attacked with a sharp lancinating pain in the solid portion of the tumor to the right of the umbilicus, which rapidly extended over the whole abdominal region, accompanied with vomiting, fever, and a frequent pulse. In the course of two hours the pulse ran up to 140, became small and thready, and the vomiting very frequent. The bowels had been constipated since her admission to the Hospital. Ordered hot turpentine stupes to the abdomen, and ⅓gr. morph. sulph. every three hours, if necessary, also a little brandy and iced water.

June 13th. The medicines and hot fomentations gave great relief, and after getting the second hypodermic injection she passed a comparatively comfortable night, but vomited several times through the course of the night and this morning. The pulse is now 140, but softer and fuller. Tongue brown, furred. Bears slight pressure over the abdomen without complaining. Bowels not moved.

Evening.—Condition improving. Pulse 140. Tongue moist, and not so thickly furred. Does not complain of pressure over the abdomen, except in the right hypochondrium. Ordered a turpentine enema, and the hypodermic injection of morphia to be repeated if necessary. Continue the iced brandy.

15th.—Improving. Had a good night after the morphia, but the bowels were not moved by the enema. Pulse 130, softer and fuller. Skin moist and cool.. Considerable tenderness in the right hypochondrium and has paroxysms of pain three or four times a day. Ordered the hypodermic injection to be administered when necessary to relieve pain; beef-tea, milk and brandy.

17th.—Continues much the same. No movement of the bowels. Rest disturbed by attacks of pain on the right side of the tumor, has had the morphine three or four times in 24 hours. The menses appeared during the night—scanty.

20th.—Rather more comfortable; the stomach bears nourishment a little better; the bowels remain obstinately constipated; the œdema of the feet and legs has subsided; pulse 120; temp. 98°; resp. 22.

22nd.—At a consultation of the Hospital staff, the critical condition of the patient—the existing peritonitis—the probability of disorganizing changes taking place within the tumor—and the sure and certain end rapidly approaching, having been recognized, and a free interchange of opinion expressed, ovariotomy was decided upon. The operation was commenced at noon in the presence of the faculty and a number of practitioners and medical students. Dr. Mullin administered the chloroform in his usual careful and attentive manner, and Dr. Malloch kindly acted as chief assistant. The abdominal section was made five inches in length, but this was afterwards increased to seven inches. On opening the peritoneum some ascitic fluid flowed away, and through this the bluish-white glistening tumor was recognized. As no adhesions could be felt with the fingers the patient was now turned on her left side, the presenting cyst seized at the upper end of the incision by a pair of strong long-toothed forceps and steadied while being tapped with a large trocar; but through the canula of this instrument the jelly-like contents, assisted by pressure with the hands, came away so slowly that considerable time was occupied in evacuating the cyst. After the parent cyst was thus lessened, several smaller ones came into view, and were one after another laid open freely with a bistoury and quickly emptied. Each of the smaller cysts was found to differ from the other, both in color and consistence.

Though about one third of the tumor proved to be solid it was thus sufficiently reduced in size to permit its being extracted through the enlarged incision, by traction with the forceps, assisted by the hands of the operator. Now it was seen that the omentum was closely adherent in several places to the superio-posterior part of the tumor. Considerable difficulty was experienced in separating these adhesions, which, on being accomplished, bled freely. The omentum was then turned up and carefully laid upon a soft napkin placed across the abdomen, and the bleeding points were secured by the use of a number of small silk ligatures. The ligatures were all cut short and the omentum was immediately returned to the peritoneal cavity. While Dr. Malloch was thus arresting the hemorrhage of the omentum, the operator was engaged securing the pedicle. This was found attached to the right side, and being of moderate length it was first tied with whip-cord, near the tumor, and the latter cut away and removed. A loop was then made with the cord, affording a convenient handle with which to manipulate the stump. This was treated by the extra-peritoneal method,—fixed ex-