out and drained. Silkworm-gut sutures were used to close the wound. The patient made an uninterrupted recovery.

Before going home she remained at the house of some friends. She was up and walking around several weeks after the operation, when a sudden pain, very violent in its character, shot down from the neighbourhood of the right kidney to the urethra; this was accompanied with a frequent desire to pass water, with spasm of the bladder. I was sent for, and on my arrival found the patient more comfortable, as a neighbouring doctor had been called in and had given her a hypodermic injection of morphine. There was no rise of temperature, but the pain was accompanied by vomiting. The pulse was slightly elevated. The question now came up, Was this a case of recurrence of the attack of renal colic from which she had suffered some four or five years before, or was there some sudden intestinal obstruction? A trained nurse was immediately obtained, and I watched the case with considerable anxiety. The symptoms all pointed to the passage of a renal calculus, but as I had seen a strangulated hernia accompanied by spasm of the bladder and frequent desire to pass water I felt that intestinal strangulation could not be excluded in this case. After a few days the vomiting ceased, and the pain disappeared. The patient then returned home quite convalescent.

The contents of the tumour were examined bacteriologically and found to be sterile. The water-colour sketch represents the tumours of Case No. 1; the other plate represents one of the tumours from Case No. 2, opened in the centre so that the budding in the interior can be readily seen. This condition of the the interior is always found in cases of papillomatous growth of the ovary. The large process jutting out from the circumference of the tumour shows the portion that filled the cul-de-sac of Douglas, Though so large, this raw mass was only adherent at one spot. The adhesion was very limited.

I report these cases chiefly to lay stress upon the main features to be taken into account in making one's diagnosis. First, the peculiar sallowish and pasty appearance of the patient. Secondly, the peculiar feeling given to the finger by the papillomatous material after it has budded through the capsule. This cannot be mistaken when it has once been felt. I have been able, with accuracy, to diagnose five cases of papilloma of the ovary by means of the sensation given to the index finger in the vagina. This point has not been dwelt upon by the text-books; I do not know that I ever seen it mentioned in any text-books.

Papilloma has been supposed by some to arise from the corbus luteum and consist of vascular villous reddish-yellow proliferations.—(Peaslee).

Some authors state that these papillary growths may develop on the surface of a solid ovary or on the wall of a glandular spot.—(Garrigues).

True cancer of the ovary is usually unilateral, while papilloma, in my experience, is always bilateral. Cancer of the ovary is found secondary to cancer elsewhere, while papilloma of the ovary is never secondary to papilloma elsewhere. Papilloma of the ovaries is considered by many to be a form of medullary cancer, producing the true villous cancer. If this view be correct papilloma is essentially from its earliest stages a malignant disease. So few are operated on before the papilloma has budded through the capsule of the ovary that it is difficult to come to any conclusion regarding the immunity enjoyed by patients from whom the growth has been removed before the peritoneum has become infected by the perforation through the capsule.