dinal folds. There was interstitial hemorrhage at the apex of the cast. Thorough microscopical examination could find nothing but decidua. There was no trace of placenta or chorion. This is what is termed "Spurious Abortion," and is defined as the development within the uterus, in the absence of gestation, of a membrane having the essential characters of the decidua of pregnancy and accompanied by signs of early pregnancy. Its separation and expulsion from the uterus with hemorrhage simulate abortion.

There are two explanations for such a condition. One is that an ovum was actually fertilized, but perished at a very early period, while the decidua continued to grow. The second theory is that some other stimulus may cause the formation of decidua and prevent menstruation. The first is the more probable explanation.

In addition to his own, Eden quotes Griffith's case, and also that reported by Dakin.

Griffith's patient had never been previously pregnant. She suffered from symptoms of early gestation. A cast of the uterus was expelled, composed of decidua. The womb was somewhat enlarged.

In Dakin's case the patient had borne a stillborn child eight months before the spurious abortion. At this time she was treated for subinvolution, and recovered. After a slight interruption of menstruation she expelled a uterine cast. There was a lump on the right side of the abdomen. The uterus was enlarged and the patient was thought to have an ectopic gestation. The abdomen was opened, when the lump was found to be an ovarian cyst, which was removed.

In this case pregnancy can be positively excluded, yet the patient had a brief, definite period of amenorrhœa and marked enlargement of the uterus with the discharge of a cast.

A Case of Strangulation of a Full-term Child, with Tympany of the Uterus and Emptying of an Echinococcus Sac through the Uterus.—In the *Monatsschrift für Geburtshilfe und Gynäkologie*, 1897, Band vi., Heft 5, BONORDEN reports the case of a patient who had lost a child in her first labor through neglect, and who had been treated for a vesico-vaginal fistula.

The patient had a tumor on the left side of the uterus, which in her second confinement obstructed labor and which had to be punctured. It yielded a clear serous fluid. This labor terminated spontaneously. When the patient came under observation she was four months pregnant, and the cystic tumor was very plainly outlined. She declined operation until after the pregnancy should terminate. She finally came into labor, and puncture of the tumor was made with very slight results. The membranes ruptured and the child's heart-sounds ceased. Fluid was again taken from the tumor and the child was gradually expelled, the cord being tightly drawn around the neck. As the body of the child emerged, very foul gas escaped from the uterus. The patient had a rapid pulse, bleeding from the womb, elevation of temperature, with a foul discharge. The tumor ruptured into the uterus and discharged through the womb and vagina. Microscopic examination of its fluid showed it to be an echinococcus cyst. The patient made a tedious recovery under stimulating treatment and vaginal douches. There remained in the pelvis adhesions at the site of the tumor.

Total Inversion of the Uterus after Abortion.—In the *Centralblatt für Gynäkologie*, 1898, No. 3, SWITALSKI reports the following case: The patient was a multipara who aborted at five months, with severe hemorrhage. The placenta was retained for several hours. On admission to the hospital the patient was found an ill-nourished, anæmic woman. The uterus was completely inverted, its mucous membrane excessively pale in color. Under chloroform anæsthesia an effort was made to reinvert the uterus by manipulation. This procedure was unsuccessful, the anterior wall of the uterus being torn and the bladder stripped up from the womb. Küstner's operation was then performed. The posterior cul-de-sac was opened and a longitudinal incision made in the posterior wall of the uterus. This loosened the contraction ring, when the womb was readily reinverted. The posterior wall was then sutured, and the peritoneum also. The patient made an excellent recovery.

A piece of the womb was excised for examination, and its muscular tissue found in a degenerated condition. It was impossible to tell how the inversion had happened, although the thinness of the muscular tissue and the degeneration of the muscle-fibre must have contributed to the result. In this case the success of Küstner's operation was very pronounced.

The Absolute Indication for Cæsarean Section.—In the *Centralblatt für Gynäkologie*, 1898, No. 3, GUEBARD draws attention to the measurement between the tuberosities of the ischia and its value as giving an indication for Cæsarean section. He was called to a patient in labor who had a kyphotic, funnel-shaped pelvis in which the distance between the tuberosities of the ischia was 4.7 cm. The pelvis was so much contracted that Cæsarean section was clearly indicated. The child was living and in good condition. The parents, however, absolutely refused to allow the operation. Accordingly, under protest, craniotomy was done. It was impossible to extract the head without removing the individual bones. The clavicles were then cut and the body of the child finally removed. The mother made a good recovery.

After her convalescence the transverse diameter of her pelvic outlet was measured by introducing a pelvimeter within the birth-canal, and the original measurement was found nearly correct. The case is reported as an example of successful embryotomy in a highly contracted pelvis.

Cæsarean Section, with Transverse Incision and Total Removal of Uterus because of Sepsis.—In the *Centralblatt für Gynäkologie*, 1898, No. 4, SIEDENTOPF reports the case of a patient brought to the Magdeburg clinic in labor twenty-four hours, and infected. The patient had a flat rachitic pelvis, so small that a living child could not be delivered. The child was in fairly good condition, however, while the mother was jaundiced, had albumin in the urine, and had constitutional infection. After waiting a reasonable time for the head to engage, and finding no progress, the patient was anesthetized, the abdomen opened, and the uterus opened by a transverse incision across the fundus. The child was readily extracted, asphyxiated, and was resuscitated. The placenta was removed and the incision closed. The cervix was then brought together with forceps, and the upper portion of the abdominal incision sutured. The bladder was separated from the