labour pains and were intermittent in character. These pains continued for about one week but there was no discharge of blood.

From the cessation of these pains until September 22nd, the patient felt fairly comfortable but on the morning of the above date she was seized with pains, similar to those which she had felt before, and which she considered to be labour pains. The doctor, who was now called, diagnosed some abnormal condition to be present and sent her to the Montreal General Hospital where she was admitted to Ward G, but her pains had now ceased.

On examination of the abdomen the usual signs of a uterine pregnancy were made out, except that a fluid wave impact across the abdomen could be obtained with exceptional ease. The child was lying transversely with the head to the left. The fœtal movements were very vigorous. The heart beats were 130 to the minute.

Vaginal examination disclosed a laceration of the perineum with some prolapse of the vaginal walls. The cervix was greatly elongated and very soft (as in pregnancy at term) and was the seat of a bilateral laceration. The external os was quite patulous, but on trying to pass one's finger high up, the cervical canal was found to be blocked by a hard mass which encroached on it from the left side. In the left fornix a hard mass the size of an orange could be felt. It was apparently firmly fixed in the pelvis.

The patient was then sent over to the Montreal Maternity Hospital where Dr. J. C. Cameron kindly saw her and confirmed my diagnosis of an intra-uterine pregnancy, near full-term, complicated by a pelvic tumour.

As the pelvic canal was completely closed by the tumour, which could not be pushed up out of the road, it was decided to remove the fœtus through the abdomen and the patient returned to the General Hospital for that purpose.

After the usual preparation of the abdomen, Drs. William Gardner and J. A. Springle assisting, an incision five inches long was made in the middle line, beginning about two inches below the umbilicus and was continuing around the left side of this structure. Upon entering the peritoneal cavity the uterus was encountered at once. The abdominal walls were kept pressed close against the uterus and two hot aseptic towels were placed between the uterus and the intestines so as to prevent soiling the cavity. As the exact site of the placenta could not be ascertained, an incision 4½ inches long was made in the middle line, the lower end terminating just above the contraction ring. On dividing the uterine mucosa the placenta was found to lie immediately beneath the incision. It was therefore separated towards the left until the