tenderness of the abdomen, low down—and examination per vaginam almost impossible from the acute pain the slightest touch caused her. Under appropriate treatment she recovered. She never became pregnant, and marital relationship was normal until six months ago. However, from the time of this cellulitis she was never quite herself, and came to my office occasionally, complaining of some slight pelvic pains. The uterus was movable, though tender. The tubes and ovaries seemed normal. Being anxious to have children, I dilated the os and cervix with electric dilators, causing no pain, until I could put my little finger up the canal. However, this did no good. Four months ago she began to have extremely painful periods. I never saw any one suffer such agony. I gave all sorts of drugs with no avail. Morphia she could not or would not take on account of the prolonged and distressing nausea. After the last menses I examined her very carefully, and found a cyst on either side, which felt like a much enlarged tube. I called Dr. Temple in consultation, and he agreed with me that operation was necessary at once, we both thinking it was a case of pyosalpinx.

We operated on Saturday last. On opening the abdomen, I found a perfect roof of old dense adhesions, which gave me a great deal of hard digging, accompanied by profuse hemorrhage, ere I could arrive at the tube. At length I got the tumor clear, and found it to be a parovarian, about the size of a hen's egg. In trying to clear the end of the tube from its adhesion to the side of the pelvis, I broke the cyst, which contained clear, limpid fluid, as is found generally in parovarian cysts. The hemorrhage becoming free, we tied in two places and removed the tumor, leaving the fimbriated end *in situ*. The patient here became somewhat collapsed. The left side was not covered with such dense adhesions, but was quite large—as big as a turnip. This was easily ligated and removed, and turned out to be an ovarian cyst. Our attention was now turned to the oozing, which was considerable, from the first pedicles and broken adhesions. We tied many, washed out, and put in a drainage tube before making the abdominal toilet. I sucked out with a syringe the tube, and found pure blood coming up. It seemed a question whether or not to reopen and plug the pelvic cavity with gauze. Here a lesson may be learned. I stayed three hours with her, using the syringe every half hour, each time bring up ʒiii pure blood. Naturally, I was most anxious, and at 9 p.m. had a consultation with Drs. Temple and Macdonald. The oozing was as great as ever, and the patient in great pain. We resolved not to open, but to keep the syringe going every half hour. To still the pain, we gave forty grains chloral by rectum; morphine, from her peculiar antipathy, being out of the question. She had a very bad night, suffering great pain, eighty grains chloral having no effect whatever. Next morning we met again at 10 a.m. I then bethought of etherodyne, a most invaluable preparation of opium; it does not cause vomiting as a rule, and acts rapidly. I gave her twenty minims every hour for four hours, when she went off into a quiet sleep, and has had since no pain whatever. The oozing continued all Sunday, lessening towards night. On Monday it was reddish. Tuesday, all that came was a little pale straw-colored serum, so I removed the tube. She was a little tympanitic; I ordered ¼ gr. calomel every hour, which had the effect of bringing away flatus, but no movement; ʒii magnes. sulph. every hour followed. This had no effect. Injected ʒii ol. R. and ii glycerine, which caused copious movements with any amount of flatus. After this the temperature fell to 99 1/5; pulse, 96. She is hungry, and seems to be going on capitally.

Dr. J. F. W. Ross showed the following specimens:

VAGINAL CYST ANTERIOR.

The first specimen is one of some interest, chiefly on account of the error made by a former attendant upon different occasions. He told her that she suffered from a prolapse of the bladder, and that nothing could be done for her. The operation was done after the method of Schroeder, owing to the proximity and intimate connection of the cyst to the urethræ.

Case of acute general peritonitis, caused by rupture of a secondary suppuration in an old clot left after intra-abdominal rupture of an extra-uterine gestation. Operation. Recovery.

The patient was seen by me in consultation with Dr. Cuthbertson. Under chloroform a mass was felt in that situation supposed to be so characteristic of parametritis, close to the uterus, between the uterus and the bladder. She had suffered from pain, and had then been laid up with peritonitis. Never missed a month more than a few days. No excessive uterine hemorrhages. I advised removal to the hospital, so that I could watch her. After being in the institution for about a week, she took a pain in the old region. It was not very severe. I saw her and found the temperature up a little and pulse also somewhat elevated. Owing to family sickness, I was unable to visit her for two days. When I called in casually on Friday afternoon, I found her very ill. On Thursday she had a chill; temperature, 103; pulse, 110. Her abdomen was now tender all over. No distension as yet. I gave orders that I would open her abdomen at 9.30 Saturday morning. I diagnosed a ruptured pus sac and general peritonitis.

On opening the abdomen, I found it full of pus and the pelvis full of grumous blood and matter. I peeled off the sac by means of two fingers in the vagina and two in the abdomen. I show it here to-night. It has been examined microscopically and proves to be a tube, the seat of an old gestation with the placenta still *in situ* and a semi-organized clot, looking at its edges like the corrugated wall in the *corpus luteum*, and showing the source of the pus that ruptured into the abdomen. The case is one of extreme interest. The patient made a rapid recovery.

The next specimen is a uterus, the seat of three myomata removed by abdomino-vaginal method. The operation was exceedingly difficult. Two years ago I removed the ovaries and tubes from this patient, but failed to relieve her hemorrhages. At that operation the uterus was firmly bound down, though small. It is now no larger than a large orange. I knew, from careful digital exploration of the uterus, that the tumors could not be satisfactorily removed, and considered that the new abdomino-vaginal method of total extirpation would give her the best chance for her life. Vaginal hysterectomy was out of the question, owing to the adhesions, and abdominal hysterec-