wall was so thin and fragile, that on endeavoring to draw the tumour into the opening with vulsella, the forceps tore through, easily allowing fluid contents to escape into the abdominal cavity before patient could be turned on her side. The size of the tumour was diminished so as to permit it to be drawn through the opening by inserting my hand and breaking up and evacuating the smaller cysts, of which there were several. The pedicle, which was very short, was tied into two parts by passing a strong silk ligature doubled, through it, cut an inch above and dropped back. The left ovary being diseased was also removed. From beginning the anæsthetic until both ovaries were removed not more than thirty minutes had elapsed, but it took one hour of steady sponging to thoroughly remove all fluid from the cavity. The loss of blood was slight, and no vessels needed tying, forceps having been applied to each, when cut. Twice during the operation the patient became very pale and the pulse almost imperceptible, and two hypodermics of brandy were given. The wound was closed by seven deep silver wire sutures $\frac{3}{4}$ of an inch apart. Fine silk superficial sutures were passed between. Strips of jute were placed under ends of wires. Several thicknesses of antiseptic gauze were laid over the abdomen, outside of that a layer of marine lint, and all secured by a many tailed bandage. Patient was now put in bed, and rubber bottles filled with hot water placed around her. She recovered consciousness in half an hour, and excepting nausea from the ether, felt well. The highest temperature during after treatment, was two hours after being in bed, $102\frac{1}{5}$, pulse, 100. At 6 p.m. temp. $98\frac{3}{5}$, pulse, 98. A record of T. and P. taken every three hours was kept for five days, after which they were taken every six hours, but neither ever indicated any serious cause for anxiety. Vomiting was persistent for three days, in spite of every effort to control it, and was finally checked by morphia and atropia under the skin. Before the operation morphia always caused vomiting. Flatus passed on third day. Diet was milk and lime water; catheter had to be used every eight hours for two days, but it caused severe cystitis which gave great trouble to control, producing wakefulness from pain, and frequent desire to urinate. It did not entirely cease until she was quite recovered from the operation. The wound was dressed the eighth day, and was united its whole length, not one drop of pus having formed. Sutures were removed on eleventh day. The sixth day an enema was given, and afterward a regular movement secured by fennel powder. For three weeks the morning tempt. was $99\frac{1}{2}$ and the evening $100\frac{1}{2}$, and I attributed the rise, partly to the irritation caused by the silk ligatures in the peritoneal cavity. The want of a skilled nurse was much felt during the after treatment, as when absent visiting other patients on three occasions I found her suffering pain with rise of temperature, caused by the stupidity of her attendant. At the end of a week, her tongue, previously thickly furred, became clean, appetite returned, and she enjoyed her food for the first time in more than a year. In thirty days had her taken to her home, she rapidly gained in flesh and is now strong and well.

The presence of such thick, straw colored syrupy fluid in the peritoneal cavity was quite new in the experience of Dr. Trenholme, and I have been unable to find a similar case related in any work on ovarian tumours. The cystic fluid was quite different in character, that in the main cyst being thick and dark in color, while in the smaller cysts it was clear and white. May the presence of the fluid in the cavity of the abdomen be accounted for by exosmosis? It certainly protected the very thin walls of the tumour from the likelihood of being ruptured, which otherwise would readily have occurred from a slight blow or push. Thinking that this, my only case of the kind, might prove of interest to some of my professional brethren, who, like myself, have had little experience in ovariotomy, and hoping that the success met with will encourage others, I have ventured to report it.

## THE IDENTITY OF YELLOW FEVER AND ACUTE MALARIA—CONSEQUENT CONTAGIOUSNESS OF MALARIA AND CURABILITY OF YELLOW FEVER.

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Considering that pathologists and physicians of all countries are of one accord in admitting that the "epidemics of yellow fever are always preceded by serious cases of acute malaria," yellow fever

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