as a suitable case for pylorectomy. The tumor about the pylorus seemed small, well defined and unattached. The patient readily consented to operation, and on August 11th, 1894, an incision was made in the median line and the tumor examined. The case seemed favorable for pylorectomy, so the omentum was tied off, and on lifting up the stomach a large mass of infiltrated glands was seen on the posterior wall of the abdomen. All idea of continuing the operation of excision was abandoned and gastro-enterostomy performed. A piece of jejunum was brought up to the anterior wall of the stomach and fixed there by a double row of sutures, the outer row of Lembert sutures was continuous. No plate, button or other mechanical device was used. The patient did perfectly well, and went out of hospital during the first week of September, being able to eat with comfort, the vomiting having altogether ceased. Dr. Shepherd had not seen the patient again until a few days ago, when she sent for him; he found she was suffering from diarrhœa. Since leaving hospital she had been attending to her household duties as usual, and had no trouble about eating. The tumor could still be felt somewhat larger than in the summer, but patient looked well nourished and had a healthy appearance and did not suffer. Dr. Shepherd said that he thought the results of this operation were excellent, and it was worth doing to obtain six months freedom from pain, and this comfort with the chance, judging from her present condition, of enjoying several months more of good health.

Dr. G. GORDON CAMPBELL said that there had been almost entire absence of symptoms pointing to gastric cancer previous to her admission to hospital. The tumor had been discovered on making an examination of the abdomen. There had been no pain or vomiting, and general debility, for which she had spent a couple of weeks at the seaside without benefit, was the chief complaint. While in the medical wards vomiting had commenced, and at one time a very large quantity of stomach contents was expelled. The tumor was about the size of an egg, freely movable and situate about one inch above the umbilicus. Its connection with the pyloric end of the stomach was easily determined by dilating that organ. A test meal had been given and absence of hydrochloric acid demonstrated.

Pulmonary Embolism.—Dr. W. G. JOHNSTON showed a specimen illustrating obstruction of the pulmonary artery by an embolus. A number of rounded masses of blood clots obstructed the pulmonary artery in each lung. The history was interesting, both from a pathological and medico-legal standpoint. The man had been dead and buried about one week, when one of his friends made a curious statement: that the deceased had expected some accident to happen to him, and some persons were reported to have been laying traps for him. A post-mortem was ordered, and this curious condition of obstruction in the pulmonary artery found. No evidence of any primary source of an embolus could be detected, and this made it difficult to decide between embolism and thrombosis. In favor of thrombosis was the atheromatous condition of the pulmonary artery, the heart showing an unusual condition of great dilatation on the right side. He was said to have had a systolic murmur, transmitted very distinctly to the right, and owing to his having a very slow, heaving pulse, it was thought to be an aortic direct murmur, and there was some thickening of the aortic valve. Dr. Johnson, however, thought the murmur was produced in the right side.

Aneurism of the Thoracic Aorta.—Dr. ADAMI exhibited the specimen, and read the report.

Dr. JAS. STEWART described the treatment of the case.

Dr. WESLEY MILLS emphasized the value of laryngoscopic examination in diagnosing aneurisms of the aorta.

Dr. FINLEY thought that Dr. Adami's explanation of the difference between the pulse in the two radials was very ingenious, and seemed to be confirmed by the anatomical conditions present. He also thought that the late Dr. MacDonnell's explanation of the tracheal tugging—the aneurism pressing upon the left bronchus and pushing it down with each pulsation—was borne out by this case.

Dr. LAFLEUR had at present under observation a case of thoracic aneurism, the diagnosis of which was made by a laryngologist, and not by himself. The patient had been suffering from aortic insufficiency for fifteen years, and had been under the speaker's care for a year. He developed pain of a fixed character in the epigastrium, generally so severe as to prevent sleep at night. A troublesome cough, with huskiness, developed, and examination of the lungs gave negative results. There was no alteration in the size of the pupils, and no evidence of intrathoracic tumor. He finally had Dr. Birkett see the man, and an aneurism was detected projecting into the trachea, immediately above its bifurcation, about the size of a walnut. This case illustrated the importance of internal as well as external examination in such cases. Here, from the point of view of external examination, there was nothing at all to suggest aneurism, except trachea tugging, which was discovered to be present after the laryngological examination had been made.

Dr. H. D. HAMILTON had often treated the patient for his laryngeal complaint at the Longue Pointe Home. He happened to be at the Home one day examining some cases with