above by the omentum, and below by the pedicle, rendered its removal a little difficult. The fact, also, that its mass being made up of small cysts with thick contents did not permit of its bulk being materially lessened by tapping, I was obliged to incise it and break up its contents. Some anxiety was caused by finding that the fluid contents of some of the cysts, when subjected to microscopic examination by Dr. Foulis, were found to contain sarcomatous elements. This led to a special examination of the tumor,and the detection of sarcomatous thickening of certain portions of its walls. But, as there were no proliferating masses on any part of the surface of the tumor, we have the best reason to expect that the patient will do well, having escaped infection from the sarcoma.

CASE II.—M. P., æt. 21, no children, admitted December 18, 1883, complaining of pain in the right groin. Twelve months ago patient was suddenly seized one evening with a sharp pain in her right side ; mustard was applied and relief was obtained for the time. From that time till now patient experienced at times a feeling of heat in the side. Menstruation natural. Health always good.

Condition on admission.—General appearance flabby and chlorotic. Abdomen distended to about the size of a seventh month pregnancy. The tumor is more developed towards the left than the right. Measurement round the most prominent part of tumor, about an inch below umbilicus, is 30¼ inches. From umbilicus to right anterior superior spine, 6¼ inches ; to left anterior superior spine, 6½ inches. Tumor feels smooth all over, appears to move with respiration. Percussion in right flanks clear, on left somewhat dull. Anteriorly over whole tumor is marked dulness. Fluctuation and fluid thrill are felt throughout the tumor. *Per vaginam.* Posterior part of pelvis and entire inlet are blocked by a tumor which moves in unison with abdominal tumor to a certain extent. The uterus is displaced to the left and upwards. Cervix uteri can be reached, but with some difficulty. Sound passes up and forwards without pain 2¼ inches.

Dr. Macdonald performed ovariotomy on Dec. 26, 1883. On entering the peritoneal cavity the omentum and a portion of the bowel were found adherent to a large cyst, which occupied the right side of the abdomen. On the left side the same cyst was bare, the aspirator was passed, and about 90 oz. of a dark amber colored fluid drawn off. On attempting to remove the cyst it was found to pass deep down into the very base of the pelvis, so that it was impossible to complete the removal without 1. separating the bowel adhesion : 2. opening the broad ligament so as to get the cyst gradually enucleated from between its folds. In doing so some hemorrhage occurred, necessitating very numerous ligatures. The tumor, towards the uterine end, was firmly adherent to the broad ligament, so that the latter had to be partly included in the pedicle and partly torn into small pieces and tied. The pedicle proper was very thick and hard and short, and proceeded from the right upper angle of the uterus. On examining for the left ovary there was found protruding from the left broad ligament, in the site of the normal ovary, an elongate bowel-like cyst, with exceedingly thin walls, which occupied the left iliac and left lumbar regions. Over its anterior surface, and firmly adherent thereto, passed a considerable knuckle of intestine. As far as could be judged, the cyst bulged between the layers of the meso-colon. The bowel was firmly adherent to this cyst down to its pedicle proper, which proceeded from the left upper corner of the uterus in the same manner as the other cyst from the right. There was considerable difficulty and much bleeding during the separation of the bowel from this cyst, numerous ligatures being used. During process of separation of cyst it burst, and a large quantity of clear serous-looking fluid was squeezed out. Pedicle was now secured close to uterus, and its other adhesions tied in portions and divided. There was seen to be still some oozing from right side and floor of the pelvis, but no distinct bleeding points could be descried. Abdominal wound was brought together in the usual fashion after the cavity had been well sponged out, wound dressed, a glass drainage-tube having been introduced into its lower angle. Patient put to bed with hot bottles, and a brandy enema given. The patient was much exhausted after the operation, and a second enema was given. On day of operation at 5 p.m. pulse was feeble, 130 per min. Dressing changed. There was squeezed from sponge and sucked from glass tube 5 oz. of sero-sanguineous fluid. An ounce of brandy ordered every 2 hours. 10 p.m.,