slight difficulty an ovoid in contour tumor could be felt reaching to the umbilicus and enlarging below where its outline to palpation became lost in the depths of the pelvis. The tumor was dull on percussion, very tender, no contractions to be felt, no fœtal movement (although the patient thought she had felt these), and no heart sounds to be heard at the time. A well-marked souffle was heard.

Per vaginam the uterus was found to be crowded to the right and front of the pelvis, but its exact position and location with the tumor could not be ascertained accurately. It was raised slightly and measured by the sound slightly over 70 m.m. The remainder of the pelvic cavity was filled by a large fluctuating tumor continuous with that observed above. It was thought at the time that a solid movable body could be detected, but the extreme tenderness precluded thorough manipulation. Dr. Fisk, then house surgeon of the hospital, detected fœtal heart sounds upon the day of operation.

When the cavity of the peritoneum was examined, it was found that the pelvis was roofed by a tumor which had a projection upwards. It completely filled the pelvis from the brim. The uterus and right appendage were easily felt in the position partially ascertained by the examination previously mentioned About one inch of the left tube could be felt close to the uterus, the rest of the tube appeared to be lost or spread out upon the tumor. Here and there small and recent clots of blood entangled in omentum and lying in between the folds of bowel were to be seen. These had evidently come from the sac or cyst wall, in which more posteriorly several small oozings were observed. Shreds of fibrin attaching the cyst wall to the surrounding parts were quite numerous, and evidently but a few days old.

A trocar withdrew a quantity of unmeasured slightly tinged with blood fluid from the cyst. The puncture bled so freely that a finger was introduced to explore the contents, and which was found to be a living child. The opening was quickly enlarged and the fœtus extracted. This was followed by the most awful hæmorrhage I have ever seen, and was only controlled by aortic compression. The cord was attached about one and a half inches to the left of the median line to the roof of the cavity. The placenta was wholly attached above, and the thickness of the placenta and cyst wall in parts did not measure more than one-fourth of an inch, and seemed to be but peritoneum and placental tissue.

Any attempt at hæmostasis by ligature, forcepressure or cautery seemed to increase the hæmorrhage. The sac was sewn by its opening to the abdominal opening, pressure on the aorta being maintained in the meanwhile and the cavity tightly packed with iodoform gauze, as were also the united openings. This stopped any active hæmorrhage. The child after delivery made a few feeble respirations and died No attempt was made to extract the placenta.

The patient recovered well from the effects of the anæsthetic considering the amount of blood lost.

For several dressings in which the gauze packing was removed it was found necessary to compress the aorta, and any attempt in detaching the placenta was followed by profuse hæmorrhage.

She continued to improve for ten days, after which symptoms of thrombosis appeared in the left femoral vein, septic in nature. This was followed by pyæmic abscesses. She recovered, however, but did not leave the hospital until October 18th, and is now in fair health.

I am indebted to Drs. McConnell and Perrigo for their able assistance in this case and its after-treatment.

CASE II. This case is of much interest, for it is believed to be now a case of retained fœtus. The patient was 30 years of age and had been married for six years. There is a history of a probable miscarriage (of about three months) five months after marriage. Since this she had been attended by a gynæcologist for some uterine disorder. She had enjoyed fair health otherwise and menstruation had always been regular.

On the 12th of September, 1893, she was seen for the first time and complained of pain in the lower region of the abdomen, syncopal attacks and vomiting. There was a slight rise of temperature and pulse rate. She had menstruated during the last week of March, nearly six months previously. About the end of the following May she noticed a slight flow of blood and pieces of skin, as she called them. This was accompanied by violent cramp-like pains, vomiting and fainting. Her friends thought she was dying. She recovered from this attack, but had more or less pain in the abdomen and occasional attacks of syncope until she came under the writer's care.

She was poorly nourished, complained of nausea and vomiting. Pulse was 100 and weak, temperature 100 1-5°. Pressure over the abdomen elicited much pain, and a smooth immovable, rounded mass was felt in the median line and to the left and in the pelvis. The breasts were hard and tender and the areolæ dark.

By bimanual examination the mass in the pelvis could be felt; it was semi-fluctuant, tender, and was harder in consistency in some parts than others. The uterus was apparently to the right and front of this mass, and could not be definitely separated from it. No fœtal