenly ill and dies from a rupture of a pus-tube, the question arises—When did that pus originate? Is it not possible that it may have originated after impregnation, when the slightest tendency to inflamation might lead to abcess.

Dr. Shepherd asked if all these cases originated in gonorrhœa. He was rather startled by Dr. Armstrong's advice to "extirpate the viper when young," for the mortality would be greater if the operation was performed by men not accustomed to it.

Dr. Armstrong, in reply, said that the diaagnosis was anything but easy. He makes a complete examination, under ether and taking symptoms that may arise into consideration, a fairly accurate diagnosis may be arrived at. If the condition cannot be determined, an exploratory incision becomes necessary. The question of when does the pus arise? is a very difficult one to answer. The disease may extend over long periods of time under varying conditions. Whenever there is distinct evidence of pus, the sooner it is removed the better.

Stated Meeting, December 4th, 1891.

F. Buller, M. D., President, in the Chair.

New Members.—Drs. T. F. Robertson of Brockville and J. V. Anglin were elected members

Mitral Stenosis.—Dr. Lafleur exhibited the organs from a case of mitral stenosis, which illustrated, in addition to the cardiac lesion, the various secondary changes. The heart was dilated the cavities being full of soft clots. It was also hypertrophied, the dilatation exceeding the hypertrophy, especially on the left side. The hypertrophy was most noticeable on the walls of the left auricle, the average thickness being four millimetres or three times the normal thickness. Marked changes were seen in the mitral valve, the orifice being reduced to a button-hole opening, which barely admitted the tip of the little finger instead of at least two fingers. On the aortic semilunar valves there was an acute endocarditis engrafted on the old disease; the same was seen, but in a lesser degree, on the pulmonary semilunar valves. The mitral and tricuspid valves showed no signs of recent endocarditis. Right lung contained several typical hemorrhagic infarctions, the rest having a mottled appearance of brownish-red tint, and and is an example of brown induration due to the stagnation of the blood in the lungs. In the pulmonary artery there was found an adherent thrombus filling the branches going to the lower lobe. The left lung showed brown induration and typical pressure atrophy; at the root there was distinct evidence of and old infarction, which was decolourized. Histologically there is a large increase of the interlobular connective tissue; it is a typical catarrhal compression of the alveolar cells best known as chronic desquamative pneumonia. The liver showed the changes due to stagnatian, the characteristic nutmeg variety. The spleen was not large and dark, as would be expected, probably on account of it being bound down by adhesions.

Dr. Jas. Stewart related the clinical history of the case. The orgin of the endocarditis was doubtful. The girl never had suffered from rheumatism, but had had a violent attack of chorea at the age of seven, there being no articular pains as far as she could remember. The physical signs were characteristic of the disease; a raugh præsystolic murmur heard solely in the mitral area, and not propagated in any direction. Before death the physical signs of pulmonary consolidation were very evident.

Chronic Alcoholic Poisoning.—Dr. Jas. Stewart brought before the Society a man suffering from a train of very marked mental symptoms, together with certain sensory, motor and reflex symptoms. There had been mental depression for several months with perverted sensations, especially of the extremities. Very fine tremors of the hand and to a slight extent of the