the Montreal G neral Hospital, there was severe pain in the hypogastric and inguinal regions. A soft movable mass, the size of a fœtal head at the 6th month, was felt behind the uterus and to the left. The uterus was anteverted. On 6th September, 1893, the abdomen was opened in the middle line and a small elastic tumor attached to the left broad-ligament found, which proved to be full of blood and clot. The left tube and ovary were ligated and removed with the tumor. Recovery was good. On examination by Dr. Adami, the tumor proved to be a hæmatoma of the Fallopian tube. The external surface of the sac was roughened, inflamed and covered with organized lymph. The inner surface of the sac and contents were carefully examined for fœtal or placental structures, but with negative results. The hæmatoma was evidently of chronic growth, and appeared to have developed as a consequence of chronic inflammation and ulceration of the tube.

Dr. ALLOWAY, commenting on the cases, said: It was interesting to know that a cyst of the ovary could become so completely separated from that organ and so simulate a parovarian cyst. In the case of hæmatoma the tube was distended to the size of his wrist, and was ruptured in removal It so resembled a tubal pregnancy that he was surprised to find no evidence of a fœtus, but now believed the bleeding due simply to rupture of the blood vessels during tubal inflammation. There was a history of miscarriage six weeks before the operation.

Double Pyosalpynx with Intestinal Fistula.—Dr. ALLOWAY also related a case where the appendages were removed from a woman suffering from severe vaginitis and pelvic peritonitis. Blood and pus had passed by the bowel. Both tubes were greatly dilated, the left being fully two inches in diameter and filled with pus which escaped into the peritoneum during the operation. The pus was not fœtid, and no bad results followed this accident. The right tube was thickened into a dense rigid cord, passing round the coils of intestine. Both tubes were extensively adherent to the intestine and the entire pelvic contents matted together. Between the fimbriated extremity of the right tube and the bowel was a fistulous opening of the diameter of a five cent piece, which was closed by the Lembert-Czerny method. Another opening was discovered in the bowel where the knuckle of the tube had become adherent. The uterus and omentum were utilized in closing this. The extensive hæmorrhage was arrested by pressure. The pelvis was not washed out. There was no rise of temperature for the first week, when there was a slight rise lasting for some days and accompanied by tympanitis. At the present date, nine weeks after operation, she appeared on the road of recovery. Nothing more than a local peritonitis appeared to have followed the operation, although some fæcal matter must have escaped into the peritoneal cavity. A glass, and later a rubber, drainage tube was used. At first some pus, but no fæces, passed through these. Starvation diet with rectal injection to relieve tympanitis were employed. Pyoctanin and peroxide of hydrogen were used as antiseptics.

Discussion.—In answer to Dr. Gordon Campbell: There was no evidence of fæces passed per vaginam. To Dr. Armstrong: The omentum was simply brought down, not sutured.

Cholecystotomy.—Dr. ARMSTRONG exhibited a large solitary gall stone removed in September, 1893, from a woman aged 42. Ten years ago she had her first attack of severe pain, with jaundice, in Harrogate Hospital, England, when an operation was suggested but declined. Since then she had attacks of biliary colic with jaundice about every six months until the last two years, since when they occurred monthly, lasting two weeks at a time. Pain severe in hypogastrium and right hypochondrium, requiring morphia. The gall bladder contained some pus, its walls were strong and readily sutured, and it was long enough to reach the abdominal wall. On palpation no stone could be felt in the common or cystic ducts. Recovery uneventful, the only unfavorable point being the persistence of the sinus, although there was satisfactory evidence of sufficient bile in the stools. If the loss of bile proved injurious to health, the only operation feasible would be that of establishing a communication between the gall bladder and the small intestine, as has been done in one case by McBurney.

In answer to Dr. Lafleur: She had no febrile attack while in hospital, but said herself that some of the previous attacks made her feverish.

Dr. F. W. CAMPBELL wondered at the excessive pain in this case. Pain usually arose from small stones passing along the duct, and in his opinion comparatively small stones gave him the most pain. It was comforting to think that if serious symptoms of obstruction arose, surgeons could now afford permanent relief by operation.

Dr. LOCKHART recalled an operation he had witnessed on a woman of about 50, when only two stones were found, one of which had two facets, having possibly been turned end for end. The other stones had three facets.

Dr. JAS. BELL thought the contraction of the gall bladder upon a large stone would easily account for the pain. With renal calculi very large stones often caused no pain, while intense agony was produced by very small ones. In one case a large gall stone was passed by the bowel, which must have ulcerated through from the gall bladder.