apparently from shock. At no time was there any discharge of blood or over-bloody fluid from the drainage-tube. Dr. N. G. Keirle, however, kindly examined the pelvic cavity *post mortem*, and reported that death was due to hemorrhage, the exact source of which could not be made out. Dr. J. Whitridge Williams kindly furnished the pathological report, which is given below.

Dr. Thomas Opie exhibited a placenta that he had gotten a few hours before the meeting from

A CASE OF PLACENTA PRÆVIA.

The patient was thirty-five years of age, and had borne one child previously. When he saw her first she was blanched and exsanguined. The blood flow began three days before with a loss of a quart, and continued with more or less rapidity up to the time of operation. Her confinement was not expected for two weeks. When first seen by him there were some rythmical pains and some dilatation. The cervix was dilated with the fingers and cone of the hand; the placenta was detached with a sweep of the fore-finger around the cervix, the bag of waters was artificially ruptured and traction-rod forceps applied. The child was delivered in fifteen minutes without further loss of blood, the placenta coming away simultaneously with the birth of the child. Though the position was occiput posterior, there was no laceration of the perineum, and the child was unscathed. Both mother and child were doing well.

Dr. Opie also exhibited a

SPECIMEN OF AN OVARIAN TUMOR

which he had recently removed. The tumor had developed into the epigastric region, and the abdomen was about as large as it would have been at the full term of pregnancy. It took two hours to break up the adhesions, which were 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 high, 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 months 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 material 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 suggested by this specimen of placenta prævia. The position which the placenta has occupied in the uterus can accurately be determined by the position of the opening in the membranes 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 reconstructing 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 membrane, 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 noticing 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 hemorrhage 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 whole 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