for the last 10 or 12 years, complained of severe dysmenorrhœa necessitating leaving off her occupation several days monthly. She also suffered from mitral regurgitation. In addition to dysmenorrhœa she complained of a pain in her left side, which persisted throughout the intermenstrual period. At last I decided on abdominal section. This was done two years ago; she made a good recovery, and the case was reported at the time. The pain, however, has not been altogether cured. Dysmenorrhœa, of course, ceased, with the exception of the first period after the operation; she has had no period since. The pain in the side and back still persisted. Soon after the operation she began to complain of passing small quantities of blood per rectum, which, at the time, I supposed was a sort of vicarious menstruation, this hemorrhage generally occurring at the menstrual period. After a time, however, she brought me some small pieces of flesh about the size of a split pea, one or several of which she noticed herself passing each time she had a hemorrhage of bright red blood. I at first thought them little polypi or warts. On examining the rectum I could find no growth there. On making a vaginal examination, however, I thought I could discover some thickening of the left vault,—some indication of an irregular shaped mass in the left iliac region, which, owing to the extreme corpulency of the patient, was difficult to outline. Hemorrhage increased steadily; last time there was a teacupful of bright red blood. She brought me several of the pieces referred to above, which I handed to Dr. Adami for microscopic examination. It is important to ascertain whether these are parts of a simple or malignant growth.

Dr. Adami described the small growths in question. He pointed out that they were evidently hypertrophic growths of the mucous membrane. From their structure he considered that they had developed in the lower portion of the colon, and this opinion gained support from the bright red, unaltered blood which passed out along with them. As to the question whether they were of malignant nature or not, he was inclined to consider them non-malignant; they contained comparatively few blood vessels—their glandular structure was typical, not atypical.

Dr. Adami exhibited a specimen of ulcerative colitis from the museum of McGill College, presenting very similar papillary growths. He pointed out the frequent relationship between the production of such papillary adenomata and chronic inflammatory disturbance. The increased nutrition in the hyperæmic zone around old ulcers, for example, may orginate such overgrowth of the mucous membrane in these positions. Other cases of these papillomatous growths are, however, accompanied by no definite history of chronic inflammation.

Dr. Smith expressed his satisfaction with Dr. Adami's clear description of the condition present. His observations of the patient confirm Dr. Adami's remarks. She does not resemble a patient suffering from malignant disease. When her bowels are moved she suffers pain; and if the motion is hard, its passage is followed by bleeding and pieces of tissue. In one of these pieces a little blood vessel was noticed.

Dr. Stewart—Was there much hemorrhage?

Dr. Reed—And how often did it occur?

Dr. Smith—A teacupful at the last occasion. As to frequency, it was generally at the time of her periods that the hemorrhage occurred; in the intermenstrual period it occurred very seldom and very slightly. The hemorrhage did not always amount to a teacupful.

Dr. England—Was there hemorrhage before the appendages were removed?

Dr. Smith—No. In removing the ovaries I noticed a subperitoneal fibroid on the back of the uterus, which I did not disturb, not wishing to complicate the operation. The appendages were very much inflamed and thickened, the ovaries also.

Dr. A. Lapthorn Smith read a paper on Tubercular Peritonitis, with report of a case treated by operation.

It is now three years since Dr. William Gardner read a most interesting paper before this Society on abdominal section for tubercle of the peritoneum and uterine appendages, reporting at the same time five cases with two deaths. We have had no discussion, as far as I am aware, on this most important topic since then, and as I had a case of the same kind to report, I wrote my paper so as to give an opportunity for a discussion on tubercular peritonitis in general, and the operative treatment of it in particular. Having seen a good many patients die from this disease, under treatment with medicine, some of which cases were diagnosed and some were not, and having made post-mortem abdominal sections of a good many children who died from this disease at the East London Children's Hospital during my term of residence there, I have always taken a great deal of interest in the progress which our knowledge of this obscure disease has been making during the last ten years, and especially in the wonderful results of abdominal section as a means of cure. How is the disease contracted? How may it be prevented? How may it be diagnosed? And what is the best treatment? These are all questions of great practical importance. I shall only attempt to throw out a few suggestions in reply to these questions, trusting that the professors of pathology, medicine, hygiene and abdominal surgery, who may be present, may give us from the abundance of their knowledge. In order to clear the ground for action, I would like to begin by expressing my utter disbelief in the heredity of this disease, no matter where situated, whether in the res-