artery forceps. A very small amount of pus and a few flakes of fibrin escaped, but the mass was in no way diminished in size. Realizing the presence of an unusual condition, I packed the opening in the vault and immediately entered the abdomen from above. Filling Douglas' sac almost completely was a tumor mass evidently springing from the sigmoid flexure, which had rotated 90° and had become firmly embedded in the pelvis. It closely resembled a rectal cancer. On careful manipulation it was brought out of the pelvis, and on inspection no lymph glands were demonstrable. The diseased segment of gut was removed and an end-to-end anastomosis done with Connell and Lembert sutures, the former being employed at the mesenteric junction and for about two-thirds the circumference of the gut. A portion of the descending colon was brought up into a small incision in the left inguinal region and made fast, so that if occasion demanded it could be opened with a thermocautery at a moment's notice. Drains were then introduced into the vagina and also through the lower angle of the abdominal incision. At the end of the fourth day there was considerable abdominal distension and the patient was very weak. We accordingly opened the descending colon at its point of attachment to the abdominal wall and at the same time forced the patient's nourishment. She promptly recovered. The small fistulous opening was a few weeks later readily closed under local anesthesia, and the patient is now perfectly well.

Examination of Tumor.—On laying the tumor open we found that there were two rectal diverticula passing out into the adipose tissues, and communicating with the lumen of the gut by openings not more than 1 mm. in diameter (Fig. 3). The larger diverticulum was 1 cm. in diameter and filled with a fecal mass. The floor of this diverticulum had given way, and the surrounding fat was everywhere infiltrated by inflammatory products. The excessive hardness of the tumor was due to the fat being in many places replaced by recent connective tissue. The small abscess between the tumor and the pelvic floor was due to the extension of the inflammatory process to the peritoneum of Douglas' pouch. The diverticula were lined by atrophic mucosa. A rectal examination of this case would have yielded little beyond some narrowing of the lumen of the bowel, which is often present in cases of pelvic abscess. In this case cancer of the bowel might very readily have been diagnosed and a colostomy made.

It will be readily admitted that the preceding cases are unusual ones, and that a positive diagnosis before operation would have been extremely difficult. The possibility of such conditions should always be borne in mind when we are dealing with cases that at first sight seem