defœcation; catamenia now stopped; commenced Dec. 22nd, ceased Dec. 24th; began again Dec. 28th, lasted till Jan. 4th; dark brown color, heavy odor, very few clots, quantity large. No other discharge. Menses occasionally, stop for 6 weeks and then last 6 weeks.

Pain.—If coughed, suddenly stooped, lifted weight, pain came on in the left groin, low down, going round to the back. Increased at time of menses. Coition unbearably painful. Dysmenorrhœa.

Previous illness.—Had no dysmenorrhœa as a girl, unwell at 13; went to Dublin hospital between first and second labors, for treatment. Had fallen on a foot scraper. Supposed something had become misplaced. Took an anæsthetic and had some operation performed on uterus.

Present illness.—Since birth of child 4 years ago, never been well. Blood discharged per vaginam irregularly for 3 months after confinement. After child was weaned menses returned in 6 weeks. Been irregular ever since and always suffered pain.

On examination found a sausage-like boogy, elongated substance pressing down into left lateral fornix and post cul-de-sac of Douglas, very tender to touch. Used considerable pressure as examination was difficult. Patient complained greatly of pain. Had just left the house when was recalled to find her in a collapsed condition, perspiration standing out on face, respiration rapid, pulse rising. She gradually rallied from this. The thought struck me at the time that perhaps the dilated tube had ruptured. She was, as soon as possible (a day or two) removed to woman's hospital. Temperature and pulse kept up. She was very ill. Consultation called, and in view of facts of case, adominal section was done. Found large mass of blood-clot filling cavity of pelvis. Cleared it out. Found left hæmato-salpinx, a large hole in the wall of dilated tube at seat of rupture. Removed the one tube and ovary only. Washed out with plain boiled water, put in glass drainage tube and closed the wound. The patient made an uninterrupted recovery. As the case is a rare one and as far as we could make out, not tubal pregnancy, I give a little of the literature on the subject which may be of interest.

Hart and Barbour says: "This is a rare condition in which the blood from the congested mucous membrane of the tube is retained there and dilates it. It is often associated with retention of menstrual blood in uterus. One plate given page 186 vol. II, of dilated uterus, and one fallopian tube, which had burst at its free end where it was changed into a thin-walled blood sac, due to attresia vaginæ. Accumulations of blood may take place in the faliopian tubes in the form of diverticula, usually situated towards the fimbriated end. These are not produced, Schroeder says, as we should suppose by a simple reflex of the blood from the distended uterus into the tubes, but by hæmorrhage from the mucous membrane of the tubes themselves. The uterine end of the tube is sometimes undilated or even entirely closed. Blood may escape gradually from the fimbriated end of the tube and set up a localized peritonitis, matting down the tube and uterus; a hæmatocele is sometimes thus produced. Diagnosis is difficult. Bandle records one case where the condition was diagnosed as a fibroid, and Lawson Tait one simulating an ovarian cyst. Rokitansky has said, "Gynæcologists diagnose this condition unfortunately too late." Tait says: "I have treated cases of hydro, pyo and hæmato-salpinx as I would cysts of liver or kidney, by stitching the edges to the edges of the parietal wound by a continuous suture so as to completely close the peritoneal cavity, and draining the cavity by a tube passing both upward and downward and into the vagina, that is, if they could not be removed. The progress is not nearly so satisfactory as when the uterine appendages are completely removed." Again he says, "Besides pus we occasionally find that an occluded tube may contain bloody fluid of menstrual origin. It has been completely established, especially by the observations of Bernutz and Gouple, that the tubes generally share in the secretion of the menstrual fluid, and when the clamp used to be employed in ovariatomy we constantly saw menstrual blood weeping from the stump." It is not therefore surprising that occasionally we should meet with a case of hæmatosalpinx. Meadows records the post mortem examination of one in 8th vol. of the "Transactions of London Obstetrical Society," in which it was found that both tubes were enlarged not regularly and uniformly, out so as to form a kind of cyst. On the right side there were two such enlargements; on the left, one. There was no evidence of any communication between these dilatations and the fimbriated opening. On the left side there was not even an opening into the uterus, the ostium