stroma. In one other case I found while enucleating the cyst that it was firmly adherent at a point in the posterior fold of the ligament where the ovary is to be found, and the vessels were larger there than anywhere else. This led me to believe that the ovary was there also, but the parts were so changed by inflammatory products that I could not positively detect any ovarian tissue. This, I think, is sufficient to settle the question of location of some of these cystomata, and presumably the larger number, if not all of such; still it may be admitted that malposition of the ovary, because of a lesion of development, may obtain in some cases.

These cystomata may be simple or multiple. I think, however, that they are more often monocysts. All of my own cases, eight in number, have been so. Another interesting feature is that they are often papillary or proliferous cysts. This, according to some authorities, notably Bland Sutton, of London, is due to the fact that they are developed from the deeper structures of the ovary, the paroöphoron.

Special attention is invited to the position of these cystomata and their relations to the pelvic organs. This question of location has a very important bearing in regard to treatment, as will be seen further on. In my own practice I have found them occupying widely differing positions. In some, the tumor was situated in one ligament, displacing the uterus to the opposite side of the pelvis, and in a lesser degree the bladder also. In others the tumor occupied a position in both ligaments between the uterus and bladder. When thus located the tumor, uterus, bladder and ligaments have been found high up out of the pelvis, so that the most dependant portion of the tumor could not be easily reached through the vagina. Again, I have fonnd the tumor behind both the uterus and bladder and yet between the folds of both ligaments. In all of these the pelvic organs were carried up out of the pelvis, but the tumor descended towards the pelvic floor. It appears that there is a rule which determines the location of those tumors in their relations to the pelvic and abdominal cavities, which may be formulated as follows: When situated between the uterus and bladder, the tumor and pelvic organs rise up into the abdomen in the latter stage of its growth, whereas if both uterus and bladder are in front of the tumor it dips well down into the pelvis. The reason is that in the one case the vagina arrests the process of burrowing, while in the other there is no resistance to the descent of the cystoma. In all cases the broad ligaments become greatly enlarged and thickened, and usually cover the whole cyst. When the cyst does not descend into the pelvis and has attained considerable size, the upper portion of it may present a comparatively thin wall, owing to the fact that the ligaments diminish in thickness and vascularity until there is but little of their structure left except the peritoneum, and hence the upper part of the cyst then appears more like an ordinary intraperitoneal ovarian cystoma.

These facts regarding intra-ligamentous cystomata and their anatomical relations, are of the utmost importance in regard to their surgical treatment, and hence the reason for this brief account of the various ways in which they may be situated.

The diagnosis is likewise of interest because of the difficulties encountered in operating and the urgent necessity for clearly comprehending the exact conditions present, in order to manage them to the best advantage.

There is nothing in their history which is diagnostic. During the early stages of the affection distressing pains in the pelvis are often present. The functions of the rectum and bladder are frequently disturbed, especially if the cyst descends into the pelvis. In this respect the history differs from that of ordinary ovarian, and especially parovarian cystomata which usually cause very little local or constitutional disturbance, unless attended with complications. The physical signs vary somewhat according to the location of the tumor and its surroundings. Examination of the abdomen shows that the tumor is fixed at its most dependent portion and that the fixation is on one side, or extends from side to side according as the tumor occupies one or both ligaments. These signs contrast with those of a cystoma having a pedicle which permits of free movement of the tumor, but an ovarian cystoma fixed to the pelvic organs by inflammatory adhesions gives similar signs, and hence the two conditions cannot be differentiated by the abdominal examination alone. The vaginal and bimanual examinations give the most valuable evidence. In those which occupy both ligaments behind the uterus and bladder the