evening, however, it rose to 100.2°. The decidua was passed, with pains on the 22nd, and on the morning of the 23rd, patient had a rigor, the temperature rising to 104°, the patient being considerably pained. On the 26th, examination revealed the fact that the cervix uteri had resumed its normal position. From this date the temperature swung badly ,and the urine became foul in odour and laden with pus. This continued despite medical treatment until 10th February, when a further examination revealed distinct fluctuation in the swelling in the right fornix. Patient at this time had no complaints whatever. On 13th February an incision was made in the convex right fornix, releasing a great quantity of most odiously smelling, brownish, pus-streaked fluid. Much green-grey membranous *débris,* fœtal skeletal parts, and decomposing fœtal soft parts were removed piecemeal with ovum forceps. A sound was passed into the uterus. In the notes of the case it is not recorded how far it entered, but my recollection is that it was just over 3 inches. Drains were inserted, and twice-daily douching was instigated. More bones were discharged, and the douches were, in part, returned *per urethram,* but no return *per cervicem* was noted. The bones consisted of the long bones complete, temporal, iliac, metatarsal, ribs, many vertebral fragments, and a heterogeneous, unrecognizable assortment of bone *débris.* Calculated from the size of the femora and humeri, the fœtus must have been between the fifth and sixth month of intra-uterine life. Dr. A. M. Kennedy, then Pathologist of the Hospital, reported that the pus contained "streptococci and coliform bacilli, also a Gram-positive bacillus showing terminal spore formation."

The operative interference, the douching, and the administration of anti-streptococcic serum seemed to benefit the patient greatly, and her temperature returned to the morning 97.5°, evening 99°, type. She had always had a little cough and expectoration, but examination of the lungs and sputum did not suggest any tubercular involvement. On 3rd February the temperature again began to mount, rising until 7th February, when it reached 102°, and falling next day to its usual level. About this time a fæcal fistula formed. On 22nd March a further operation was deemed necessary. The uretha was dilated, and more osseous remains were removed from the bladder. On 26th March patient retrogressed rapidly, and despite all efforts at stimulation, died.

From the time of her admission patient had maintained a particularly optimistic outlook, and had in every way co-operated with us for her own benefit. At various times during her residence in Hospital all hope had been given up, and the fact of her having lived so long with such a serious complication I attribute mainly to her extraordinary pluck and endurance. All the time patient never suffered really acute abdominal pain, nor was there any rigidity, tympanicity, nor, in fact, anything suggestive of intra-peritoneal involvement. Death was certified as being due to "exhaustion two days after a second operation for missed tubal abortion."

Unfortunately, permission to perform *post-mortem* operation was refused. Interesting as the intimate pathology would have proved it was unavailable, but we were at least left with a case demonstrating a series of most unusual clinical points which deserved full consideration.

The first feature of note was the