[90] ureter. This gauze of course was covered over with peritoneum and was accordingly extraperitoneal. Another piece of gauze was dropped down into Douglas's sac as a safeguard should there be any slight sepsis, as it was impossible to thoroughly cleanse the vagina prior to operation. The patient stood the operation well.[1]

In this case one naturally asks why was not the large submucous myoma removed per vaginam prior to the hysterectomy? In the first place, the patient was an unmarried woman and removal in such a manner was almost out of the question without first making a deep incision in the vaginal wall. In the second place the bleeding was so free during the slightest manipulation that we hesitated to give the necessary cleaning.

The situation of the ureter in this case was of especial interest as it was far out of position and right up beside the ovarian vessels. We only had a narrow chink of about 8 mm. in breadth in which to tie the ovarian vessels and it was impossible to control them in any other situation.

Case 3.—*A partially parasitic myoma receiving its blood supply chiefly from the enlarged omental vessels and a densely adherent bladder. Also associated with over 50 litres of ascitic fluid and clinically presenting the typical picture of a patient suffering from a tremendous ovarian cyst. Removal of parasitic myoma. Recovery.*

Miss P., referred to me October, 1902, by Dr. Hopkins. The patient is 54 years of age, very thin and has the typical expression of one suffering from an ovarian cyst. For several years she has been complaining of abdominal distension. The abdomen is greatly enlarged, and in the lower portion near the pubes there is much œdema. There is, however, little or no swelling of the extremities. The entire abdomen is dull on percussion but in the flanks there is some tympany. On palpation a slight wave of fluctuation can be elicited. I saw this patient several days ago but on account

[1] The patient left the hospital November 29, 1902, feeling perfectly well.