uterus will often cause it. I have seen a case following curetting, but this was merely a relapse, as the patient had suffered from chronic ovaritis and peri-ovaritis for six years. She had been quite free from all pain in the ovaries for some time, and masses of peri-ovarian exudation had entirely disappeared, but, as the uterus remained large and heavy and the patient had leucorrhœa and pains in the back, the uterus was curetted with the result that a sharp attack of chronic ovaritis was set up and lasted for some weeks. That was the only time that I have seen harm follow curetting, but it shows that harm may occur and that therefore the operation should be very carefully performed and only in cases where there are no signs of ovarian trouble.

SIGNS AND SYMPTOMS — I. ACUTE. This occurs oftenest in puerperal and is usually bi-lateral. It is then rarely primary but is apt to follow a septic condition. Pain is felt at the side of the uterus. This quickly increases in intensity, and the part becomes very tender. The pulse becomes more rapid and the temperature rises. In a day or two the enlarged ovary may be felt at the side of the uterus, if the parts are not too tender. The organ rapidly enlarges to the size of an orange, rarely to that of a small cocoanut.

Acute ovaritis of non-puerperal origin somewhat resembles the above. Pain, rapidly increasing in intensity, is felt in usually one ovarian region. The area over the ovary is tender on palpation and fever developes. On making a vaginal examination, the ovary is felt to be enlarged, extremely tender and prolapsed, often into the pouch of Douglas. The prolapse may be due either simply to the increased weight of the ovary or else to adhesions dragging it down. The ovary is usually fixed.

Course.—Acute ovaritis frequently goes on to the formation of an abscess. After the first attack, the patient feels much better for a few weeks under proper treatment, but before long she has a relapse. The pain becomes worse, and she suffers from insomnia, bad appetite, etc. This goes on for a varied period until the abscess bursts. This oftenest occurs into the intestine, rarely externally, or into the vagina or bladder. After rupture, the walls of the abscess cavity usually fall together and become united to each other in a short time, but if the abscess is of long standing, the walls are too rigid to come together and the cavity closes by granulation. Rupture into the peritoneal cavity may take place, in which case, death from peritonitis is likely to follow.

II. CHRONIC.—Usually *the* symptom is pain in the ovarian region, but, in rare cases, this is either entirely absent or else only present as dysmenorrhœa. When pain is the most marked symptom, as it is in a typical case, it is constant, but is increased in severity at the menstrual period. It is worse during the two or three days preceding the flow, at which time I have seen patients writhing about the floor and almost crazy from the extreme agony they suffered. As soon as the flow sets in, all pain sometimes ceases, and is usually lessened at all events. The cause of the dysmenorrhœa is easily understood, when we remember that the capsule of the ovary is usually thickened by peri-ovaritis. The ovary gets congested and distended with blood just before the flow sets in, and, as the thickened capsule is not distensible, the nerves ending in the ovary get pressed on. The local congestion becomes lessened on the onset of the flow and so the tension in the ovary is lessened, thus reducing the pain. The pain may radiate towards the sacrum and down the thigh of the affected side.

As in the acute form, defœcation causes intense pain very frequently. This is especially the case when the left ovary is affected, as it lies so near the rectum. Women being so careless about their bowels, one can readily understand what an important factor the passing of the dried and hardened faeces over the inflamed and tender ovary must be in causing pain.