masses somewhat irregular in outline, soft and boggy, but not fluctuating. The uterus could not be isolated from the masses beyond the portio vaginalis; a bruit could be heard on both sides, low down. Patient was advised to enter Grace Hospital for further examination, which she accordingly did. At subsequent examination the before-mentioned conditions were verified, and the sound showed the uterine cavity to be of normal depth. Laparotomy was performed October 28th, 1898. On opening the peritoneal cavity, some two gallons of normal ascitic fluid escaped, and a long cord-like structure, shown in Fig. 2, floated out of the incision. This was white in color, as thick as a lead-pencil, and suggestive of a shrunken umbilical cord. One end appeared to be free, while the other was adherent to the anterior abdominal wall, a couple of

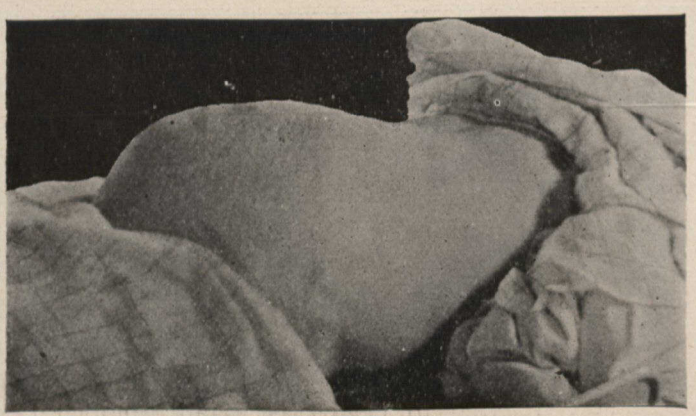

FIG. 1.—Showing contour of abdomen, large quantity o ree ascitic fluid, together with papillomatous ovarian tumors—shown in Fig. 2. Note the bulging of the flank, and very gradual rising of outline from the ensiform cartilage downwards, as also the abrupt rising of line from pubes towards umbilicus.

inches to the right of the umbilicus, where it was spread out in a circular mass, a quarter of an inch thick and an inch and a half in diameter. It was, however, easily detached, no bleeding following its separation. The larger mass showed in Fig. 2 was then separated from its pelvic adhesions, and the rather broad pedicle by which it was attached to the uterus was ligated by a triple interlocking ligature of silk, and divided. The cyst contained four imperial pints of fluid and had proliforating papillomatous masses growing from both inner and outer surfaces. The smaller mass shown in Fig. 2 was then removed in similar manner from left side. The position of the Fallopian tubes is indicated in the illustration. Several gallons of normal saline solution were used, temperature 120°, in flushing out the abdominal cavity, thus washing out