

tion leukocytosis is often the only indication of complicating purulent disease of the adnexa, or possible suppuration of an hæmatocele. Tubercular pus does not cause an increase in the number of leukocytes, and gonorrhœal only moderate, a fact explained by the greater resistance of the peritoneum to the specific organisms of those diseases. A high leukocytosis attends torsion of the pedicle of ovarian cysts, though pus may be absent; the iodine reaction is absent, however.

In septic infection the leukocyte count is especially valuable as regards prognosis, a persistent high leukocytosis being favorable, while a decline is to be regarded in the contrary light. In puerperal sepsis the proper time for interference may be judged accordingly. In eclampsia with hyperleukocytosis the attacks are less frequent, while a decline is noted in a less favorable case. The writer infers from this that in eclampsia there is a true infection (?)

Ovarian Hemorrhage.—ROUSSEAU (*Jour. méd. de Bruxelles*, 1903, No 50) reports 6 cases, the following being the most interesting:

Case I.—Three days after the beginning of menstruation the patient was seized with a severe pain in the right groin radiating down the thigh. Similar attacks followed at intervals of two months, and a tumor the size of the first developed in the cul-de-sac, which, on opening the abdomen, proved to be a large hæmatoma of the ovary.

Case II.—The patient had a sudden attack of pain, with tenderness and resistance over McBurney's point. Bilious vomiting and elevation of temperature. Several similar attacks followed during the next few months, the diagnosis of recurrent appendicitis was made, and on section a small hemorrhagic ovarian cyst was found with a twisted pedicle, the appendix being normal.

Case III.—The patient had a violent attack of abdominal pain, with vomiting and rapid increase of a pre-existing ovarian neoplasm. On section the abdomen was found to be full of blood which had escaped from a cancerous cyst. All the patients made a good recovery.

Operation for Prolapse of the Ovary.—MAUCLAIRE (*Semaine Gynéc.*, 1903, Nos. 35 and 36) describes the following operation for the relief of retroversion associated with prolapse of the ovaries which resists ordinary treatment: After opening the abdomen a slit is made in the upper part of either broad ligament midway between the uterus and the pelvic wall, the fimbria ovarica divided in order to free the prolapsed ovary, and any adhesions are separated. Any necessary conservative work is done. The ovary is drawn through this opening, which is contracted with sutures, so that the gland cannot slip back again, and, finally, the end of the tube is sutured to the anterior surface of the broad ligament near the ovary. Hysteropexy is performed to keep the uterus in an anterior position.

[Barrows, of New York, describes a similar operation, which he calls "shelfing" the ovary. Both seem to be open to the objection that the gland is not left in its normal relations and that its blood supply may be consequently interrupted.—H. C. C.]

Cancer of the Ovary in a Child.—KUSNETSKI (*Jour. Akuschi Shensk. bolesnej; Zentralblatt für Gynäkologie*, 1904, No. 13) reports the case of a girl, aged fourteen years, who had never menstruated. She had an