led to its detection, whilst purgation preparatory for ovariectomy caused acute torsion of a cyst of the other ovary.

Tumours irregular in form, are very liable to become twisted, and short pedicles are particularly subject to torsion. It has for long been known that dermoids are specially exposed to this complication. Where there are two tumours the one may cause the other to rotate on its pedicle. All these predisposing conditions were present in my case. Irregular dermoids, forming a cluster of cysts, usually, as in this instance, have very small pedicles, consisting of the Fallopian tube and mesosalpinx, hardly if at all hypertrophied. The same is seen in malignant ovarian tumours of the same irregular form and also in fibroma. It is not clear why the pedicle does not in these instances undergo the well-known hypertrophy so familiar in the common multilocular ovarian cyst. But it is not hard to understand that an irregular tumour longest in its horizontal axis may easily rotate around a short and narrow pedicle. I observed this condition once in an ovarian fibroma. I made a 4-inch abdominal incision, lest the parietes should be bruised by the hard tumour during extraction. The pedicle was twisted half a turn to the right, causing œdema of the Fallopian tube. This pedicle was relatively short, though fairly long for a fibroma, where shortness is the rule. In this case, as in that which is the subject of these notes, the tumour was extracted entire and the twist of the pedicle was detected before extraction. We must not forget that when a big cyst is tapped during ovariectomy it often produces, as it empties and slips out of the abdominal wound, a torsion which did not exist before. I have observed rotation of a collapsing cyst many times; it must not be registered in statistics as torsion existent before the operation.

Dermoids specially tend to rotate on their pedicles, partly because they are often irregular in form, and partly because they are often overweighted at one point by masses of bone or other solid, heavy structures. The phenomenon of one tumour twisting its fellow has been noted more than once. In the present case the right tumour probably pushed against the left and caused it to roll over into the pelvis. Some other cause, however, may have brought about the torsion of the left pedicle, which was typically chronic. The acute torsion of the right pedicle is of greater interest. It followed immediately upon the action of the bowels about twenty-four hours before operation. The subsequent enema thrown up six hours before operation did not, by the way, aggravate the symptoms. The contraction of the abdominal walls against the right tumour during defæcation, when little was passed though not without much straining, must have been the chief, if not the sole, cause of the torsion. The action of the abdominal muscles seems more likely to be effectual than peristalsis or the passage of fæces along the intestine in making a tumour rotate.

Authorities are divided on this question, but Cario believes that all these agencies in defæcation unite in causing torsion. If so, it seems strange that torsion is not even commoner than statistics show it to be. In one instance the complication was caused by the struggles of a patient under nitrous oxide at a dentist's (Fântes, Martin). Here rigid contraction of the abdominal muscles was probably the sole cause, and this contraction may as probably be the only cause of torsion set up during defæcation. I admit that when a large irregular ovarian tumour lies down in the pelvis, the passage of scybala may cause it to rotate for a quarter of a turn or so, but in my case the right tumour, which underwent acute rotation, lay entirely above the pelvic brim.

As to treatment, no delay was indicated in this case. The acute torsion was an accident caused by the preparations for ovariectomy, decided upon before it occurred. Both tumours were removed before peritonitis had been set up by the complication. It is not torsion of the pedicle in itself, but the secondary disturbances which it causes within a short time that so greatly increase the difficulty and danger of ovariectomy. This fact is very manifest in neglected cases where the torsion is associated with pregnancy and labour.

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TWO CASES OF CONCEALED ACCIDENTAL
HÆMORRHAGE.

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CONCEALED accidental hæmorrhage, according to Galabin, occurs only once in nearly 50,000 cases. It is very rare and very fatal, more so than placenta prævia. In accidental hæmorrhage, when there is hæmorrhage from the vagina, the treatment is to rupture the membranes at once in order to induce uterine contraction. In both these cases there was no hæmorrhage from the vagina, and the amniotic fluid was so scanty that very little effect would have resulted from rupture of the membranes, and it was evident that labour had commenced in both cases. They were both suffering so much from shock that one was loath to do much. Their general condition did not get worse, and in all probability the internal hæmorrhage ceased after the first few minutes. The uterine contraction was sufficient to stop the hæmorrhage.

Mrs. C., a strong, healthy woman, aged 33, seven and a-half months pregnant with her seventh child, was sitting in a chair one afternoon at 2.30, when without obvious cause she became suddenly faint, and fell on the floor unconscious. When seen shortly afterwards she was lying on her bed with a weak, quick pulse, greatly blanched and collapsed, but conscious.

There was continuous uterine pain of a very severe character, a sensation of pressure over the pubes, and desire to micturate. The uterus felt hard, and was tender to touch; it had increased in size since the beginning of the attack. There was no hæmorrhage from the vagina; the os uteri admitted the tip of the finger only; the membranes were felt in close contact with the fetal head, and did not bulge. Owing to the collapsed state of the patient, active treatment was postponed, and she was given quinine, ergot, and fluid nourishment. Her general condition remained the same or slightly improved, and at 10 P.M. the os admitted two fingers. The next morning, at 2 A.M., slight vaginal hæmorrhage occurred, and the membranes were ruptured, but the liquor amnii was very scanty, amounting to less than 6 ounces. The head descended into the cervix, and the patient suffered excessive pain, which was continuous with exacerbations. Whiffs of chloroform were given.

As the os remained rigid, Champetier de Ribes's bag was introduced to dilate it, but this burst. An effort was then made to seize a leg and perform version, but, owing to the clots tightly surrounding the fœtus, it was impossible to bring the leg down. Forceps were applied, and after some difficulty the child was delivered dead. The placenta was expelled with ease, and fully two chamberfuls of blood clot followed it. The uterus contracted well, and no post-partum hæmorrhage occurred. The patient was doused with perchloride of mercury, and ergot was given. She slept for some time afterwards; the pulse remained quick and weak, and she was much blanched. The head was kept low, liquid food, in the shape of Carnrick's liquid peptonoids, milk, etc., was given, also alcohol. Her pulse remained at 120 for some days, but her temperature never rose above 100°. She made a slow recovery, complaining for some time of severe temporal headache. She is now quite well.

Mrs. M., a weak anæmic woman, aged 37, when about full time of pregnancy with ninth child, was taken suddenly faint at 8 A.M. without obvious cause, and had to go to bed. Labour pains commenced, she had vomiting and several fainting attacks. When seen at 10 A.M. she was very blanched, pulse weak and slow, but she was conscious, and said she felt very ill. There was continuous pain in uterus, with exacerbations; patient stated that the uterus had increased in size since the attack began. There was no hæmorrhage per vaginam, the os was the size of a two-shilling piece, the head presented, and the membranes were intact.

The patient was evidently suffering severely from shock; stimulants were given, also ergot. The pains increased, but the os remained rigid, and did not dilate. Her general condition remained the same. At 12.30 the membranes were ruptured, but the liquor amnii was scanty; the os was dilated by the fingers. As the head did not come down forceps were applied, and delivery took place at 1.30 (5½ hours after first symptoms). There was no loss of blood per vaginam before delivery, and immediately after the dead child was born the placenta was in the vagina. The uterus contracted well, and clots amounting to half a chamberful were pressed out. The patient was doused. The foot of the bed was raised and the head kept low. Owing to vomiting she could retain very little nourishment. Two hours afterwards she had not rallied; she had two or three convulsive attacks; the pulse was weak, but she was conscious. The uterus remained well contracted, and there was no hæmorrhage. Rectal injection of hot water and brandy was given, and strychnine and digitalis administered hypodermically. She died at 6 P.M. in convulsions.

Intravenous injection was not performed, as in the first case one thought the condition was a recoverable one, and in the second the patient's death in a convulsion took one by surprise.

The second case presented symptoms more of shock than hæmorrhage. She had few of the symptoms of death from hæmorrhage, such as loss of sight, noises in the head, hallucinations, sighing respiration, and imperceptible pulse. She was a woman of weak health, and had had much domestic worry and trouble, and from the first was under the fixed impression that she was going to die.