den dragging upon them of the retreating uterus, the tubes being probably held back by adhesions." Again, "The distended fallopian tubes may burst, or without bursting an overflow of blood may escape into the peritoneum, causing peritonitis. The constitution suffers from hectic, the result of pain and the absorption of the altered blood."

In his classification of hæmatocele, he only mentions the fallopian tubes as concerned in connection with obstructed menstruation and does not say anything about primary dilatation of one tube with blood, with or without its rupture, into the peritoneal cavity.

I find in Spencer Well's work no mention of hydro, pyo or hæmato-salpinx. The work is unfortunately not indexed. On pages 18 and 19 I find under the head of what he calls tubo ovarian cysts, he relates a case that was evidently one of hæmato-salpinx. It was recorded by Dr. Lionel Beale, in the "Pathological Transactions for 1867-68." A married woman *æt* 30, died of renal disease. For last year of her life she had not menstruated. Was no history of any uterine affection. She had never been pregnant; after death two tumors were found in the pelvis, one on each side of the uterus. The left one was circular, about size of a small orange, and distended with fluid; on its upper and inner surface was seen a tortuous, but not uniformly dilated canal, which was closed at the uterine end but opened freely into the larger cyst at its ovarian extremity, this was the uterine portion of the fallopian tube, while the cyst was the dilated fimbriated extremity. The tumor on the right side was smaller and the inner portion of the tube was uniformly dilated into a canal one third of an inch in diameter. Like the one on the other side it communicated with the cyst by a smooth circular opening. On each side the inner constriction was just outside the uterus where the tubes seemed to be merely fibrous cords. Externally the fimbriated extremities were also closed and dilated into roundish cysts. Each cyst had thin walls with fluid contents of a dark brown color. The left ovary could not be seen, the right was flattened out and lying in the wall of the cyst but not communicating with it. No traces of ovarian structure were left but a mere cyst with semi-fluid contents of a chocolate color. Uterus, normal in appearance, but no distinct opening, could be seen at the fundus where the tubes generally enter; outside the peritoneal surface was normal. Dr. Savage says, "In some instances I feel sure there is nothing to be felt in the pelvis before operation, and we have nothing to guide us but the more or less constant pain and recurring attacks of inflammation; each attack making the adhesions stronger and more extensive, and rendering the subsequent removal by operation more difficult, and therefore, more dangerous." Emmet says, "Some writers make a third division (after speaking of pyo and hydro-salpinx), hæmato salpinx. I have never known an instance of blood accumulating in the fallopian tubes unless it was secondary to the retention of menstrual blood in the uterus, and as such should not be recognized as a distinct condition. The outline of a distended tube as felt from the rectum is unlike the accumulation of any other fluid to be found in the pelvis, for the tube, as it fills, twists upon itself like a distended intestine. If the collection is of a bland character but little disturbance may follow its rupture into the peritoneal cavity, and this may account for the rapid disappearance of supposed ovarian tumors, as the tube is not likely to refill. If the collection is of pus, rupture of the tube is of serious consequences. With pyo-salpinx a woman's life is in jeopardy each hour of delay, and we have no other means of relief than the removal of both tube and ovary. Again, he says, it can scarcely happen that one tube should be so diseased as to require its removal and the other be in a healthy condition."

Thomas says, "Extravasation of blood in the mucous membrane or bleeding in the canal of the tube from menstruation or following inflammatory processes in the uterus, or after acute infectious diseases, does not appear to be very rare. They are, however, of no very great importance, as the blood, as a rule, is re-absorbed, and thus rupture of the tube is prevented. Still, we cannot lose sight of the fact that they are important in this respect, namely, that the blood may escape through the abdominal opening and set up a peritonitis. If we except tubal pregnancy and hæmato-salpinx accompanying hæmato-metra, effusion of blood into the tube is seldom followed by death."

Schroeder says regarding the diagnosis of a dilated tube, "The diagnosis in cases where the mass has attained large proportions is difficult and often, indeed, impossible. I would base it on the following points: The swelling is long, fluctuating,