does not dip down very far into the pelvis. Such cases are described in books, as having a very broad pedicle but the most that can be correctly said of them, is that they are only partially pedunculated. In that condition the ligament can be ligated with what I may call the repeated continuous ligature, which is applied in the following way: A long ligature is passed through the ligament an inch from the outer edge and that portion tied; then one end of the ligature is passed through the portion already ligated, then carried forward and brought back through the ligament in such a way as to secure another portion and the two ends again tied, and so on, until the whole is secured. The cyst and its its capsule are then cut off. This leaves no cavity, arrests all possible hæmorrhage and in this respect is all that can be desired. But there are difficulties and dangers that may arise, even in cases where it is applicable. There is a danger of wounding the ureter, or including it in the ligature, and a knowledge of its anatomical relations is not always sufficient to guard against this accident, as it may be displaced. By drawing the cyst and ligament out of the abdominal wound it may be possible to see that the ureter is not in the way, but when this cannot be done, one must depend entirely upon the touch to localize and avoid it. This is possible, when it can be felt like a cord crossing the ligament, and by holding it in the grasp of the thumb and finger for a moment the upper side will become dilated from the accumulation of urine. This is a sure guide which I obtained from Keith. But in case the tissues are thickened by inflammatory products it is difficult, by any means to find the ureter.

There is still another way of managing these cases and that is a combination of the two methods already described. It is well adapted to the class of cases in which the cyst can be enucleated easily and the capsule is so situated that it can be ligated without injuring the ureter. The cyst is first enucleated and the capsule or so-called pedicle is tied and cut off. The advantages are, that the capsule is easier to handle after the cyst is removed and there is no danger of including any portion of the cyst in the ligature, an accident that may occur in operating by the second method alone. There is one fortunate feature in this method of treatment, viz., in case enucleation cannot be effected, ligation alone can be resorted to. It is well then to try enucleation even if it has to be abandonded.

There still remain for consideration cystomata that cannot be removed by any of the methods known at the present time, and there are such cases. A cystoma that descends into the pelvis and has beeome firmly adherent to the ligaments by inflammatory products cannot be enucleated, neither can the capsule be ligated. At least enucleation cannot be done with any degree of safety. That complete removal of such tumors has been tried is no doubt true, but the result has been to open into the rectum or bladder, or to cause uncontrollable bleeding or peritonitis, either of which may prove fatal.

These complications are always present in suppurating intraligamentous csytomata and hence, when pus is found on tapping, it may be inferred that enucleation is impossible. I have found, also, that cellulitis has so firmly united the cyst wall to the ligamentous capsule that they could not be separated. The treatment of such cases should be by drainage alone. I am well aware that the more skilful the operator the more surely will he overcome difficulties and the more seldom will he have incomplete operations, but when the conditions which have been named are present, I am confident that it is wiser and better to empty the cystoma and unite the cyst to the abdominal wall and then drain by means of the ordinary tube.

In such cases the cyst fluid is usually septic, (this is especially so in suppurating cysts), and it is very difficult to save the peritoneum and abdominal wound from contamination. After emptying the cyst it should be thoroughly cleansed with sponges or absorbent cotton, and papillary tissue if present, may be scraped off. This should be done with the cyst drawn up in the wound. It is also well to remove as much of the cyst as possible. The best means of accomplishing these objects is a matter for discussion. Therefore I may briefly state, that I leave enough to come up and join the abdominal wall without any traction, and then treat the remaining portion in the manner described, in treating the ligaments after enucleation when drainage is employed. To do this and at the same time keep the peritoneum free from septic infection is so difficult, that I may be pardoned for giving some of the details. If the cystoma is