stomach, four-fifths of all the ailments medical men were called on to treat being caused by derangement of this organ.

Dr. Ferguson, Wesley, Mills, Gardner and Praeger discussed the paper.

The meeting then divided into sections, Dr. I. H. Cameron presiding over the Surgical side, while Dr. Moorhouse presided over the Medical.

SURGICAL SECTION.

Dr. Primrose presented a paper, subject, "A large sarcomatous growth in the neck, with secondary deposit in the lung." It was found in a boy four years of age, a patient in Victoria Hospital, Toronto, under Dr. Cameron. It extended on the right side of the neck from the median line in front to a point near the vertebral spine, and from the lobule of the ear to the clavicle. Was noticed two years and three months before, corresponding to the region of the right lobe of the thyroid gland. Caused little pain, was somewhat lobulated, with prominent veins coursing over its surface. Fluctuation distinct. Measurement on tumor side of neck, horizontally, 15½ inches; left side, 6 inches from lobule of ear on right side (over tumor), to outer extremity of the ciavicle 7 inches, on left side, 2⅓ inches Left pupil twice the size of right. Some dysphagia. Child died in July. The tumor was found in the P. M. to possess several processes, but it had not infiltrated or eroded the surrounding tissues, a point to be considered in the diagnosis. There were secondary deposits in the lungs. The anatomical relations of the various structures adjacent were much altered. The large vessels on the tumor side were entirely obliterated; those on the left side were enlarged. The processes spoken of were in the direction of least resistance. The muscular structures in the neighborhood were atrophied.

In the upper part of the tumor there was a predominance of fibrous tissue, and septa of this tissue divided it off into lobules of spongy tissue. A peculiar condition was found in the spinal cord, the cord being surrounded below the dura mater, by a mass of tissue, resembling in gross appearance the tumor growth, but it was not the same. It contained connective tissue corpuscles and nerve cells and fibres. Its nature Dr. Primrose had not made out. The tumor itself was examined microscopically, and proved to be sarcomatous. The beauty of Dr. Primrose's paper was that he had frozen transverse sections through the child, which exemplified in a most splendid way his paper. The sections were much admired by the Association. Photographs of the same were also presented for inspection.

Dr. Praeger spoke in high terms of the paper and the sections.

Dr. R. Ferguson, of London, then gave a report and presented a recent successful case of cholecystotomy. The symptoms of gall stones in this case were for a long time obscure, the pain being referred to the epigastrium; no pruritus, fæces lacking the characteristic color, and the absence of jaundice. Pulse and temperature remained normal. She had many attacks of pain which were relieved by hot appliances and morphia. These paroxysms did not appear or disappear suddenly. Gastric ulcer, gastritis and intestinal colic were excluded. Gastralgia was probable. Stomachic treatment gave no relief; the ordinary treatment for gall stones afforded no relief. But finally some of the typical symptoms of gall stones began to show themselves. Patient was transferred to the hospital with a view to operation. But after lying quietly for two or three weeks, she improved so much that she went home, operation being postponed. But she soon became worse. On one occasion she had felt, after a severe paroxysm of pain, a dropping of something in the region where the pain existed. Operation was gone on with. Eighty gall stones removed. The edges of incision of the gall-bladder were sutured to the edges of the wound. A cough retarded the process of healing. Repair did not take place well. Suppuration set in. Parotitis in left gland set in; also a localized peritonitis. The attacks of pain returned. Dr. Ferguson then tried to insert a catheter through into the bile duct, which he thought he accomplished. The side of the catheter appeared to grate on some hard substance, but improvement took place, and patient returned home in ten and one-half weeks after the operation. But in four weeks the symptoms reappeared, pain very severe, chloroform had to be administered constantly, as morphia seemed insufficient. She inhaled thirty-six ounces. Another operation was decdied on. The incision was extended downwards 1½ inches lower, allowing exploration with the finger in the region of the bladder. A body 2½ inches long, ⅛ inch thick was scooped out of the gall-bladder. Its structure had not been determined. The opening in gall-bladder was secured by a purse string suture, and a drainage tube inserted into bladder. Patient made a good recovery, although very nearly collapsed at the close of this operation. The pain in the second instance the Doctor thought might have been due to the presence of the mucous cast (if such it was), which might have been forced out of the bile ducts into the bladder. The Doctor's paper was valued highly. The patient was present, and the seat of operation exposed for operation. A small biliary fistula was still to be seen, but in other ways the patient seemed perfectly well.

Dr. Cameron, Chairman of the section, asked why cholecystectomy might not be done in such cases rather than cholecystotomy.

Dr. Praeger had had a case where the pain was