consisted in the administration, either by the mouth or by the rectum or by both, of sufficient water to keep the patient free from thirst (usually a most urgent symptom in profuse hæmatemesis) and to abstain from all attempts at feeding until the patient is able to take solid food by the mouth without pain or vomiting, when well-cooked meat is probably the most valuable and most easily digested aliment. In the second case it was feared that perforation had taken place, and the abdomen was opened between the umbilicus and the ensiform cartilage, but no evidence of peritonitis could be found. The wound was closed, and the patient, surgically speaking, made an uninterrupted recovery; but she still suffered from a certain amount of pain after food and occasional vomiting, with slight hæmatemesis. The operation was justified by the signs that were present, but perhaps the occurrence of profuse hæmatemesis ought to be regarded as strongly negativing the likelihood of perforation at the same time.

Dr. SHARP showed a specimen of the Fruit of the Cream of Tartar Tree from the Transvaal, and said it was stated in text-books that the cream of tartar tree was Adansonia Gregorii, a native of Northern Australia, but it was not possible to say, in the absence of leaves, &c., whether his specimen belonged to this species or to Adansonia digitata, which is a native of Africa, and is called the baobab, monkey bread, or Ethiopian sour gourd. The fruits of both Adansonia digitata and Adansonia Gregorii have a very similar composition. The extract of the leaves of the former evidently contains an agent which checks excessive perspiration, the pulp of both species is employed as a remedy in dysentery, and the juice expressed from the pulp is used as a drink in the fevers which prevail in the districts. Two German observers found tartaric acid and cream of tartar in the pulp, but there seems some doubt as to the species, while an English observer, whose specimen was also doubtful as to species, found chiefly acid malate of potassium. Dr. Sharp said he owed the specimen to the kindness of Mr. Richard Reynolds.

Dr. HELLIER showed a case of Tetany in a woman, aged twenty-nine years. Five years ago, when near the end of her second pregnancy, labour was brought on by a fright. Since then she had suffered at frequent intervals from attacks of painful tonic contractions of the wrists and elbows, the fingers being extended and adducted. The attacks last eight or nine hours, and she is rarely free for two or three weeks. The flaccid muscles contract on percussing the facial nerve (Chovstek's symptom).

Dr. BRONNER showed a Knife in shape resembling a sharp-edged ophthalmic tenotomy hook with a probe point, which he used for slitting up tonsils, the probe end being inserted into the distended follicles.

Mr. LITTLEWOOD showed an old case of Trephining. The patient was a male, aged nineteen years. In June, 1893, he was trephined over the left Rolandic area a month after a fracture of the vertex. He made a good recovery, and did hard work until June, 1896. He then fell ill with vomiting, headache, nystagmus, and weakness on the right side, and was under medical treatment until January, 1897. As he made no improvement and appeared to vomit everything, an operation was decided on. Mr. Littlewood turned down the old flap and exposed the trephine opening; it was about two inches in its longest diameter, and was closed with firm fibrous tissue. This membrane was cut through near the bony margin except at the lower part, and separated from the brain, to which it was adherent over an area of about one and a half inches in diameter, and replaced without stitching, so as to allow the brain to bulge through the opening. The scalp flap was stitched over this. The patient made a good recovery, and has not vomited since the operation. Mr. Littlewood remarked that it was difficult to understand why the operation had succeeded in such a remarkable way.

The following cases and specimens were also shown:—

Dr. NUNNELEY: (1) Case of Optic Neuritis, and (2) case of Pulsating Exophthalmos.

Dr. TREVELYAN: (1) Tremor of the Right Arm, and (2) Sections of Cerebral Tumour.

Mr. LAWFORD KNAGGS: Cæcum and Appendix, the latter having sloughed.

Dr. CHURTON: (1) Case of Enlarged Spleen, and (2) case of Syphilitic Spinal Meningitis.

Dr. WHITEHEAD: Microscopical Preparations of (1) Sarcoma of the Choroid, and (2) Glio-sarcoma of the Retina.

MIDLAND MEDICAL SOCIETY.

Mediastinal Tumour.—Resection of Colon.—Spinal Caries.

A MEETING of this society was held on March 3rd, the President, Dr. A. H. CARTER, being in the chair.

The PRESIDENT showed a case of Mediastinal Tumour in a man aged fifty-five years. The sole pressure signs were intense venous hyperæmia of the head and face, coupled with prominence of the superficial veins of the neck and the arms, more particularly the right arm. The diagnosis lay between aneurysm and tumour; if the latter, probably lympho-sarcoma.

Mr. F. MARSH showed a woman, aged thirty-two years, who was admitted into the Queen's Hospital, Birmingham, on July 22nd, 1896, for Chronic Intestinal Obstruction of five months' duration, which, however, had been complete for ten days. The abdomen was tympanitic and very tender to manipulation. Nothing definite could be detected by external, rectal, or vaginal examination. Enemata having failed to give relief, an exploratory opening was made in the middle line of the abdomen on July 24th, and a constricting growth was felt in the upper part of the sigmoid colon. The median incision was therefore closed and a second was made in the usual site for iliac colotomy. With a little difficulty a loop of the sigmoid colon with the part involved was brought out through the wound, and fixed, after the manner first described by Mr. Marsh in 1890, by passing a glass rod through the meso-colon. The following day a small opening was made in the colon above the constrictions to permit the escape of flatus and liquid fæces, and on July 31st the whole of the protruding loop with the growth was removed with the thermo-cautery. Owing to the yielding of adhesions in the lower angle there was after the final severance smart hæmorrhage from a large mesenteric vessel, which was stopped by pressure forceps left on to prevent the lower segment of colon from slipping back into the abdomen. The patient made a rapid recovery and left the hospital eighteen days later with a very satisfactory artificial anus. The growth was a large annular adenoid carcinoma. As the patient was in a collapsed condition at the time of the operation, and the abdomen and intestines were greatly distended, Mr. Marsh thought it wise to wait for a few months before performing an intestinal anastomosis. On Nov. 10th the patient was re-admitted, and on the 20th an elliptical incision was made round the artificial anus, which had become much contracted and indurated, and the tissues with the ends of the colon were excised. The lumen of the lower segment had considerably diminished from disease, and there was little difficulty in inserting the largest size Murphy's button, which was used to approximate the two ends. There was no recurrence either locally or in the abdominal glands. The button was felt in the rectum and was extracted on the eleventh day. The patient steadily gained weight after the colectomy and had no difficulty with the action of the bowels since the anastomosis. She is now in robust health.

Mr. JORDAN LLOYD read a paper on Practical Observations on the Symptoms, Diagnosis, and Treatment of Spinal Caries. He referred to the variability of the cardinal symptoms and deformity, rigidity, and pain in the several regions of the spine, and described the best methods of examining the vertebral column in its different parts. He thought that Sayre's plaster-of-paris support gave the best results in the majority of cases, and insisted on the advantage of recumbency as far as was consistent with good general health in all cases. He thought chronic abscesses were best left alone until they came quite near to the surface, and referred to a series of cases of laminectomy for paraplegia attended with the best results.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

Exhibition of Cases and Specimens.

A MEETING of this society was held on March 11th, the President, Mr. RECKLESS, being in the chair.

A letter from Lord Lister in acknowledgement of a resolution of the society congratulating him on his elevation to the Peerage was read and ordered to be entered on the minutes.

Dr. PORTER showed: (1) A case of Lead Poisoning with

fine general tremor like that of disseminated sclerosis; and (2) a case of Lateral Sclerosis.

Dr. BURGESS showed: (1) A case of Syphilitic Laryngitis; and (2) two cases of Muscular Atrophy.

Dr. ANDERSON demonstrated the method of Serum Diagnosis of Typhoid Fever. He showed under microscopes (1) a hanging drop culture to which serum from a patient suffering from typhoid fever was added; and (2) a similar hanging drop culture to which serum from a healthy person was added. He referred to the researches of Pfeiffer, Gruber, and Durham, and pointed out the bearing of their observations on the later work of Widal and Grünbaum. He described the microscopic and macroscopic methods of observing the re-action, and showed capillary tubes illustrating the latter method. He insisted on the necessity of avoiding contamination in the collection and examination of the blood, and thought it was always better to obtain a clear serum, which was most easily done by collecting the blood in sterilised pipettes and blowing it into a sterilised test-tube, as Durham suggested. It was necessary to dilute the serum, but more extended observations were required to fix the limit of dilution and the time-limit of observation by the re-action. Bacilli from old agar cultures were very rapidly agglomerated by typhoid serum and even more powerfully affected by normal blood than young growths twenty-four hours old. With very virulent cultures the re-action is delayed. Dr. Anderson had examined thirty-five cases; twenty-nine were clinically typhoid fever, and of these twenty-seven gave the re-action within half an hour, but in two the re-action was incomplete after twenty-four hours. Three cases of acute lobar pneumonia, one of pleurisy, and two of gastritis gave no re-action.—The PRESIDENT, Dr. HARGREAVES, Dr. RICHARDS, and Dr. BURGESS made remarks.

NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

Exhibition of Cases.

A MEETING of this society was held on March 11th, the President, Mr. WILLIAMSON, being in the chair.

Dr. McDONALD showed a man whose abdomen had been opened in Hamburg for an Abscess following Dysentery, but there seemed to be no positive evidence of its hepatic origin. He went home apparently recovered, but a month later was attacked with a violent pain in his right side, when he developed a swelling in the hepatic region and a typical pus temperature. The abscess was opened in December and characteristic chocolate-coloured pus escaped. The patient had recovered, but at the site of the first incision a hernia formed into which the stomach had prolapsed. Troublesome gastric symptoms now existed for which a third operation was required.

Dr. McDONALD next showed three children operated upon for Tuberculous Peritonitis. The fluid had been washed out, adhesions broken down, and the wound sutured without drainage. All had made good recoveries.

Dr. McDONALD also showed a woman whose Breast and Axillary Contents were Excised in January, 1895. She was operated upon for recurrence three times subsequently, and was free from any local growth. She presented the swelling over the sternum characteristic of bone-marrow infection and had pain in her lumbar spine.

Professor GEORGE MURRAY showed typical examples of Exophthalmic Goitre and of Spleno-medullary Leukæmia.

Mr. PAGE showed a girl twelve years of age who when ve years old had suffered from Tabes Mesenterica. She recovered, and, though not robust, had not been ill since. Nine days before admission into the infirmary she was suddenly seized with abdominal pain and developed peritonitis. She was admitted with a large pericæcal abscess, which was incised and drained. For two days she was much relieved and promised well, but on the fourth day her condition again became critical. She was in great pain; her abdomen was much distended, neither flatus nor fæces had passed for two days, and she frequently vomited fluid with a distinct fæcal odour. A small opening was made in the middle line below the umbilicus; the first distended coil was drawn out and a Paul's tube was secured in it. The vomiting ceased at once, and for more than a month the evacuations all escaped by the fæcal fistula. This had closed up spontaneously. The bowels were now acting regularly by the natural channel and the patient was well.

Dr LIMONT showed several patients with skin disease, including cases of Rodent Ulcer, a case of the Band Form of Morphœa in a child causing great deformity and incapacity, and a case of Universal Seborrhœic Dermatitis of fourteen years' duration nearly well after a month of treatment.

Mr. RUTHERFORD MORISON showed a patient, together with a Skiagram of his Forearm, which had been recently Fractured between the Pronator and Supinator Muscles. The arm was much disabled, as the power of supination was markedly diminished. He also showed a dissected specimen of a similar fracture which illustrated the Pronation of the Lower Fragment of the Radius and the Supination of the Upper.

Dr. DRUMMOND showed a woman, fifty-four years of age, with Dulness and Pulsation under her Manubrium Sterni and a Pulsating Swelling extending into the Neck. The patient had no dyspnœa such as could scarcely fail to be produced by direct pressure on the trachea if a large aneurysm existed in this situation. The diagnosis was fusiform dilatation of the aortic arch and high origin of the innominate.

Dr. DRUMMOND also showed a man who had partaken freely of all kinds of liquor, and was admitted into the infirmary a month ago with Advanced Œdema affecting his whole body surface (alcoholic œdema). Everywhere his skin pitted deeply on pressure, and in addition he was in a dazed mental condition. There was no albumin in his urine, and beyond the cardiac feebleness and dilatation due to alcohol he had no heart affection. With rest, nourishment, and abstinence from alcohol he was now almost well mentally and bodily.

Mr. OUSTON showed a series of cases illustrating varieties of inflammatory diseases of the Maxillary Antrum. He advocated an opening above and behind the apex of the socket of the right canine tooth, the patency of which was to be maintained by a lead style worn as long as necessary.

Mr. OUSTON also showed a young woman whose symptoms had commenced after a serious illness, probably Typhoid Fever. Fourteen years before she had complained of gradually increasing dyspnœa and had paroxysms threatening life. Laryngeal examination showed complete abductor paralysis; tracheotomy had been performed, and she was now entirely relieved, but it seemed probable that she would be permanently dependent on the tube. No cause could be found or explanation given for her condition.

EDINBURGH OBSTETRICAL SOCIETY.

Extra-uterine Gestation.—Substitute for Forceps.—Electro-negative Puncture in the Treatment of Fibroids.—Fœtal Malformations.

A MEETING of this society was held on March 10th, Dr. ALEXANDER BALLANTYNE, President, being in the chair.

Dr. BERRY HART read a paper on the Extra-peritoneal Incision in Extra-uterine Gestation Intact and at Mid-term. While the conditions of an extra-uterine gestation may be very varied, there are practically three possibilities in intact forms. In the first two months the gestation is in the Fallopian tube, and intact or ruptured. At the third month it begins to develop between the layers of the broad ligament and lose its pediculated characteristic. At the fourth and fifth months it is usually embedded in the pelvic connective tissue and broad ligament, and may go on developing extra-peritoneally, but as a rule the fœtus escapes into the peritoneal cavity and the placenta remains extra-peritoneal or tubal. He specially referred to the second variety, having operated on five such cases. The first case had ruptured before operation and the patient died subsequently; the others recovered. The treatment should be wholly operative. In this class of case—mid-term and intact—the gestation is extra-peritoneal; the possibility of its being an ovarian pregnancy is most remote, and primary intra-peritoneal gestation is a myth. Dr. Hart advocates extra-peritoneal incision where possible, immediate removal of the fœtus, and, to avoid bleeding, the tamponade of the sac till the placenta is thrombosed if it cannot be easily separated. He thinks it better to open the abdomen in the middle line first, and thus to find the relations of the gestation and the reflection of the peritoneum. The vaginal route for operation is more difficult if the fœtus and placenta are present, and control of hæmorrhage is very difficult, as the tampon cannot be so effectively applied.

Dr. J. W. BALLANTYNE communicated a paper by Dr. C. F. Ponder (Kalimpong) on the Action of Midwifery Forceps. He believed that, apart from pelvic deformity,