birth of her child menstruation has been almost painless until it stopped at the age of 46. Twenty-four years ago her left breast was removed for cancer, by the late Dr. R. P. Howard, and there has been no recurrence of the disease. Three years ago she began to have trouble with her water, being unable to hold it, and six months before my seeing her she had noticed a lump growing in the abdomen. On bi-manual examination I found a hard, oval tumor rising to the level of the umbilicus above and projecting into the pelvis below, and it had a nodule on either side of it the size and shape of ovaries. The abdominal wall was very thin, and the tumor was freely movable in the abdomen. On pushing up the cervix uteri, motion was communicated to the tumor, and pressure on the tumor caused motion of the uterus. It presented the symptoms of a fibroid tumor in the fundus uteri, with portions of it in a cystic condition. Fearing that the tumor might be cancerous, the patient was very anxious for an operation. Accordingly, with the assistance of Drs. Perrigo and Springle, and in the presence of Drs. Aubrey and Mitchell, I performed abdominal section at Strong's Hospital. On opening the abdomen the tumor was found to be fibro-cystic, but there were a great many very tensely filled loculi, the larger ones of which I emptied. But it had no connection whatever with the uterus or ovaries. It seemed to spring from the mesentery about the level of the second lumbar vertebra. On endeavoring to find a pedicle to tie I found that a coil of intestine was so intimately connected with it that it would have been impossible to have enucleated it down to the vertebra without tearing the peritoneum off the intestine. The tumor was behind the peritoneum, and in endeavoring to peel the latter off it I exposed the right ureter and right common iliac artery. As I was prepared for hysterotomy I had a *serre-nœud* with me, so I passed the cord of it around the base of the tumor as far back as I could without catching the above-mentioned coil of intestine, and tightened it up and cut off the tumor. In freeing it from adhesions a good deal of oozing occurred, which required a great many silk ligatures to arrest, but finally the abdomen was cleaned dry and the *serre-nœud* was brought out with its very short stump, which was not more than three-quarters of an inch long from the spinal column. In fact, it would be more correct to say that the very slack abdominal walls were brought under the *écraseur* so as to embrace the stump, and two pins were passed through the stump above the *serre-nœud* to prevent it from slipping off. The abdomen was closed with silkworm gut and no drainage tube was used, the wound being dressed with dry boracic acid and absorbent cotton. The *écraseur* came away about the twelfth day with a small slough, the temperature never going above 100°. About the fourth day a clear, slightly yellow, watery discharge was noticed welling up from the inferior angle of the wound in considerable quantity. It had no odor, and I was uncertain of its nature, although I thought it might be lymph coming from the thoracic duct, which I feared I had included in one of my ligatures which had been placed very near the duct. On the other hand, it might have been urine escaping from a possible wound of the bladder. I therefore introduced a glass catheter into the bladder, and left it for some hours without at all diminishing the flow from the wound. In order to be certain about it, I placed the patient on her face for a few hours, and collected a few ounces of the fluid, which I handed to Dr. Bruère without telling him where it came from. He next day handed me the result of a careful chemical analysis, clearly proving that it was urine, and convincing me that it was due to a wound of the ureter. The patient made an excellent recovery for her age, being able to walk about outside in two months, and frequently driving into town since. I devised a great many contrivances for catching the urine and conveying it into a rubber bag attached to her leg, but none of them was satisfactory ; but after a few months the fistula gradually ceased to flow, and now there is only a slight moisture.

Mrs. W., æt. 36, came under my care in January, 1891, for a very close stricture of the rectum, which would hardly admit a No. 8 catheter. Her abdomen was enormously distended. She had no previous history of syphilis, nor did the stricture present the appearance of being malignant. It seemed rather to have been due to simple ulcer of the rectum, which had been repaired by cicatricial retracting tissue. She called my attention to a lump in the abdomen extending across from one hypochondriac region to the other, and extending downwards and backwards in the direction of the descending colon. I took her into my ward at the Women's Hospital, and called a consultation of the staff. In the opinion of the majority, myself among the number, this lump was thought to be an accumulation of fæces due to the impossibility which existed of anything but liquid motions passing so small an opening as her rectum. I divided the stricture backwards towards the sacrum in the middle line, and opened it up to two inches in diameter. She took a powder containing 40 grains of compound jalap and 10 grains of calomel, with the result that she passed a great many very copious stools with great relief of the distension and partial disappearance of the tumor. The purgation was repeated a few times with still further benefit, and she was discharged feeling remarkably well. She remained so for about a year, when, having