Dr. Churchill states "that the theory of superfœtation is opposed by physical difficulties, which are insurmountable in the present state of our knowledge." Dr. Ramsbotham says, "It is impossible to suppose that a subsequent impregnation can occur while one fœtus of four, five, or six months growth occupies the uterus." Dr. J. M. Duncan affirms "that the decidua reflexa is not in contact with the decidua vera till after the third month, and that up to that time there may be free communication between the ovary and vagina, and consequently, liability to a second impregnation." The possibility of such an occurence is also, I think, implied in the statement of Dr. Ramsbotham. Dr. Churchill remarks that "additional evidence, however, would be necessary to establish this opinion."

In the present instance there are no fixed data upon which to base a decided opinion; but from all the attendant circumstances of the case, I believe it to have been one of twin conception occuring at or about the same time. From an early period to the termination of utero-gestation, the patient complained of feelings and sensations quite different to any experienced during her former two pregnancies—she suffered from considerable pain and weight about the vagina and hips, and could not take the same amount of exercise as on previous occasions. She also complained of a hardness on one side of the abdomen, distinct from the general uterine enlargement. During the whole period of utero-gestation there was no discharge of liq. amnii—no flooding. There was but one placenta and one membranous receptacle. Had this been a case of superfœtation would there not have been two placenta? Then how account for the condition of the undeveloped fœtus which *must* have been four or five months dead in utero, and still was perfectly free from decomposition, and gave rise to no uterine action? According to Dr. Ramsbotham "this may be explained by the fœtus never having been in contact with the external air," then how account for some having been born putrid, under conditions similar to those related above, if the non-admission of air is of itself sufficient to prevent decomposition? Dr. Ramsbotham adds, "or perhaps it may be accounted for by the powerful vital principle which is resident in the gravid uterus, and which is in fervid operation for the purpose of bringing to perfection the living being it contains, protecting the dead mass from the ordinary changes of decay; and acting as an antiseptic power." This, if not quite satisfactory as an explanation, is at all events a beautiful hypothesis. There is nothing in the after history of the case necessary to be mentioned; convalescence having been rapid and uninterrupted.

THE INTERNAL USE OF CHLOROFORM IN CONVULSIONS.—Dr. Case of Tremont, Ill., recommends the internal use of chloroform in puerperal and hysterical convulsions, finding it to act better than when inhaled. He gives twenty drops and repeats it in half an hour. This however is a very small dose; probably he intends minims (there are four drops to a minim). A fluid drachm of chloroform is equal in soporific effect to 35 drops or 21 minims of laudanum. Dr. Hartshorne has given it in doses of from 50 to 75 drops every half hour for several hours together. And we are constantly in the habit of prescribing from 80 to 100 drops in colic and delirium tremens, and have never noticed any ill effects from its use in these quantities.—*Ed.*

The Montreal General Hospital was erected in 1821.

ON PLEURISY.

BY HYDE SALTER, M.D., F.R.S.

Being part of a Clinical Lecture delivered at Ch Cross Hospital. From the British Medical Journal.

The cases to which I wish to draw your a tion are cases of pleurisy; by which we mean you know, inflammation of the membrane lines the cavity and covers the viscera of thorax.

After giving the history of three acute cases, one s severe one, which he had successfully treated, with pletion or mercury, by means of ten minim doses of l num and chloric ether, with a grain of quinine, and employment of turpentine fomentations to the side, tinuing the mixture every four hours for two days, withstanding the frequent pains and semi-delirium and every six hours afterwards, iodine ointment applied externally towards the last. For turpentine the milder cases, he substituted a sedative liniment. He continues:—

You will observe that in all three cases the circumstance that brought the patient to the h tal was pain in his side; and pain of a pa character—severe, circumscribed, stabbing, greatly aggravated by inspiration. In Fran case, as we have seen, this pain was of the violent kind, resembling the plunges of some more than anything else. Now, such a pain almost always accompanies pleurisy; it is ra find pleurisy without it; and hence when pain is present, pleurisy is the thing one thinks of and looks out for. But pain in the may arise from fifty causes besides pleurisy; since some of these are very trifling, while pl is often a very grave affection, the diagnos lateral pain frequently becomes a very mome as well as interesting question. How then, in given case, can we ascertain if pain in the s due to pleurisy or not? I will endeavor to show as clearly as I possibly can. But I must s that the diagnosis is sometimes difficult.

If physical signs show the anatomical cond pleurisy to be present, then pleurisy clearly or has existed, and the pain in the side is pro due to it.

But supposing there are no physical sig pleurisy, is the pain on that account non-pleu Certainly not. I believe it perfectly possib pleurisy to be present, and yet not reveal its any physical signs whatever; either, becaus inflammation is not intense enough to give anatomical changes sufficiently marked to r themselves by physical signs, or because the of the inflammation is too early, and the ti not yet arrived for the development of changes: in such a case as this how are we t termine whether the pain points to pleurisy o

If there are other signs of lung mischief, w is often associated with pleurisy—as, for ex pneumonia, or tubercle, or cavity—then the probably pleuritic.

If pressure *between* the ribs produces the while pressure on the ribs does *not*, if inspir the great aggravator of the pain, if *there* is if there is fever and much constitutional di ance, and if the pain is circumscribed, and o without or below the nipple, then it is pro pleuritic, although there may be an entire a of all physical signs of lung disease.

If the pain is very severe and the pulse hi fected, the pain is *certainly (I think I may* s pleuritic.

If moderate pressure *over* a rib, as well as the ribs, produces the pain, the pain is ne ritic.