neglected to pass the bougie, her stricture returned and the abdomen filled up as before. I again divided the stricture and cleared out the bowels, but the abdomen remained distended with ascitic fluid, and the lump between the umbilicus and the ensiform cartilage could now be felt very distinctly. She was very anxious to have this fluid drawn off, but declined any serious operation for the present. I therefore decided to make an incision to let out the water, and at the same time to settle the diagnosis of the tumor, whether it was fæcal accumulation or malignant disease of the intestine. Accordingly, assisted by Dr. England, and in the presence of my class, on the 20th of February, I made a two-inch incision between the ensiform cartilage and the umbilicus, allowing a quantity of straw-colored serum to escape. On introducing my finger and raising the omentum, a hard, slightly nodular tumor could be felt occupying the situation of the head of the pancreas, which was enlarged to the size of an orange. As I had not been able to obtain the patient's consent to removal of the tumor at present, I replaced the omentum and sewed up the incision with silkworm gut, obtaining union by first intention and without the temperature ever rising above 99¼° during the next two weeks, when she was discharged. In fact, she was sitting up next day. It is my intention, as soon as she consents, to undertake this rather formidable operation of removing the tumor, as it is evidently beginning to endanger her life very seriously.

Miss X. came under my care at the Women's Hospital on the 27th February, 1892, with the following history: She had always been healthy, with the exception of having lost the use of one eye and ear after scarlet fever. She was seduced by a commercial traveller, and was delivered at term on the 29th January. The perineum was very unyielding, and a laceration of both it and the cervix occurred, the former being torn through into the rectum, which latter, however, was promptly sewed up by Mr. Hackett, the house surgeon. On the 30th her evening temperature was a little over 99°, on the 31st it rose to 103°, and next day to 104°. From that time till the 24th February, her temperature oscillated between 104° at night and 97½° in the morning. As soon as the temperature began to rise, Dr. Reddy ordered the stitches to be removed from the perineum, which was found to be suppurating, and every antiseptic measure was employed, such as bichloride intra-uterine injections, etc. She was transferred to my care on the 27th February, when, on examination, I found the uterus and appendages all glued together in a mass of peritonitic exudation, as though they had been set in plaster-of-Paris, the roof of the vagina feeling like a solid board. In Douglas's cul-de-sac could be felt a prominent oval body extremely sensitive to touch, which was thought to be the ovary. I diagnosed pus tubes leaking into the peritoneal cavity, and strongly advised abdominal section, in which my colleagues concurred. Accordingly, as soon as the consent of the patient and her friends was obtained, which required eight or ten days, during which her condition became more and more alarming, I opened the abdomen, with the assistance of Dr. England, on the 5th of March, in the presence of twenty members of my class and visitors. After cutting through the abdominal wall I was unable to get into the peritoneal cavity owing to omental peritoneum being glued to the parietal peritoneum by solid cheesy exudation. On extending my incision a little lower down I came upon an abscess cavity containing half an ounce of pus apparently between the omentum and the parietal peritoneum, which had been walled off by exudation. After cleaning this out with a weak bichloride solution I tried to get into the pelvis by that road, but could make no headway. I then tried to enter by the upper end of my incision, which I managed to do. By pushing aside the omentum above the point where it was adherent half way up to the umbilicus, I was able to introduce my finger into the abdomen. I then dug away for a quarter of an hour in Douglas' cul-de-sac, and succeeded in extracting the two ovaries, which I brought to the surface. The patient had given her consent to the operation on condition that I would spare her ovaries if they were not seriously diseased, and as they appeared healthy I returned them. I then made a search for the tubes, but it was impossible to distinguish them from the solid lymph in which they were imbedded. At one time I dug out with great difficulty what seemed to be one of them, and tied and removed it, but no trace of the tube could be found in it. On the left side of the uterus I could feel about a half an inch of the tube. On the right side I could not distinguish it from the solid material in which the uterus was imbedded. Even the space between the uterus and bladder was filled in with this lymph cement, so firmly, that I could plough a furrow with my finger tip between them, but could not tear this material off the uterus. By this time I felt that to continue longer would be endangering the patient too much, so I washed out the abdomen with several gallons of hot water, introduced a good sized drainage tube, and closed the wound with silkworm gut. The patient vomited a good deal, but reacted nicely, and on the fourth day the drainage tube was removed, by which time the bloody exudation had changed to lymph. On removing the tube I had to rotate it, when something gave way, and on examining the tube I found a tiny segment of intestine in one of the holes. The day following, my attention was called to the