uterinum being completely occluded. They were filled with dark, thick grumous fluid of a prune juice color. It is evident that in this case we have an example of what Bernutz and Gouple contend for—menstrual retention within the fallopian tube. The one fact which is clearly revealed is that the tubes do, as well as the uterus, take part in the menstrual secretion; hence, when any obstruction occurs to the passage of that secretion into the uterine cavity and so externally, we get the resulting symptoms of menstrual retention.

Tait records the following case occurring in his practice :—"Miss M., *æt* 38, sent to me in beginning of 1877, by my friend, Mr. Alfred Greer. In Nov., 1876, she had an ill-defined illness, during which she had obscure pelvic pains, accompanied by fever. Previous to this illness she had been in good health and had menstruated regularly. After it she had severe pain during the whole period of menstruation, and she gradually increased in size until Mr. Freer discovered a pelvic tumor to be pear-shaped, quite moveable, to be attached to uterus at left cornua, evidently unilocular and about size of an infants head. I diagnosed a cyst of parovarium, and advised tapping when sufficiently increased in size to warrant interference. She returned to me in May with the tumor increased so as to be felt above the umbilicus. I advised her to come again in a month. She came before the expiration of that period, on account of a sudden accession of serious symptoms; and when I saw her, June 20th, there could be no doubt she was suffering from peritonitis. Pulse 130, temperature 101.12, which rose to 103.38 in the evening. Excessive pain all over abdomen with flatulent distention. I gave opium freely and applied counter-irritation over the epigastrium. On morning of 21st, was easier, but temperature and pulse had not fallen. I proceeded to open abdomen. The tissues of abdominal wall were very vascular and it was necessary to use ligatures to arrest the bleeding. Peritoneum adherent to tumor and it became evident that the latter was not ovarian but had the red muscular appearance of the uterus. Passing the forefinger of my left hand down as deeply as I could in front of the tumor with that of my right in vagina, I made out distinctly that my original conception of the relations of the tumor to the uterus were correct. Under the suspicion that it might be a tubal pregnancy, I did not separate the tumor further, as I had not opened the cyst by means of a knife. As soon as I reached its inner coat I passed my small trocar in and evacuated about six quarts of thick, dark brown fluid, having the peculiar smell of menstrual blood. After the cyst was emptied I passed my finger through the hole made by the trocar, and to my amazement I found that the cyst had contracted; moreover, as I kept my finger in the cavity I distinctly felt it contracting round and grasping my finger. Passing the forefinger of my other hand into the vagina I made out that what I had opened was without doubt the left fallopian tube and that I must have opened its fimriated extremity. I could find no canal leading to the uterus and did not deem it advisable to make one. I washed out the cavity freely with a weak solution of carbolic acid, by reversing the siphon action of my trocar. A piece of wire drainage tube was fastened in and a piece snipped off for microscopical examination. This proved to be composed of an abundance of unstriped muscular fibre, conclusively supporting my view that this singular tumor was a dilated fallopian tube. Her temperature fell slowly. Wound suppurated freely and sheds of mucous membrane came away. She is now in perfect health and has never menstruated since the operation. The illness from which she suffered and which was undefined, was undoubtedly a localized salpingitis, resulting in closure of the two ends of the tube. The peritonitis was probably due to a threatening rupture of the tube, or possibly a slight escape of its contents." Arthur Farre quotes a case of this kind, in which the distention by the menstrual fluid advanced to rupture, followed of course by death.

Barnes says, "The tubes may be distended by accumulations of blood. One cause of this is menorrhagia. Usually the uterine opening gives it passage; but sometimes if this opening is obstructed as by a clot, the blood continuing to be poured out by the tubal mucous membrane, may overflow by the abdominal end and give rise to a retro-uterine hæmatocele." He also says, "The fallopian tubes in cases of atresia of uterus vagina or vulva, commonly undergo extreme dilatation and are liable to burst. He describes under the dangers of puncturing of the closed hymen the more common event, namely laceration of the tubes at the weakest part, caused by the sud-