up ulceration of the cervix uteri, metritis, septicæmia, or peritonitis.

It must be remembered that a polypus may cause abortion, but, as a rule, they prevent pregnancy.

Treatment.—This variety is best treated by the ecraseur, and the after application of nitric acid. There is generally free hæmorrhage.

The Mucous Polypus.—This variety generally grows from the os uteri. They are usually very vascular, red in colour, small, soft, and pedunculated, and are made up chiefly of connective tissue containing one or more mucous follicles, and a soft and viscid fluid, the whole being capped with a very vascular mucous membrane.

These polyi generally produce either menorrhagia or leucorrhœa, and at times dysmenorrhœa, There may be no symptoms.

Treatment.—Torsion, and the after application of nitric acid, or the cautery or the wire ecraseur may be used.

The Granular or Cystic Polypi.—These generally occur in the cervical canal, and are sessile and multiple. They are bluish-white in colour, soft, and seldom larger than a grape, and are composed of a mucoid fluid enclosed in a thin membrane. They cause leucorrhœa or hæmorrhage.

The channelled polypus of Oldham belongs to this variety.

Treatment.—They may be treated like the mucous polypi, or else broken up by being seized by the forceps. Thus killed, the hæmorrhage generally ceases, but the cautery had better be applied to the spot as a further security.

The Placental Polypus.—This variety is not recognized by many authorities. It is formed from a retained portion of the placenta, and produces severe bleeding.

The Fibrinous Polypi.—These polypi always cause profuse menorrhagia, and are thought to be the result of an abortion, or produced from retained menstrual blood, &c.

Diagnosis.—A polypus which has emerged from the uterus may be mistaken for inversion of the uterus or prolapse. In the latter the os uteri may always be discovered at the lowest part of the tumour. A prolapsed uterus is very sensitive to compression. A polypus is not at all sensitive.

Dr. Barnes says complete inversion is distinguished by:—

1. The absence of an os uteri at the lowest part.

2. By the neck of the tumour being continuous with the roof the vagina, which is directly reflected off from it.

3. By determining the absence of the body of the uterus from its normal position, &c.

The following tests, he states, will commonly distinguish partial inversion (in partial inversion, as in polypus, there is a rounded tumour encircled by a ring, permitting a sound or the finger to pass up between). The sound will not run more than an inch, perhaps less, beyond the margin of the encircling ring, whereas, in the case of polypus, it will generally run at one part or another at least two and a-half inches, &c. Other diagnostic signs will be found under "Inversion."

Fibrous Tumours.—These tumours vary much in size, some being no larger than a small pea, whilst others are bigger than a cocoa-nut. They are often multiple, but may occur singly, and they are formed of the same strictures as the uterine walls—non-striated muscular tissue, with a varying quantity of connective tissue.

The amount of connective tissue present depends on the age of the tumour, the oldest ones containing the largest amount, while those newly-developed consist almost entirly of muscular tissue.

Fibrous tumours are encapsuled, and occasionlly cysts are developed in their interior—fibro-cystic tumours.

There are three varieties:

1. The sub-peritoneal or extra-uterine. This variety grows from the peritoneal surface of the uterus, and can be felt through the abdominal walls.

2. The sub-mucous or intra-uterine, growing directly beneath the mucous membrane and projecting internally.

3. The intramural or interstitial. These grow within the substance of the uterine walls, and they become converted in the sub-peritoneal and sub-mucous varieties. The sub-peritoneal variety may be solitary or multiple, sessile or pedunculated. They do not generally cause enlargement of the uterus, nor do they necessarily influence menstruation or cause hæmorrhage. The only symptoms which are often present are due to pressure. By descending into the pelvis, bladder and rectal irritation may be set up. If pregnancy should take place, abortion would probably be the result, or a tedious labour, followed by post-partum hæmorrhage.

Pedunculated tumours floating about in the abdomen may interfere with respiration, the circulation, or with the intestines.

The sub-mural fibroids are very common, and they cause hypertrophy, enlargement, and frequently distortion of the whole uterus. They nearly always produce hæmorrhage and leucorrhœa, and often dysmenorrhœa. Local pain is usually present, and it is generally of a spasmodic character. Owing to their mechanical pressure various other symptoms may be present, and they are often largely influenced by menstruation and pregnancy. At any period a tumour producing no discomfort may become greatly enlarged, and very painful. Pregnancy also intensifies the symptoms of fibroids; while, on the other hand, delivery is often followed by great diminution or complete disappearance of a fibroid. Fibroid tumours are often the cause of sterility, and, if impregnation takes place, abortion is very liable to occur.

Prognosis.—Fibroids do not, as a rule, cause death, but they may do so from hæmorrhage, asthenia, peritonitis, blood-poisoning, metritis, or