the sacral nerves. This symptom is indicative of some lesion in the posterior half of the pelvis, and it has seemed to me that it is nearly always referable to subacute or chronic inflammation of the perimetric tissues. It is, of course, noted in connection with retro-displacement of the uterus, prolapsed ovaries, and malignant disease; but a careful study of such cases will generally show that it is most constant and severe when these conditions are associated with inflammatory processes in the peritoneum, or connective tissue, or in both. With reference to the latter, "it by no means follows (to quote from Mundé's 'Minor Surgical Gynecology') that the plastic exudation is of great amount, forming an actual tumor." "As a rule," the author adds, "sacralgia increases in proportion to the size and extent of the exudation." This explains why pain in the sacrum is so common in connection with acquired anteflexion, where there is no question of direct pressure on nerves; the cause is to be found in the parametritis posterior which precedes, and leads to, the displacement. It explains, moreover, why adhesion of the retro-flexed uterus is associated with so much more constant and severe pain than is simple retro-displacement, without imprisonment of the organ. We can hardly attribute the pain to direct pressure on the sacral nerves, because the rectum is interposed and Barnes' explanation seems rather forced. This author (Diseases of Women, page 105) says: "The pain is probably not due so much to direct pressure of the body of the uterus, even when enlarged, upon the sacral nerves, as to the indirect pressure occasioned by the accumulation of hardened fæces in the rectum." The rectal symptoms due to the mechanical pressure of the fundus are unmistakable, but they are clearly localized, are not continuous, and are easily distinguishable from the deep-seated aching pain which results from chronic para- and perimetritis. From these brief statements it seems fair to assume that when a patient states that she has a more or less continuous, aching pain referred to the lower part of the sacrum, but seated deeply within the pelvis, we are justified in assuming that it is directly due to a subacute or chronic perimetric inflammatory process in the posterior pelvic fossa, which may, or may not, be associated with a retro-displacement or tumor. In other words, the pain is due principally to the inclusion of sympathetic nerves in the exudates or adhesions, and not to direct pressure on the sacral plexus. This will appear more plausible on studying the effect of such adhesions when situated in the broad ligaments.

In selecting as another fairly typical variety of pelvic pain, that due to malignant disease of the uterus, it may seem as if I had made a serious omission in not mentioning laceration of the cervix. But, it must be evident that not only is the cervix a relatively insensitive region, but that laceration is only one link in a pathological chain, so that by itself it cannot be regarded as giving rise to any distinctive symptoms.

The popular idea is that commencing epithelioma of the cervix is almost invariably accompanied by such pain as that described by Rigby, i. e., "A sudden, sharp, burning dart of neuralgic severity, always proceeding from one spot, and sometimes transfixing the whole pelvis." From what we know of the comparative poverty of the cervical tissue in nerve-filaments, we are forced to question its frequency on anatomical grounds alone; in this we are supported by the clinical evidence. Pain (to quote from Hart and Barbour) "is not present so long as the disease is limited to the cervix; hence, it is of no use as a diagnostic of carcinoma of the cervix in its early stage unless the cellular tissue has been at the same time involved." Hewitt (Diseases of Women, page 127) expresses the same thought when he says: "The pain due to cancer frequently arises from local attacks of peritonitis." In other words, the pain in this case has the same origin as in the former condition, although it is more severe, neuralgic and intermittent. Moreover the patient is more able to localize it, since it is at one time sacral, at another hypogastric, is sometimes described as "a dull, gnawing pain localized in the pelvis or back," sometimes as "a sharp pain, shooting through to the back or down the thighs to the knees." The latter points, of course to direct pressure on the nerve-plexuses by secondary growths.

Carcinoma of the body of the uterus early gives rise to pain, just as does disease of the cervix after it has extended to the body. Sir James Simpson describes it as "slight and intermittent perhaps, at first, but soon reaching a high pitch of intensity, at which it continues for an hour or two, and then gradually subsides." Sarcoma, on the contrary, often occasions remarkably little pain. Can it be because in the case of carcinoma the intra-muscular nerves are more directly affected by the inroads of the disease than occurs in sarcoma of the endometrium? The acute or subacute peritonitis, which invariably attends the progress of carcinoma, readily explains the more severe, continuous and diffuse pains which mark its later stages. Here again, it may be assumed that the pressure of exudates on included nerve-filaments is an important causal factor.

It remains to consider a third common variety of pelvic pain, which is frequently spoken of as "ovarian." It is variously described as "shooting," "darting," "sickening," and is usually located in the left groin or iliac region, is deeply seated, and is frequently associated with referred pains in the sacral and sciatic nerves, and mammary neuralgia, all of which are aggravated at