times, in the diagnosis of follicular tonsillitis from diphtheria, and *vice versâ*. A case which he had lately seen presented all the appearances and symptoms of a follicular tonsillitis, which he would have pronounced as such but for a small suspicious patch on the side of the uvula. The case proved to be one of diphtheria.

Dr. England mentioned the case of a child whom he had seen with a temperature of 101° F., glands swollen at the angles of the jaw, and both tonsils covered with white membrane. The case looked very much like diphtheria. In three days the membrane had all disappeared and the child was better. Another child in the same family was similarly affected, but in this case a large cervical abscess formed. The mother of these children was also taken ill shortly afterwards; membrane appeared on both tonsils, temperature rose to 101°F., and she was considerably prostrated. He questioned whether these were cases of true diphtheria, and was more inclined to consider them cases of septic sore throat, as mentioned by Dr. Johnston.

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*Stated Meeting, 15th May,* 1891.

F. J. SHEPHERD, M.D., PRESIDENT, IN THE CHAIR.

Dr. G. Laforest was elected a member of the Society.

*Combined Lateral and Posterior Sclerosis.*—Dr. J. Stewart exhibited this case. The patient, a man aged 42, first showed symptoms of his trouble two years ago, in the form of weakness, stiffness, and difficulty in walking and standing, especially when the eyes were closed. When he came under observation two months ago, there was paresis of the lower limbs with marked ataxia and increased knee jerks. It was noticed, however, that in the course of the following month the knee-jerks gradually diminished, and were now completely absent. This was considered to be evidence pointing to the extension of the degenerative process from the postero-internal to the postero-external columns.

Dr. James Stewart read the notes of a similar case which had been under his observation at the Montreal General Hospital for a period of some weeks two years ago. The patient was 43 years of age, and presented the characteristic symptoms of combined lateral and postero-internal sclerosis. The patient died from erysipelas.

Dr. Finley, who performed the post-mortem, was able to demonstrate the existence of degeneration of both the lateral (crossed pyramidal) and postero-internal fibres.

Dr. Roddick inquired as to the cause.

Dr. Elder asked, if a case be seen early, what symptoms would lead to a diagnosis between postero-lateral sclerosis and tabes?

Dr. Stewart, to Dr. Roddick's question, replied that the patient had a history of syphilis, which he believed to be the cause. To Dr. Elder he answered that in tabes the knee-jerk was invariably lost, besides the presence of the Argyll-Robertson pupil, and lightning pains.

*Pericarditis.*—Dr. Finley exhibited this specimen for Dr. Wilkins. The pericardial sac contained a large quantity of pus. The inner surface was covered with lymph and some fibrinous adhesions between the visceral and the parietal layer. The outer surface was also involved. The left lung was found glued to the pericardium. The endocardium was healthy. The chief point of interest was that the lesion was primary, there being no history of Bright's disease or rheumatism.

*Appendicitis.*—Dr. Armstrong read a paper on this subject from a case in practice.

*Discussion.*—Dr. Hingston was doubtful as to the case being one of appendicitis. He had seen more than one case of appendicitis, when on the eve of an operation there would be a discharge of the pus. He thought that in such cases the pus emptied more frequently into the bowel.

Dr. Johnston had found pus in the retro-peritoneal region, the result of an appendicitis,—a large peri-nephritic abscess which he believed at first to be connected with the kidney, but on careful dissection, a narrow sinus was found leading down to a perforated appendix which lay behind the cæcum.

Dr. Shepherd had seen the case reported by Dr. Armstrong and was still of the opinion that the case was one of appendicitis. The appendix had been found bent on itself and closely attached to the posterior wall. It had perforated beneath the iliac fascia and extended upwards.

*The late E. H. Trenholme, M.D.*—The following resolution of regret was proposed by Dr. Hingston, seconded by Dr. Armstrong, and carried:—

"That this Society has learned with regret of the death of Dr. E. H. Trenholme, for many years a useful and active member: That it records its sense of his ability as a gynæcological surgeon and as an original observer."

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Prof. Keen selects the following points for the passage of the needle in the operation of paracentesis. In paracentesis thoracis the place of election is between the eighth and ninth ribs in the line of the axilla. In paracentesis abdominis the needle should enter in the middle line, the patient being in a sitting posture and the bladder having been previously emptied. In paracentesis pericardii the patient should be in the recumbent posture and the needle should enter at the fifth interspace in front, due regard being had for the heart and large vessels.—*Col. and Clin. Record.*