October. Although the ovaries and tubes were covered with adhesions, the latter were easy to break, and both tubes and ovaries were removed, and the uterus attached to the abdominal wall. No drainage tube was used. The fascia was sewed with catgut, and the silk worm gut previously introduced was then tied. She made a successful recovery, being up in two weeks. On examining the tubes they were both found to be distended with fluid, which could be squeezed out of their uterine ends in a clear stream, but it was impossible to introduce the finest filiform bougie into the uterine ends at all, and only a distance of half an inch into the fimbriated ends. The tubes were bent by adhesions so as to form a number of knuckles, which were probably the cause of the severe pains every month. One ovary had a cyst in it, which ruptured while removing it, and into which one can introduce the end of the thumb. It apparently contained clear fluid. The other ovary has a thick hard surface, due apparently to chronic inflammation of the peritoneal coat. When the ovaries and tubes when first removed were placed in water, they were found to be covered with fringes of shreds representing the torn adhesions. Dr. Joseph Price had a quaint way of saying to his assistant, when he removed appendages like these: "Don't let these tramps out until they have seen the specimens in water, for fear they will go away saying that they had seen healthy ovaries removed."

It will be admitted that if one cannot relieve a woman in these circumstances by the means which were employed during three years of treatment, and if, at the end of that time, she is not able to keep a situation from this cause, we are fully justified in removing the appendages. My experience of tearing the appendages loose and leaving them to contract fresh adhesions has not been favorable, and I have never tried to save distended tubes by opening them and sewing them up again, as I feel sure that fresh adhesions would continue to worry the ovaries, and the tubes would refill. Pozzi and Polk have been doing it, but from recent reports of Polk's cases the result has not been satisfactory.

Primary Carcinoma of the Kidney.—Dr. J. G. McCarthy reported this case as follows:

The rarity of primary carcinoma of the kidney in the adult has induced me to give a short résumé of the clinical aspects of a case, of which the specimen has already been brought before the Society.

The patient, a female, aged 42, was married at 23, and has had eleven children, nine of whom are living. She first consulted me at the latter end of August for recurring attacks of pain in the back and loss of strength. The pain was severe, and extended on the left side from the lumbar region of the spine to the front of the abdomen, and occasionally was felt down the left thigh. She attributed her ill health to the after-effects of her previous confinement. Notwithstanding the number of her pregnancies, and the arduous duties of a large family in one in poor circumstances, she had always been in good health. Two months previous to the birth of her last child, which occurred on the 3rd November, 1893, she commenced to suffer with attacks of pain in the back, and noticed for the first time that the urine was blood-stained and contained blood clots. Her confinement was normal. She was delivered of a healthy child at full term, and, I am told, went to her work on the morning of the fifth day. Two months later hæmaturia returned, and appeared at intervals in small quantities till June, 1894. The pains continued, and she felt weaker and found it difficult to attend to her household duties. In January she noticed a small growth on the left side of her neck, which gradually increased in size, and had occasionally been the seat of pain. The family history contained nothing of importance.

When first seen she presented a pale, careworn expression, and was somewhat emaciated. The tongue was clean; appetite good; no vomiting; bowels fairly regular, but she had previously suffered from obstinate constipation. The pulse was 115, small and compressible; temperature normal.

In the neck was a growth about the size of an egg, situated in the triangular interval between the sterno-mastoid and the trapezius above and parallel to the clavicle. It was hard and nodular to the feel, and quite mobile. The cephalic vein of that side was dilated, and pursued an unusual course across the front of the chest, over the first intercostal space to the sternum. I looked upon the tumor as most likely a secondary growth, originating in the cervical lymphatic glands. There were no signs of disease in the mouth, throat or thorax. The apex of the heart was displaced upwards and outwards to the lower border of the 4th rib in the mammary line. Percussion dulness was made out at the upper border of the 3rd costal cartilage, nearly two inches to the left of the median line, and extended from the apex to nearly across the sternum. There was no distension of the abdomen. Its walls were soft, flaccid, yielding readily to pressure. A portion of the large bowel, distended with fæcal matter, could be easily felt beneath the abdominal parietes, extending from the ninth costal cartilage in the mammary line, downwards on the confines of the umbilical and left lumbar regions. Beneath the bowel, which I thought was the descending colon displaced forwards, could be felt a large growth, quite hard, non-fluctuating, with a smooth and rounded contour, having at its inferior border a smooth nodular projection.