wall.† Should his cases have really been correctly interpreted in this fashion, I am inclined to rank among them the specimen Eh 24, in the London Hospital Museum. Still, I suspcet that some such cases were tubo-uterine cysts. When developed to a very great size their relation to the Fallopian tube might become confused and constitute a source of fallacy. As to pregnancy in one horn of a double uterus, it has so clearly nothing to do with the specimen I exhibit this evening, that it is unnecessary for me to discuss that subject.

The cause of the arrest of the ovum in the uterine part of the Fallopian tube is not, in Mr. Roberts' case, self-evident. The cavity bearing the fœtus appears to be a pure dilatation of the tube; as in most similar cases, there is no evidence that the muscular structure of the uterus itself has been ruptured; hence the unsatisfactory character of the term "interstitial." Such a rupture would if it could be proved by dissection, have occurred from some uncertain cause, before the arrest of the ovum, for a very young ovum could hardly burst the tube, whilst, were the tube ruptured in its uterine part already, we can understand how an ovum might be forced into the uterine tissue, in stead of into the uterine cavity. The uterine orifice of the tube, that is to say, in this case, the aperture in the lower part of the cyst, is quite patulous, and there are no traces of any polypi-obstructing it, as in cases related by Beck, Breslau, and Leopold.* Yet, although the uterine orifice of the tube was unobstructed at the date of the patient's death, it might very possibly have been obstructed by catarrhal swelling of the mucous membrane some eight weeks earlier, and this would have been sufficient to arrest the ovum. On the other hand, a dilatation or tortuous condition of the uterine part of the tube might have existed before conception, and if so, it is easy to understand how the ovum was arrested in it; Leopold discovered an abnormal and crooked condition of this part of a left tube, in a case where the corresponding portion of the right tube held a fœtus. I believe that the truth lies between these two explanations, but that the second is more probable than the first.

† Since this paper was read, a "Case of Intra-mural Pregnancy Resulting in Missed Labor" has been contributed to the "British Medical Journal" (November 18th, 1882), by Mr. C. E. Steel, of Liverpool. In this case "the Fallopian tubes were normal, and opened into the uterus separately from the sac." Thus there can be little doubt of the nature of the sac, which could not possibly have been tubo-uterine.

* "Zur Lehre von der Graviditas Interstitialis," 'Archiv. fur Gynæokogle,' vol. xiii. heft 3.

Society Proceedings.

Stated Meeting, April 27th, 1883.

THE PRESIDENT, R. A. KENNEDY, M.D., IN THE CHAIR.

Case for Localization.—Dr. Osler presented a patient with the following history: Francis ———, aged 41, married fifteen years. Not known to have had syphilis, though he lost one child shortly after birth with a skin eruption. Has enjoyed good health, with exception of present trouble. For six years he has had epileptic fits; at first at rare intervals—one in three months—but now one every fortnight. Liable to have them at any time if much excited. They are, his wife says, confined to the right side, towards which, also, he tends to fall. Not known whether they begin in hand or foot, as he has not had a fit since under observation; always loses consciousness. Nearly two years ago he began to have trouble in the right leg, jerkings and stiffness, which have steadily increased. The right arm was also weak, and for the past five months the speech has been affected. His memory is not so good as it was, and at times he is irascible. He has had two injuries to the head; the first when a lad of seven or eight, which has left a long scar on the right side, high on the parietal bone. There is no adhesion of the skin and no depression. The other was received by the fall of a scantling, seventeen years ago, and is a flat scar a little behind bregma on the left parietal bone. It is not depressed, and the skin not adherent. At present nutrition of muscles good; he walks with difficulty, owing to stiffness of right leg, in which the spastic gait is well marked. Reflexes greatly increased in the leg. Knee-tap somewhat exaggerated also in the left. Right arm does not appear much affected, but he says it feels weak. Grip is good; dynamometer shows it to be a little weaker than the left. Slight paralysis of lower facial muscles; tongue deviates strongly to the right, uvula drawn towards the left. Speaks with hesitancy, and is often at a loss for a word. No impairment of sensation. No optic neuritis or retinitis. The patient's head was shaved and Broca's lines drawn in order to define the exact position of the old injury on the left side. It is just behind the bregma, and would correspond on the cortex of the brain to hinder part of the superior frontal convolution. The symptoms point to a lesion of the