the tumor had increased considerably in size, bulging from the chest-wall as large as half a cricket ball; it was pulsatile, and its walls were thin. The pulse in the right wrist was now present, though small. Death took place in six days. The reappearance of the pulse was attributed to the rapid enlargement of the tumor in the direction of the front of the chest, which relieved in a slight degree, the pressure upon the innominate, and allowed the blood to flow again through the vessels.

Dr. Johnston exhibited the specimen. It was situated at the junction of the first and second part of the arcus aortæ. The innominate lay just within the sac; another sac lay in direct contact with the innominate artery all the way to its bifurcation, and was closely bound to it by inflammatory connective tissue. The sac was as large as two fists, and had eroded the first and second ribs in the right supra-clavicular region. The anterior wall of the sac was formed by the pectoralis major. The sac contained a large amount of fibrin, not very firm. The great arteries and veins were free. The sac lay in front of the trachea and pressed upon the right bronchus. The left bronchus was quite free of the tumor. The recurrent laryngeal nerves were normal. There was intense tracheitis, with an ulcer on the anterior wall of the trachea one and a half inches above its bifurcation. There was acute broncho-pneumonia of the right lung.

Dr. James Bell was interested in the case, inasmuch as the patient had originally been sent to his wards for surgical treatment. Ligature of the carotid and subclavian had suggested itself, but an examination revealed the fact that these arteries were already occluded. The absence of syphilis in the history, and of any atheromatous change in the vessels, together with the comparative youth of the patient, were very remarkable. He spoke of the cases recently reported by Macewen where the formation of white clot was artificially produced by pricking the sac through and irritating its inner surface with fine needles. Encouraging results had followed this treatment in the four cases reported by Macewen, in two of which the results were verified by subsequent post-mortem examination.

Dr. Geo. Ross regarded the case as being most interesting, but it was not in his experience a very unusual thing to find innominate aneurysm closely resembling in its symptoms and physical signs aneurysm of the arch, or *vice versâ*, and he had already a case closely resembling that brought before the society by Dr. MacDonnell. A correct diagnosis was impossible under the circumstances of this case. The points brought forward by Dr. MacDonnell with regard to tracheal tugging were interesting, though he was not prepared entirely to agree with the opinions expressed. He was under the impression that tracheal tugging could be produced by an aneurysm pressing upon the trachea from in front and exerting pressure downwards as well as backwards. He must, confess, however, that the result of the autopsy in the case before the Society strongly supported Dr. MacDonnell's view of the causation of this physical sign, and the aid it could afford towards the localization of the tumor. In the present state of our knowledge relating to the localization of thoracic aneurysms, surgical interference with innominate aneurysms will always be extremely hazardous. It is very desirable that all cases presenting themselves, in which it is difficult to determine whether a given aneurysm is innominate or aortic, should be most carefully examined and reported, so that some points might be determined by which to establish the diagnosis.

Round Ulcer of the Stomach causing Fatal Perforation.—Dr. R. L. MacDonnell stated that the patient, a woman, aged 59, had been under his care in the Montreal General Hospital up to about ten days before her death. Her case was interesting in the duration of the symptoms. The patient, who had been a needlewoman, began to suffer from pain and distress after food, with occasional vomiting, some twenty years ago. She was supposed to have dyspepsia up to 1877, when she was first seen by Dr. G. E. Fenwick, who noticed the "coffee-ground" appearance of the vomited matter. He elicited from the patient that she had been vomiting a darkish fluid for some years past. She was then suffering from severe pain in the epigastrium, vomiting after food, and hæmatemesis when she entered the hospital, and was under treatment for gastric ulcer for six weeks. She derived much benefit. With the exception of slight epigastric pain, she remained free from severe symptoms until 1888, when she was again admitted complaining of severe pain and vomiting after food. There was no hæmatemesis. She recovered, and continued apparently well till the beginning of this year, when she again applied to the hospital with symptoms of gastric ulcer. She was admitted under Dr. McDonnell. The patient was now much emaciated; the abdomen was very flat, and its walls extremely thin. There was diffuse tenderness over the epigastrium; no tumor perceptible. The patient was kept in bed several days and her symptoms carefully watched. Milk diet was ordered. Gastric distress was noticed to increase until evening, when vomiting gave her relief. It was thought that the symptoms pointed to cicatrized ulceration, which was probably delaying the advance of food through the stomach. A soft tube was therefore introduced every day at 4 p.m. and a pint of water slowly passed through it. The discomfort was relieved, no vomiting occurred, and she was able to sleep without epigastric discomfort or pain. At the time of her leaving the hospital she was free from pain and able to take most of the common articles of diet without