neal connective tissue of the abdominal wall, it will give rise to a smooth, hard swelling beneath the abdominal muscles, occupying either the region immediately above Poupart's ligament, which forms its lower boundary, or the subra-pubic region. No such swelling or sense of superficial resistance is found in peritonitis.

"What, then, are the characteristic signs of pelvic peritonitis? There is a hard, tender, irregular swelling, felt on bimanual examination, lying posteriorly in the pelvis, above the vaginal roof, and not implicating or depressing it. This mass consists of thickened peritoneum surrounding the thickened fallopian tube and the ovary, the two latter being matted together by adhesions to each other, to the back of the broad ligament, and to other parts in the neighborhood. The uterus is seldom pushed aside by this mass and does not form, as it were, a part of it, as in cellulitis of the broad ligament. If the uterus is displaced at all, it is displaced forward, unless it has been retroverted or retroflexed to begin with, when it will have become adherent in its abnormal position. Very often the mass can be felt to extend behind the uterus, and to be adherent to its posterior surface. It is very seldom that any evidence of the presence of a pelvic mass of the kind just described can be obtained on examination of the abdomen. This is only possible when there is superadded an encysted peritoneal effusion, or when some of the pelvic viscera have happened to contract adhesions to the abdominal wall."

Shortening of the Round Ligaments for Uterine Displacements.—Dr. HENRY P. NEWMAN read a paper upon the remote results of uterine displacements by the new direct method before the Gynæcological Society of Chicago in November, 1890, in which he says he presented to the same society this new method of operation at a meeting in September, 1888, and reported several consecutive cases. In the original technique of Alexander, the primary incision is made over the spine of the pubes, an inch and a half or more in length, upward and outward along the course of the inguinal canal. In operating after this plan, it is often impossible to find the ligament, and the new method is intended to overcome this difficulty, the distinct advantages of which are: (1) The single sweep or two with which we cut down upon the inguinal canal, or the glistening aponeurosis of the transversalis muscle, directly