

solid fatty material, surrounded by definite capsules, may quite rightly be described as cysts. Clearly, there had been a tendency towards the formation of chronic suppurative foci, not only in the tubes and ovaries, but also around them, so that we have cysts of inflammatory origin (1) in the ovaries themselves, starting in the corpora lutea, (2) in the broad ligament, (3) upon the outer wall of the Fallopian tube, and (4) in the Fallopian tubes; for these have become occluded, and each with its lumen distended by old inflammatory products may be looked upon as cystic.

Case II. *Pedunculated Sub-peritoneal Fibro-myoma: Cystic Graaffian Follicles.*—Here was a sub-peritoneal fibro-myoma attached to the posterior portion of the uterus by a ligamentous membrane, which allowed it to be quite distinct and separable from the uterus. The ovaries in this case also showed evidence of disease. The right one was of fairly normal size; on section, a cavity with a sinuous wall was seen; this cavity is certainly nothing other than a large corpus luteum which has undergone cystic degeneration and is now being absorbed, so that here is another form of cyst of the ovary. In the last specimens we had to do with a cyst which resulted from the suppuration of a Graaffian follicle or corpus luteum; in this one we have a corpus luteum which, instead of undergoing its normal course of enlargement, followed by atrophy, has increased abnormally (it was at least 30 millimeters in diameter). The blood first poured out had become absorbed, and was replaced by a fairly clear fluid, and only now, judging from the sinuous capsule, was absorption taking place. The left ovary in this case showed two other cystic conditions. One appeared to be a comparatively recent corpus luteum, the blood pigment still being in it, with little crystalline masses of hæmatoidin, the centre being a clear cystic space. The second was a simple cyst partially filled with semi-solid broken-down cell matter, the rest of the cavity being filled with clear fluid.

Case III. *Multilocular Ovarian Cyst of Great Size: Cystoma Proliferum Glandulare.*—This case, sent by Dr. Gardner, is interesting on account of its great size, and from the fact that upon first sight it appeared to be one huge single cyst, completely filling up the lower abdominal region. There were, however, towards the lower and hinder portion a few small cysts connected with it, corresponding, it would seem, to the region of the original ovarian tissue, and upon the anterior wall could be felt three or four hardened areas, or "plaques," the largest being several inches in diameter. Upon opening the large cyst and removing the mucoid material contained, these flattened plaques could be seen projecting lightly into the interior. The specimen had

been sent in order to determine the nature of these thickenings of the wall.

Waldeyer has divided the ovarian cystadenomata into two classes, which, it must be admitted, are not sharply separated, for a very large proportion of ovarian cysts, if carefully studied, must be placed under both of his headings. These are: (1) that of the "cystoma proliferum papillare," in which the connective tissue of the wall of the mother cyst undergoes great proliferation, forms papillomatous projections, and the papillæ, covered by a layer of epithelium, and coming into contact here and there, form thus the secondary cysts; (2) in the second class, or that of the "cystoma proliferum glandulare," it is the columnar epithelium lining the mother cyst that is the more proliferous, and that dipping down into the underlying connective tissue, there form follicles, which, becoming occluded, develop into the secondary cysts. Now, the plaques in this specimen, when examined microscopically, are seen to be composed of a relatively small amount of fibrous stroma, enclosing very numerous small follicles and cysts lined by a single layer of columnar epithelium, tending to invade the capsule of the mother cyst. Hence to this extent the tumor must be classed as an adeno-cystoma of the glandular type.

We have, therefore, in the series of examples brought before the Society, a not uninteresting series of the main forms of cystic growth in the ovary, the dermoid cysts alone being deficient. We have the Graaffian follicle, which, owing, it would seem, to coincident inflammation in and around the ovaries, forms a corpus luteum of great size and aberrant course, becoming either the seat of inflammatory change itself, so that the cavity contains eventually broken down cell material, puriform debris, or again becoming a cyst of moderate size filled with clear fluid. And again, we have a very fair example of the form of multilocular ovarian tumor of the more important type clinically, with regard to whose etiology there is still divergence of opinion.

Are the multilocular ovarian cysts, the cystadenomata, also developed, like the simple cysts above described, from Graaffian follicles, or have they another origin? The fact that the columnar epithelium lining them is of a simple type, that they and the tumor which they form are of an embryonic type, and that coincident with this more or less embryonic nature the tumors are of fairly rapid growth and incline towards malignancy, are, on the whole, against the view that they develop from mature Graaffian follicles. And with Waldeyer and Malassez it is generally held that they are developed from an earlier stage; that just as the Graaffian follicles themselves originate from processes or follicles growing inwards from the epithelium covering the surface of the foetal