very dense between the tumor and the intestines, and between the tumor and the omentum. The second tumor was taken from the pelvis. It was ovoidal in form, about seven inches in length, by five inches wide and four inches thick. It was removed entire, and upon section it proved to be a dermoid growth. There was no history of peritonitis to account for the extensive adhesions. The patient had never had a day's discomfort. other than from the size of the cyst. She did not know until four weeks ago that she had a tumor. The material in the large cyst was colloid. Notwithstanding the extensive adhesions, the length of time consumed in breaking them up, and the injury resulting from the operation, the patient has made a good recovery, this being the seventeenth day after the operation.

Dr. Howard A. Kelly: The term colloid is often used in two senses. An incorrect use, describing the yellowish, more or less opalescent, thick, viscid materials, often found in ovarian cysts; it is employed in such cases, as more or less synonymous with gluey. The other use of the term is to describe a rare condition, in which the contents of the cyst are more like calf's-foot jelly, and have a vitreous fracture; they are with great difficulty removed, clinging to everything. This latter is true colloid, and when found such tumors are of a suspiciously malignant character. We should limit the use of the word to the latter condition.

I wish to refer to two minor matters of interest supported by this specimen of placenta prævia. The position which the placenta has occupied in the uterus can accordingly be determined by the position of the opening in the membrane made by the passage of the child, inasmuch as the fundus uteri must of necessity be just opposite to this perforation; we can, therefore, by re-constructing the membranes see just in what part of the uterus the placenta lay. In one of my placenta prævia cases there was no hole at all in the membranes, as I had extracted the dead child through a perforation in the placenta. We can do still more than this in the way of a diagnosis with the membranes. By allowing them to be expelled untouched into the bed and carefully observing their exact position, we can tell as well on which side of the uterus the placenta was attached.

The second point is, that we may have placenta prævia hæmorrhage without being able to detect a placental margin, owing to a low attachment of part of the placenta, near the internal os, below the contraction ring, but not over the hole of the cervical canal. The lower part of a placenta thus attached is separated by the opening up of the lower uterine segment.

Dr. L. E. Neale said: although Dr. Kelly had alluded to a point of some interest, it is of far more practical importance to recognize placenta prævia prior to its expulsion and as far as he knew this could only be done with certainty by digital examination; partial placental separation and rupture of the membranes during labor in cases of placenta prævia was outlined by Mariceau as early as 1668, but was fully described by Puzas in 1759; he saw nothing in the history of the present case as related by Dr. Opie that contra-indicated the method of Broxton Hicks, a method that up to the present time had given by far the best results—viz., 4½% maternal mortality. If this method when practicable could be performed earlier than delivery by any other method, and was not difficult, and gave the best results, why not have applied it in the present case?

Dr. Wilmer Brinton asked why Dr. Opie objected to the tampon in cases of placenta prævia; he thought no arbitrary law could be applied.

Dr. Opie said in closing the discussion that results of operative procedure depended largely upon the skill and familiarity of the operator with the special operation resorted to; in his first case of placenta prævia he had attended, he had turned and lost both mother and child. With rapid dilatation and forceps he feels that he has command of the situation, and having resorted to that method repeatedly, has gained greater skill and does better work. While Dr. Neale might do better by some other method, he is fully satisfied that he does best himself with the forceps; he is opposed to the use of the tampon because it conceals what is going on; it is not best to wait for pains. He is in favor of rapid dilatation and delivery in placenta prævia, in puerperal eclampsia and in abortion; to put in a tampon and go away is hazardous; the tampon is of very little help in hæmorrhage.

Dr. Kelly read a paper upon, "The Examination of the Normal Pelvic Viscera"; describing various new dimanual and trimanual methods of palpating the normal ovary.