lateral side of the abdominal cavity. At this point we find the dulness which belongs to the liver, and as we pass downwards we reach the resonance belonging to the ascending colon. Turning the patient now upon the right side and percussing over the left side, we find in the posterior part of the lumbar region, the resonance depending on the presence of the descending colon. As we come to the median line, the sound becomes dull or flat, showing that this mass projects more into the left side than into the right side of the abdominal cavity.

Testing for fluctuating, I find it impossible to obtain any wave. We can therefore say that there is no fluid, either in the abdominal cavity proper or in any cyst contained in the abdominal cavity.

Continuing the examination, I place my ear over the abdomen at the point which I have before mentioned. I am, however, unable to hear any sound which may be regarded as indicating the presence of a fœtus in the uterus or any aneurismal bruit which would be found in dilatation of the aorta. Auscultation, therefore, gives altogether negative signs in this case.

Examination per vaginam shows that the uterus is small. The cervix is slightly elongated and that of a woman who has not been pregnant. The uterus is fixed and immovable in a position of marked retroflexion. Palpation through the vaginal walls reveals the presence of hard, unyielding masses. These, so far as can be ascertained, are attached to the body of the uterus. Owing to the displacement of the uterus, it is impossible to introduce the sound completely. It simply passes into the cervix, but not beyond the internal os.

Rectal examination has not been made, nor has any examination by the bladder been made, as the symptoms were sufficiently prominent and characteristic to enable us to arrive at a conclusion without employing this manipulation. In any case of doubt, however, it is necessary that examination by the rectum and bladder should be made as before stated.

Having passed in a systematic manner through the different steps of the examination, we are enabled to arrive at a conclusion in regard to the nature of this growth. In other words, we are prepared to make the diagmosis. From what I have seen, and from what I have felt, I am prepared to say that we have here fibroid tumors which are of the subperitoneal form. Whether the uterus itself is involved to any great extent cannot be positively determined, owing to the impossibility of introducing the sound. It is, however, quite possible that in addition to the subperitoneal form of fibroid tumors there is also the mural form or that in which the body of the uterus is affected.

Before passing to the question of treatment, I would say that there are three varieties of fibroid growths, or if you choose to call them so, of fibromyoma or fibro-myomatous growths. These varieties are the subperitoneal. in which the tumors lie beneath the peritoneum; the interstitial or mural, in which the tumors are located in the substance of the uterus itself, and the submucous, in which the tumors are situated beneath the mucous membrane of the uterine canal. In the subperitoneal variety the tumors project from the surface of the uterus, being covered with a layer of peritoneum and sometimes attached to the body of the organ by a broad aud short pedicle, in which case, as I have said, they are called sessile growths, or by narrow and long pedicles, in which case they are called pedunculated growths. In those eases in which the pedicle is small and long, the mass can readily be moved about the cavity of the abdomen. Not only so, but it falls about if no adhesions exist, as the patient changes her position from side to side or rises from the recumbent to the erect position. In the case of mural tumors, which, as already stated, occupy the substance of the uterus, the organ is uniformly enlarged. Where they exist without the presenee of subperitoneal or submucous tumors, the uterus is uniformly enlarged, as is found in pregnancy. In the submucous variety the growths form beneath the mucous membrane and project into the cavity of the uterus. Sometimes they get into the canal, and the contraction of the muscular fibres forces them on down until they escape from the cervix, forming what are known as polypi, the pedicle being in these cases elongated so as to permit the growth to pass into the cavity of the vagina. Frequently these submucous fibroid tumors are very large, and they do not pass into the canal and become pedicalated, but distend the cavity of the uterus and change the direction of the canal.

The symptoms in the submucous and mural varieties of fibroid tumours are largely connected with the menstrual flow, and they relate to an increase of the flow. I have had some patients who have lost enormous amounts of blood at these periods. This is a prominent symptom and should always lead to a suspicion of this form of growth. Hemorrhage at the menstrual period is not so marked in the mural as in the submucous variety. This symptom may be entirely absent in the subperitoneal variety of fibroid tumors.

I next come to the question of treatment. At the present day, various methods of treatment are practised. In the first place with regard to medication. Mural and submucous growths are amenable to treatment by means of such remedies as ergot, which, by contracting the bloodvessels of the organ, diminish the nutrition, and in that way limit the growth of the tumor. There has been sufficient experience obtained in the use of ergot and its preparations to warrant the conclusion that these forms of growth can be positively limited. Whether or not they can be ultimately removed, is still a question, but their growth can be checked. Ergot