History.—On Jan. 25, 1904, I saw the patient, who was 48 years of age. Her menstrual periods had continued regularly until she was 44. Since then the flow had appeared every three or four months, and there had been a slight vaginal discharge. Two years previously she had passed a calculus, apparently from the left kidney.

Examination.—On vaginal examination I found the uterus half as large again as normal. Projecting from the fundus on the right side, and very prominent, was what appeared to be a subperitoneal myoma about 5 cm. in diameter. The right side of the pelvis was filled by a growth which apparently sprang from the uterus and filled the broad ligament. This growth in contour and consistence resembled a myoma.

Operation.—On opening the abdomen (Feb. 2) I found the uterus moderately enlarged. The supposed subperitoneal myoma proved to be a very tense hydrosalpinx, which was kinked forward, thus accounting for its prominence. The growth on the right side was a carcinoma of the ovary. It filled the broad ligament and had infiltrated the bladder wall. Attached to the cancerous mass was the omentum with a loop of small gut. As the gut at this point was markedly constricted, I attempted by gentle dissection to release it, but the bowel was so infiltrated by cancer that it commenced to tear and resection of a portion was imperative. It was decided that the only hope of even temporary relief would be hysterectomy with as thorough removal of the growth as possible. This was done, but a raw, green, offensive, cancerous area, fully 6 cm. in diameter, remained attached to the surface of the bladder. Three inches of the bowel were then resected, and the ends united by means of the Connell suture, supplemented by the Lembert suture. The anastomosed bowel was then placed among healthy loops of gut as far removed from the necrotic area as feasible. The pelvis was drained through the vagina and abdomen. The patient recovered promptly, but naturally still has a small abdominal sinus. We have employed a retention catheter continuously, as even its temporary removal was promptly followed by the signs of ascending renal infection. In November, 1904, the patient was in fairly good condition and had been entirely relieved of abdominal distension and cramps, to which she had been subject for some time prior to the operation.

In this case the clearly outlined subperitoneal nodule associated with the growth on the right side gave us a clinical picture very characteristic of multiple myomata, and this diagnosis was further strengthened by the healthy appearance of the patient. Some may doubt the wisdom of attempting any operative procedure in these cases, but in the liberation of the constricted and