now passed per rectum, and what appeared to be a localized ascitic collection on the left side of the abdomen became revealed. The abdominal wall over this collection was quite flaccid, and within certain limits the fluid moved with movements of the patient, though definitely localized on the left side, reaching from pelvis to ribs. Gradually this collection became more distinct, and I was considering the advisability of section to determine its nature, when on Dec. 9th she was seized with a severe chill, and the temperature rose to 104 deg. F. This soon dropped to normal, but went to about the same level on the following day. The pulse rate was increased to about 130, and the facial expression was bad, breath foul, and in short every evidence of a severe toxemia.

On Dec. 11th I opened the abdomen by a median incision, great care being taken to avoid soiling of the wound by the discharge from the artificial anus. On incising the parietal peritoneum, a dark red ecchymotic membrane was found everywhere adherent. I punctured this with a trocar and drew off a large quantity of hemorrhagic fluid, then introduced a finger into the cavity and proved it to be an intra-abdominal cyst. I then carefully separated the adhesions upward and laterally, separating adherent omentum, large intestine, and numerous coils of small intestine, and was finally able to deliver part of the cyst wall through the incision. I was then able to work down behind the cyst into the pelvis, and finally to follow the cyst wall to its pedicle, which sprang from the right ovary, was about the size of an ordinary lead pencil, and contained the most clearly defined example of axial rotation, from the patient's right to left. The wall of the cyst was ecchymotic, and in many places very soft, being punctured and torn in numerous spots while separating the adhesions. In other words the cyst wall was undergoing necrosis. Feeling that herein was the complete explanation of the symptoms, I ligated the pedicle, removed the cyst, mopped out the abdominal cavity, closed the incision without drainage, and had the satisfaction of seeing the patient make a complete and uneventful recovery.

After some weeks the skin around the artificial anus was becoming pretty raw and excoriated, and as considerable fecal matter was being passed per rectum, I decided on closing the artificial opening, which was accordingly done on Jan. 4th. The adherent bowel being carefully separated, the loop of ilium was drawn outside the abdomen, the opening closed with a two layer suture, the loop returned, and the abdominal wall closed in layers. Again an uneventful recovery ensued.

Torsion of the pedicle of an ovarian cyst is not a very rare con-