median raphé. Posteriorly the softening does not extend further than the lower third of the pons. The softening affects the fibres going from the cord and not the superficial transverse fibres from the cerebellum. The grey matter in the floor of the fourth ventricle is not affected. No other lesion was found in the brain, and the cord, as far as examined (a little way below the medulla), was healthy.

Echinococcus Cyst of the Liver.—Dr. Lafleur found in the same patient an echinococcus cyst It was situated in the upper part of the right lobe of the liver, just three quarters of an inch below the diaphragmatic attachment. It was found to be a firm non-infiltrating tumour with walls 1-12th of an inch in thickness, inside of which is a soft lining membrane, and from which spring a number of septa dividing the interior into alveoli, containing cheesy matter and distinct gritty particles of lime salts. At first the exact nature of the tumour was doubtful; whether it was a calcified solitary tubercle, a residual abscess or an echinococcus cyst that had undergone retrograde change The microscope proved the absence of the tubercle bacilli and, after a careful examination, the presence of the hooklets.

The patient from whom these specimens were taken was brought into the hospital suffering from a right sided motor and sensory paralysis. No history could be obtained from him as his speech was a mixture of bad French and bad German. He was not a native of Canada.

Suppurative Appendicitis.—Dr. Lafleur exhibited the specimen and gave the account of the autopsy. The abdomen was distended, and on opening it a condition of acute purulent peritonitis was found; 100 c.c. of pus were removed. The coils of intestines were matted together with recent lymph. In the right illiac fossa there was dense matting of the intestines about the head of the cæcum; on dissecting a cavity was found full of thin grumous pus containing a number of greyish particles. This was removed with part of the illiac and psoas muscles to show its relationship. The abscess was purely circumscribed, and there was no rupture, the cause of the acute peritonitis being the conveying of the poison through the lymphatics. The abscess was not of long standing, as shown by the moderate thickness of the walls. There was a commencing septic pleurisy on the right side.

Dr. Jas. Bell stated that the patient had been under his care for a few hours in the General Hospital. The illness had been a matter of ten days, and she has been attended by Dr. Finley for typical perityphlitis, and it was not until a week after the onset that he was able to detect a fluctuating mass in the right illiac fossa. He then advised her removal to the hospital for operation. At one o'clock on the day she entered the hospital she became suddenly collapsed, with subnormal temperature, the mercury not registering above 96°F. In this condition she remained for fourteen or fifteen hours, when she died. A consultation had been held, but it was thought, as the peritonitis was general, and as she had œdema of the legs and addomen, with albumen, in the urine. that operative interference would be hopeless, and the autopsy showed the wisdom of this decision.

Dr. Shepherd had seen the patient and had advised her removal to the hospi[illegible] He thought that it was a favourable case [illegible] operation, as he he had found a distinct fluctuating tumour in the right illiac fossa. The extension of the peritonitis was very rapid, and the intense shock with the accompanying low temperature is unusual when there is no perforation. Another point of interest about the case is the age of the patient, she being 52. Authorities say that appendicitis is very rarely met with after 35, but this is the second case that has died in the General Hospital between the age of 50 and 60. The other case was a German aged 60, who was admitted in a moribund condition, and in whom was found a perforative appendicitis.

Anatomical Anomalies.—Dr. Shepherd exhibited—

(1) *Meckel's diverticulum*, the specimen being of unusual size. This condition exists in about three per cent. of individuals, and is situated ten to sixty inches from the ileo-cæcal valve. It is due to the persistence of the omphalo-mesenteric duct.

(2) *A fœtus of a puppy* with closure of the facial and buccal clefts. There were no openings for mouth, eyes or nose. The ears were present, but situated very low down. When the specimen has been more fully examined a further report will be given. The specimen had been sent by Dr. Connell.

(3) *Secondary Astragalus* or Talius Secondarius is an ununited epiphysis of the Astragalus, and has inserted into it the posterior fasciculus of the external lateral ligament of the ankle-joint, and it overhangs the os calcis. Dr. Shepherd remarked that some ten years ago he published a paper in which he described this condition as due to fracture, but that he had since then altered his opinion and had come to the conclusion that it was due to an ununited epiphysis. It occurs not uncommonly, the speaker having no less than nine specimens in his possession.

(4) *Skeleton of a double monster* with single pelvis but double spinal columns and sacrum. In the lumbar region the union between the two columns is very close, the transverse processes being absent the columns are united by fibrous tissue. In the lower dorsal region the contiguous ribs are continuous, forming an increasing bony arch as they ascend and the vertebral columns diverge. The upper five ribs on