covered by dense adhesions, and posterior to it a cystic structure about  $4 \times 1\frac{1}{2}$  cm. in size. This had a bluish color, thin wall, and was intimately connected with the rest of the mass. Imbedded in adhesions a piece of the ampullar end of the tube was found, which could be traced for about 4 cm., and then lost itself in the mass, and appeared to have no connection with the above mentioned cystic portion. The main portion of the mass or section was shown to be composed of ovarian tissue, which was covered and completely hidden from view by very dense adhesions. It contained two tolerably fresh corpora lutea about 11/2 cm. in diameter. The larger of these corpora lutea communicated by a small opening with the cystic portion above mentioned, which contained a thin, reddish, watery fluid containing blood cells. On cutting open this cystic portion its walls were found perfectly smooth, with several smaller cysts pro-These varied in size up to 2 cm. jecting into it. in diameter, and were filled with a clear watery fluid, and arose directly from the ovarian tissue. On examining the scraping from the walls of these cysts, I found that they were lined by a layer of almost flat cuboidal cells, which were distinctly ciliated. These cysts could not have originated in the tube, as was readily demonstrated by their arrangement in relation to the larger cyst, and by the living epithelium, which was totally different from that of the tube. Their smooth interior precluded the idea of a ciliated papillary cystoma; and the only probable thing for them to be were dropsical Graafian follicles, which had been prevented from rupturing by the dense adhesions covering them, and so obtained their large size. The fact that they were lined by ciliated epithelium is not at all opposed to this supposition; for cilia have previously been found in the dropsical Graafian follicle, as was shown by Von Velits, of Budapest, about a year ago ; and as I found altogether independently of him last spring. But as yet I have not made a sufficient number of observations to assert that all dropsical follicles are lined by ciliated epithelium. The blood in the large cyst in all probability came from the corpus luteum with which it was connected. The adhesions about the ovary were particularly dense and resisting. The diagnosis from the specimen is pelvic peritonitis, with adhesions binding down the adnexa on both sides, particularly the right side, with several very large dropsical Graafian follicles.

The specimen submitted to me by Dr. H. P. C. Wilson was a small myoma about 3 cm. in diameter, and bore on one surface a piece of vaginal mucous membrane, the size of a two-cent piece. The tumor was submitted to me to decide whether its origin was from the anterior fornix or from the uterus itself. Sections made through the tumor and the vaginal mucous membrane readily showed it to be a myoma, which was separated from the sub-mucous tissue and epithelium by numerous bands of nonstriated muscular tissue. From the presence of muscular fibres between the tumor and epithelium, I think we are justified in concluding that it was not of vaginal origin. Were it of vaginal origin, it should arise from the submucous tissue and be immediately adjacent to the epithelium and not separated from it, as it was in this case, by muscular tissue. Force is lent to this conclusion by the fact that vaginal fibroids are very rare indeed, and many of the reported cases, especially fibroids from the anterior fornix, had their origin in the anterior wall of the uterus instead of the vagina.

The specimen submitted by Dr. Opie was a greatly hypertrophied posterior lip of the cervix, which measured 5 cm. in length, and 2 cm. at its broadest part. Microscopically it was found to consist of almost normal cervical tissue, with only a very slight increase of the connective tissue. Except at its cut surface, the entire mass was covered with the usual stratified epithelium.

Generally speaking, we may distinguish two forms of hypertrophy of the portio-vaginalis follicular and diffuse or simple hypertrophy. The first form is due to an increase in the number and size of the cervical glands, with frequent retention of their contents, and is quite frequent but never attains a very great size, and is readily distinguished by its nodular appearance. The diffuse or simple form of hypertrophy is far more important. In this there is a general increase in all the elements that compose the cervix, though there may be a slight increase in the amount of connective tissue, as there was in this case.

Dr. Howard A. Kelly read a paper upon the palpation of