The heart appeared sound.

The left lung adhered by old lymph to the parietes of the chest at the upper part.

6. *Case of Hemorrhage into the Ventricles of the Brain, and into the Theca of the Chord.* By William Brown, Esq. F. R. C. Surgeons, Edinburgh.

Hugh Anderson, aged 9. During the night of 18th May 1829 he awoke, complaining of his head. He then had something resembling a slight convulsion, and vomited freely. When I saw him next day he complained still of his head, and vomited occasionally. His bowels were bound. Cold was applied to the head, some blood was taken away by leeches, and a purgative was administered. On the 25th he was almost well; but in the afternoon he had a convulsion. When seen in the evening he complained much of his forehead, and his pulse was 64. 28th. He had been keeping easier under the use of cold, purgatives, and a blister; but his pulse continued slow, he had a tendency to drowsiness, and his bowels were obstinate. This morning he had first a slight convulsion, and soon after a very violent one, which lasted without intermission for several hours. During this the left arm and leg were in constant motion, the right side only occasionally so. His countenance exhibited an appearance of satisfaction, and he was constantly performing the actions of chewing, sucking, and licking his lips. After the violent motions ceased, the fingers continued to be twitched for some time. In the evening his sensibility returned to a considerable degree: his pulse was then 130. During the last day of his life coma became more profound, diarrhœa supervened, and at length, after several hours of convulsions, he died on the 3d of June.

On dissection the *dura mater* and *pia mater* exhibited a healthy appearance. The lateral ventricles contained each a coagulum of blood, and were distended with reddish serum. Coagulated blood was contained in all the other cavities, was spread in considerable quantity on the base of the cranium, and distended the theca of the spinal chord till nearly its termination. The structure of the brain and chord seemed to be sound.

7. *Case of Hydrocephalus.* By Charles Ransford, M. D.

I was sent for, October 4, 1833, to visit Margaret May, aged 18 months, whom I found in a comatose state, lying sunk in the bed upon the back. Her face appeared swollen, and unnaturally pale; slight convulsive twitches about the angles of the mouth; and deglutition was performed with difficulty. There was complete paralysis of the right arm and leg. The pupils were considerably dilated, but contracted when a lighted candle was

put near to them; no strabismus. Respiration was hurried and laborious; pulse 125; skin hot and dry; no vomiting; bowels had been confined for two days previously; the abdomen was not swollen, and had a perfectly natural feeling; the legs and feet were œdematous; urine secreted in small quantities.

I learned that she had been ill for a fortnight,—had been first seized with headach and general uneasiness, manifesting much irritability,—and the day previous to the one on which I first saw her she became insensible. She had always a heavy appearance, but never suffered from worms or any complaint, except occasionally constipation; but I understood that in September she had fallen upon the ground from a chair, and sustained a severe blow upon the back of the head; not complaining of this, however, longer than the day following the accident, no traces of the injury remained. Cold was applied to the head; a blister to the nape of the neck; and two leeches to the temples.

A grain of powder of foxglove, one grain of powder of ipecacuan, with eight grains of calomel, were divided into eight powders, of which one was ordered to be given every six hours. An enema of gruel, containing a drachm of oil of turpentine and castor oil, with the warm bath in the evening. The gums of the left molar teeth, which were swollen, were divided by the lancet. The following day the leeches had bled well; the blister had risen; and was ordered to be dressed with mercurial ointment, —ʒ i. of which was also ordered to be rubbed on the thigh every six hours. No evacuation from the bowels; the powder had been taken regularly; and secretion of urine much augmented. Enema ordered to be repeated.

October 7th. The blistered surface was much inflamed; the bowels had been freely opened; and deglutition was easier.

October 9th. The child appeared much better; pupils contracting more freely; and the state of coma less complete. The calomel was now relinquished on account of diarrhœa supervening. A relapse took place within a few hours, accompanied with convulsive shrieks.

She died on the morning of the 11th.

Inspection thirty-six hours after death.—The body was much emaciated. There were considerable adhesion between the *dura mater* and *calvarium*; the brain was large and soft; both it and its membranes were more vascular than usual; the ventricles were much distended, and contained each about two ounces of serum, clear, and without flakes. In the centre of the right anterior lobe of the brain, a small portion was of the consistence of cream, perfectly white. There were about two ounces of serum at the base, where the arachnoid was considerably thickened, of white opaque colour; a gelatinous deposit extended over the *pons Varolii* and origin of the nerves.

The abdominal viscera were healthy. The lower end of the ileum, for the space of about three inches, was filled with much dark greenish-coloured matter, similar in colour and consistence to the contents of the gall-bladder.

§. III.—Morbid Changes in the Blood-vessels.

8. *Case of fatal Apoplexy, with unusual symptoms connected with Disease of the Arteries of the Brain.* By the late Dr James C. Gregory.

Udny Marshall, aged 49, a stout, active, healthy-looking man, had been in the army for many years, and had been affected with yellow fever and dysentery in the West Indies. But since that time he had enjoyed good health for many years, with the exception of occasional dyspeptic symptoms and headach, so slight as not to interfere with his duties as porter to the Royal Infirmary.

Early in May 1831, he consulted me on account of a dull pain indistinctly referred to the *epigastrium* and the lower part of the *sternum*, and somewhat increased on full inspiration. I examined him particularly at this time. He had no cough, and no signs of an affection of the lungs or heart could be detected by auscultation. The apex of the heart was felt pulsating between the fifth and sixth ribs. There was no increased impulse, and the sounds accompanying its contractions were natural. But in addition to the ordinary dyspeptic symptoms to which he was subject, his tongue was white, his bowels confined, and his appetite impaired. His pulse was soft, rather frequent, and occasionally slightly irregular. Under the use of purgatives and stomachics, the pain, which had never been so severe as to interfere with the active duties of his situation, and the other symptoms, disappeared in a few days, and his pulse became quite regular and of natural frequency. He continued in apparent good health till the 27th of June, when he appeared to be seized with a febrile attack. He complained to one of the physicians' clerks of headach, general uneasiness, and restlessness. His tongue was foul, his skin hot, and his pulse frequent. These symptoms increased towards evening, and continued during the night.

About nine o'clock on the morning of the 28th, he suddenly complained, while in bed, of impending suffocation, with a sense of constriction at the lower part of the neck, and pain referred to the upper part of the sternum. His countenance was anxious; his face pale and clammy; his respiration rather slow and prolonged; his pulse frequent, small, feeble, and irregular. The pain and difficulty of breathing were somewhat relieved by an