area being left behind and requiring drainage, we found it necessary to push the loop containing the anastomoses far over to the left among healthy loops; otherwise it would certainly have been infected by the necrotic and gangrenous tissue. As noted in the history the bowel gave no further trouble.

*Tentative diagnosis: Subperitoneal and intraligamentary myomata. Actual condition: Hydrosalpinx, adeno-carcinoma of the right ovary, involvement of the small bowel and marked extension to the bladder. Hysterectomy, partial removal of the cancerous growth, resection of a portion of the small bowel; temporary recovery.**

History.—On Jan. 25, 1904, I saw the patient, who was 48 years of age. Her menstrual periods had continued regularly until she was 44. Since then the flow had appeared every three or four months, and there had been a slight vaginal discharge. Two years previously she had passed a calculus, apparently from the left kidney.

Examination.—On vaginal examination I found the uterus half as large again as normal. Projecting from the fundus on the right side, and very prominent, was what appeared to be a subperitoneal myoma about 5 cm. in diameter. The right side of the pelvis was filled by a growth which apparently sprang from the uterus and filled the broad ligament. This growth in contour and consistence resembled a myoma.

Operation.—On opening the abdomen (Feb. 2) I found the uterus moderately enlarged. The supposed subperitoneal myoma proved to be a very tense hydrosalpinx, which was kinked forward, thus accounting for its prominence. The growth on the right side was a carcinoma of the ovary. It filled the broad ligament and had infiltrated the bladder wall. Attached to the cancerous mass was the omentum with a loop of small gut. As the gut at this point was markedly constricted, I attempted by gentle dissection to release it, but the bowel was so infiltrated by cancer that it commenced to tear and resection of a portion was imperative. It was decided that the only hope of even temporary relief would be hysterectomy with as thorough removal of the growth as possible. This was done, but a raw, green, offensive, cancerous area, fully 6 cm. in diameter, remained attached to the surface of the bladder. Three inches of the bowel were then resected and the ends united by means of the Connell suture, supplemented by the Lembert suture. The anastomosed bowel was then placed among healthy loops of gut as far removed from the necrotic area as feasible. The pelvis was drained through the vagina and abdomen. The patient recovered

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