

been a separation of epiphysis of the lower end of the humerus. It was displaced forwards and inwards, and had become attached to the front of the lower end of the shaft and at right angles to it. The sigmoid cavity of the olecranon fitted upon the inner epi condyle and the head of the radius rested upon the outer half of the articular surface. The patient's age was 12 years.

Dr. Gurd exhibited a macerated foetus of rather more than three and a half months' gestation, from a case of missed abortion. The following history was given: The patient is a very large, healthy woman, mother of four living children, had menstruated last on January 23rd, and believes she became pregnant on the 5th of February. She was troubled with uncomfortable symptoms of pregnancy until about the 25th of May, when these suddenly stopped and her abdomen ceased to enlarge. From this time till September 23rd she complained of weight and coldness at the lower part of the abdomen. Every evening she had chills, but says she had no fever. Dr. Gurd was sent for on September 25th, and found a bag of membranes presenting. In about three hours afterwards the foetus was expelled. The cervix was hard and unyielding, so that he was unable to remove the placenta with the fingers. Dr. Alloway's assistance was sought, and under ether removed the closely adherent placenta piecemeal. The placental mass was unusually firm and hard in texture.

Dr. Trenholme said, with regard to this interesting specimen, the question arises how can such a dead and decomposed foetus be retained for four months. This can occur in but two ways; first, by the occlusion of the cervical canal; and, secondly, by the imperfect development of the decidua. The first mode he would not dwell upon, as it could not have existed in this case. The second cause of retention is of deep interest, and will never be found apart from exhaustion, general or local, and is due to imperfect and abnormal development of the decidua. In these cases he believes the foetus is destroyed for lack of uterine vitality whereby the reflex decidua fails to expand and give the required space, and thus the membrane must give way or the child perishes. Again, the question arises, why should this take place? and my reply would be that this is due to the lack of the union of the reflex and the true decidua. In these cases Dr. Trenholme has found the decidua smooth—not congested—and the uterine muscular tissue cartilaginous. In short, no pre-disposition on the part of the uterus to carry on the work it undertook to perform. This state of things enables us to understand how such a foetus is so long tolerated; also, how it is that such patients may menstruate regularly, have attacks of metrorrhagia, and even conceive again.

Drs. George Ross and Johnston suggested that a committee be appointed to ascertain the age of the foetus.

Dr. Major exhibited for Dr. Corsan a membranous cast of the trachea which had been coughed out after intubation in a case of diphtheria.

Dr. Major then read a paper on "The use of peroxide of hydrogen in diphtheria." This paper will be published at length.

In the discussion which followed, Dr. Corsan stated that he had used it frequently in nasal cases and found it very useful in keeping the passages clear.

Dr. Birkett remarked that Vogelsang had in 1885 used peroxide of hydrogen as an internal remedy in cases of diphtheria with remarkable success.

Dr. Major then read a few notes on "Two cases of deformity of the nasal septum, which will appear in full in our next issue.

The publishing committee was then appointed by the President as follows: Drs. James Stewart, F. W. Campbell and James Bell.

Dr. W. Gardner then read his retiring address, in which the work of the past session was carefully reviewed.

Regular Meeting, November 1st, 1889.

DR. SHEPHERD, FIRST VICE-PRESIDENT, IN THE CHAIR.

Dr. Johnston exhibited a pathological specimen from a case of chronic suppurative otitis media, in which there was, on the anterior surface of the right petrous bone, posterior to the edge of the semi-circular canal, and anterior to the region of the mastoid cells, a perforation a quarter of an inch in diameter, with thickened, rounded edges. At the edges slight adhesions exist between the petrous bone and the corresponding portion of the dura mater; but the dura mater readily removed, and is intact. The superior petrosal sinus is plugged with a recent thrombus; the right lateral sinus is filled with greyish-brown, fetid fluid, extending half way up to the torcular herophyli. The inferior petrosal sinus and the internal jugular vein are filled with a similar material, their walls thickened, rough and, in places, necrotic. On the external aspect of the inferior petrosal sinus the bone is exposed. On sawing into the temporal bone the cavities of the middle and internal ear are filled with a cheesy, fetid mass, which consists microscopically of leucocytes, crystalline fatty acids and bacteria; the drum membrane represented only by a few fibrous bands holding the ossicles in place. The tympanic cavity, the Eustachian tube, obstructed by granulations, and its surfaces, in places, have become adherent. Near the mastoid process the soft parts are free from oedema and infiltration. The external auditory meatus shows no obstruction. The