note over the tumor was continued into the pelvic cavity. The doubt as to diagnosis was the most interesting feature in the case.

Ovarian Cyst.—Dr. ADAMI showed a second specimen of an ovarian cyst received from Dr. Alloway. This also showed secondary cysts, but not so highly developed as in the former case. There seemed to have been a certain amount of inflammation about the main sac.

Dr. ALLOWAY.—The patient was an unmarried woman, 40 years of age, who had been suffering from, and been under treatment for the last six months, for recurring attacks of pelvic inflammation. Recently the abdomen began to enlarge very much, and seeking advice, a diagnosis of ovarian tumor was made. The whole cyst wall was united to the parietal peritoneum, and in some places to the intestines. These adhesions were very dense and had to be separated inch by inch, thereby increasing greatly the difficulty of the operation. The intestines were of the color of port wine, and the coils were united together by a soft gelatinous material, which was easily broken down without injuring the bowel. This latter condition Dr. Alloway had never before seen in abdominal sections, and thought it might have been the result of the very recent peritonitis.

Tubal Pregnancy.—Dr. ALLOWAY gave the following history: The patient, a lady 28 years of age, had four or five miscarriages, never having a full term child. She had her last miscarriage about six weeks ago, which was followed by a metrorrhagia of three weeks' standing. He found the parts so exquisitely tender as to preclude exact diagnosis, at the same time he came to the conclusion that there was some mass growing upon the left side of the uterus, and that the interior needed curetting. The curetting he first performed, and while the patient was under ether he made a thorough examination with a view to ascertain the nature of the growth to the left of the uterus. This seemed to be in the broad ligament, and as the idea of tubal fœtation presented itself, he advised an immediate operation for its removal. One week later the patient was again put under ether and the abdomen opened. A large mass was noticed coming up on the left side, which shoved the uterus to the right. It was of a dark bluish color, hard in parts, while in other parts it had the feel of a cyst filled with fluid. The sigmoid flexure of the large intestine had become adherent to the tumor which it completely encircled, and entered the pelvis by the right instead of the left side. The ovary was not distinguishable but was part of the tumor mass. The mass was removed, and the patient has done very well, and is now almost convalescent. The condition here could not be distinguished from a hæmatoma of the ovary, which condition it really was, but, in his opinion, it was likely to be caused by a ruptured tubal pregnancy.

Dr. ARMSTRONG said he had now seen quite a number of extra-uterine fœtations, and his experience was that the clinical history in these cases has been anything but uniform and clear. In none of his cases has he seen that clear clinical history which the text books laid down. There is often no definite history of a skipped menstrual period, no severe pain, no condition of collapse indicating a serious internal hæmorrhage. This indefinite element in the history should always be borne in mind, as many of those cases if neglected will likely go on to a second rupture which must prove fatal. Whenever there is a localized mass on one side of recent occurrence, Dr. Armstrong thought the matter should be thoroughly investigated with a view to exclude extra-uterine fœtation.

Dr. J. C. CAMERON wished to know upon what data Dr. Alloway has based his diagnosis of extra-uterine fœtation?

Dr. ALLOWAY in answer said that the patient had gone three weeks over a menstrual period; when the flow did commence there was no history of any clots or solid masses being passed, nothing but a constant trickling flow of blood; there was also a history of a sudden acute attack of pelvic inflammation accompanied by a certain degree of collapse—not the collapse due to a large hæmorrhage, but the collapse accompanying shock. This acute inflammatory attack was passed over very lightly at the time, being regarded as some transient alteration in the bowel. But when taken in connection with the missed menstruation, and the mass to the left of the uterus, Dr. Alloway thought there was an abundant evidence of extra-uterine pregnancy. The operation moreover confirmed his diagnosis, inasmuch as a hæmatoma of the ovary is a very rare condition, and the failure to find a fœtus proves nothing, since in those cases where we have very early fœtation, no evidence of the embyro proper is found.

Dr. J. C. CAMERON believed it to be rare for pregnancy to have existed, for the ovum to have attached itself to, and grown in the tube or uterus without leaving some evidence of the fact behind. Unless one could produce some such evidence, he did not think they were justified in pronouncing and reporting it as a case of extra-uterine pregnancy. The symptoms of inflammation and shock upon which Dr. Alloway lays such stress are just as fully symptoms of ovarian hæmatoma as of extra-uterine pregnancy.

Dr. ADAMI, while admitting that Dr. Cameron's remarks were in some respects well founded, he yet wished to suggest the possibility that after all it might not be so easy to detect fœtation by the miscroscope. He referred to the recent