will be increased by fresh hemorrhage and the adhesions will no longer be able to retain the mass, and, as a consequence, free blood will be poured into the peritoneal cavity, and, if in any large quantity, will be found as high up as the liver and spleen. When the blood flows slowly the patients have attacks of syncope and of pain, and if the hemorrhage ceases for a time they resume apparent good health. The mass continues to increase in the pelvis so long as the hemorrhage continues intermittently.

In support of his argument in favor of broad-ligament rupture, Tait says that peritonitis rarely occurs in cases of broad-ligament rupture and that the talk about collections of blood becoming encysted is the veriest nonsense. I beg to assert that the blood does become encysted and that I have removed such encysted blood many times. It is not difficult to understand how we may have the organization of this blood clot without an appreciable amount of inflammation. Such organization of the blood is not a result of inflammation. Campbell recognized this feature years ago, and said in his book that the connection with the original mass—meaning the poured-out blood—through time, with the adjacent parts becomes so intimate that, when superficially considered, the ovum may seem to be involved by the layers of the broad ligament.

Tait considers that, in many cases after other operations upon the tubes, the mass that occasionally forms is an intraligamentous hematocele. There has been no proof adduced that these masses are intraligamentous hematoceles. Secondary hemorrhage is a well-recognized occurrence after the ligature of the blood vessels in other parts of the body, and among these friable, dense, and edematous structures in the pelvis there is no reason why secondary hemorrhage should not also occur. When these hemorrhages do occur it is difficult to understand why they should select the layers of the broad ligament instead of the pelvic cavity itself. I am satisfied that oozing may take place from the stump of an amputated ovary and tube into the general peritoneal cavity among the intestines, and that this oozing may cease and the blood clot may be absorbed or require vaginal section for its removal (as in a case of Dr. E. O'Reilly, of Hamilton).

Tait says in his "Lectures," on page 37: "Thus I tied the pedicle of one ovarian tumor with catgut and the patient died on the fourth day after operation. I found a large intraperitoneal hematocele, due to the gestation and loosening of the ligature." He states that these hematoceles produced by rupture