On lifting the mass out of the pelvis, it proved to be a gravid sac apparently attached to the extremity of the left Fallopian tube. The tube was of normal length and extremely narrow as it approached the uterine cornu. The ovary on this side could not be found, and both broad ligaments were intact. The gravid sac had rotated upon itself and fallen into Douglas' pouch. The ovarian vessels, very greatly enlarged, stretched over the tumour before entering it. These and its other connections were ligated and the tumour removed entire.

The right tube was occluded at its fimbriated extremity, was greatly enlarged, and contained thin purulent fluid, and it, together with the appendix, was removed.

The patient made an uninterrupted recovery, and when seen seven months later had menstruated on three occasions. The pelvic condition was then very good.

The Specimen.

The specimen is a completely encapsuled pregnancy, weighing 4¾ lbs. and presenting a pedicle (cut very short), containing the main afferent and efferent vessels. Remnants of the loose peritoneal adhesions are universally present over the outer surface of the "tumour." No trace of anything resembling Fallopian tube is discoverable macroscopically.

The wall of the foetal sac is made up of a thick **placental portion** and a thin **membranous portion.** The placenta is fairly well developed and measures 8 inches in its longest diameter. It occupies the left lateral aspect of the mass, encroaching extensively, however, on both anterior and posterior surfaces. The remainder of the sac is much the same thickness as brown paper, and may be spoken of as the "membranous" portion, representing as it almost certainly does the foetal membranes re-inforced by layers of organised fibrin deposited upon the outer surface.

The pedicle of the "tumour" is inserted into the membranous portion, the vessels coming on its surface for an inch or more before reaching the placental margin.

The foetus, a male, is to all outward appearances quite perfectly developed—about seven months. The umbilical cord also looks normal. Merely as a guide to the size of the foetus, the following necessarily imperfect measurements are given:—

Occipito-mental diameter of head ..	4 ins.
Occipito-frontal diameter of head	3¼ ins.
Bi-parietal diameter of head	3 ins.
Bi-trochanteric measurement	2¾ ins.
Occiput to coccyx measures	9 ins.

The best idea of the macroscopic features of the specimen is that afforded by the accompanying photographs, the negatives of which are by Mr. W. Dickenson, Pathology Department, University of Melbourne.

Histology.—Microscopical investigation of the sac wall reveals two important features. First and foremost is the presence of **undoubted ovarian tissue** at three separate points in the mebranous portion. It occurs in the form of white "button-like" thickenings (two of which are indicated in Fig. 1) ,which on section prove to be **corpora albicantes.** The lutein cells have for the most part withered, but the unmistakable "ruffle-like" deposit of lutein, a lipochrome, is easily demonstrable on staining with Sudan III.

The second feature of importance is the fact that prolonged search failed to reveal any definite ovarian tissue in the placental portion of the sac, but showed, on the other hand, a thin muscular stratum bounding its periphery. As a consequence we have been led to suppose that some portion of the Fallopian tube has formed a large part of the "implantation area."

Summary.

The following are the more noteworthy points:—

1. The uterus was only slightly enlarged and did not participate in the pregnancy.
2. The adnexa on the right side had no connection with the gestation sac.
3. No ovary was discoverable on the left side.
4. The pedunculated gestation sac occupied the position of the left ovary.
5. The presence of some inches of Fallopian tube on the left side with its distal extremity attached to the gestation sac.
6. The finding of ovarian tissue at several distinct points in the sac wall.
7. The integrity of both broad ligaments.
8. The presence of the greatly enlarged ovarian vessels in the pedicle of the "tumour."

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TWO CASES OF UNUSUAL FRACTURE OF THE TIBIA.

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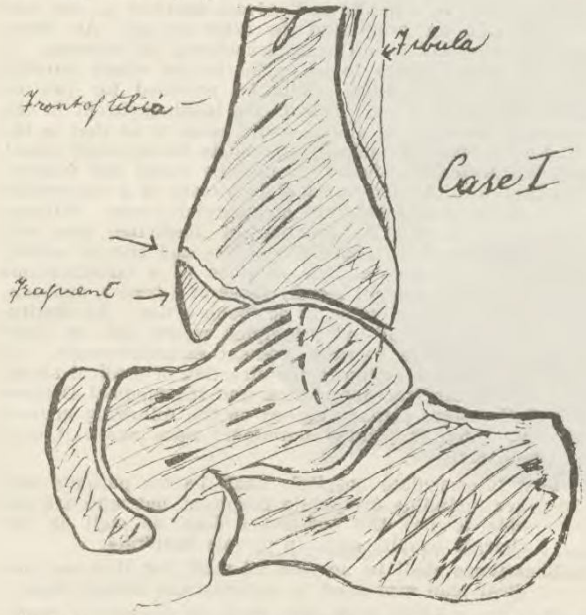
The two following cases which have recently come under my notice appear to me worth reporting on account of the unusual nature of the fracture in each case. I have never seen an account of any similar case, nor have I seen any skiagram of a fracture similar to either case.

In the first case the injury consisted (as will be seen in the diagram) in the detachment of a triangu-

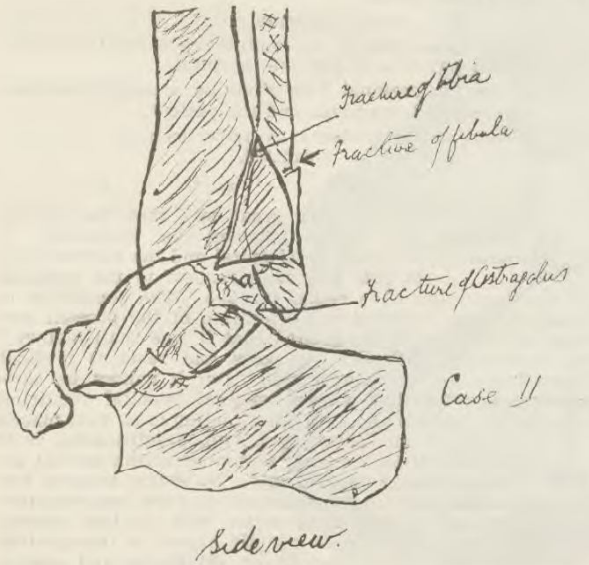
lar piece of the front of the tibia, the base of the triangle corresponding to the anterior part of the articular surface of the bone.

The injury was caused by the patient, an elderly woman, stepping backwards off a box on to the ground, apparently hyper-extending her ankle.

The diagram is taken from a lateral skiagram, one taken in the antero-posterior direction, not showing the injury.



In the second case the fracture of the tibia was the reverse of the above, a triangular piece being split off the back of the bone with the base of triangle at the joint. It was further complicated by a simple transverse fracture of the fibula and a comminuted fracture of the posterior part of the body



of the astragalus, the front part of the body of the latter bone being partly dislocated forwards.

The injury was caused by the patient—a middle-aged man—jumping from a moving gig and landing with his foot everted; the weight of the body evidently being transmitted through the posterior part of the tibial articular surface on to the posterior part of the astragalus.

The diagram from the lateral skiagram shows the condition well, while the antero-posterior view shows the lateral displacement after attempted reduction.

Gastric and Duodenal Ulcer.

From 1,000 cases Friedenwald (Journ. Amer. Med. Sci., August, 1912) concludes:—

From a careful study of the 1,000 cases of ulcers of the stomach and duodenum, the following conclusions may be safely drawn:

1. In patients suffering from various gastric disturbances, 7.8 per cent. are affected with ulcers.

2. The largest proportion of ulcers occur between the twentieth and fiftieth year of age.

3. More than twice as many males are affected as females.

4. Anaemia is present in a large proportion of the cases of ucler.

5. A history of over-indulgence in food or drink can be obtained in almost half of the number of cases of ulcer.

6. The greatest proportion of cases of ulcer presents a normal acidity, i.e., 46 per cent.; 30 per cent. a hyperacidity, and 23 per cent. a subacidity. Hyperacidity is proportionately more frequently observed in males and subacidity in females. In recent ulcers, and especially those accompanied by recent haemorrhage, the acidity is very high, while in chronic forms the acidity is low.

7. The average duration of symptoms is twelve years.

8. The most prominent symptom of ulcer, pain, occurs in 94 per cent. of cases, and pain is most frequent in cases associated with a high acidity. Pain appears sometimes immediately after the taking of food (gastric ulcer), and at times long after the taking of food (duodenal ulcer). In many instances there are one or more periods of intermission of pain as well as the other symptoms; these periods vary from one to many months.

9. An epigastric tender area is present in at least 90 per cent. of all cases, a dorsal tender area in 32 per cent.

10. Vomiting is a very prominent symptom occurring in 67 per cent. of cases.

11. Hematemesis is present in 22 per cent. of cases and melena in 51 per cent. Melena is more than twice as frequent as gastric haemorrhage. Occult blood is present in 81 per cent. of the cases.

12. Of the 1,000 cases of ulcer, 52 per cent. are duodenal and 40 per cent. gastric; the largest proportion occurring in males (58 per cent.).

13. Of the duodenal ulcers, 48 per cent. present normal acidity, 35 per cent. hyperacidity, and 16 per cent. a subacidity; hyperacidity being more frequently observed in males and subacidity in females.

14. Pain is present in 96.5 per cent. of duodenal ulcers, and is most prominent in cases with hyperacidity.

15. Distinct periods of intermission from pain and other symptoms, varying from one to twelve months or more, exceedingly common in this affection.

16. Epigastric tenderness is present in 89 per cent. of the duodenal cases; a tender area to the right or left of the median line in 7 per cent.

17. Vomiting occurs in 21 per cent. of duodenal cases, and is more frequent in those accompanied by high acidity.

18. Melena occurs in 54 per cent of duodenal cases, and occult blood is found in the stools in 83 per cent.

19. Seventy-two per cent. of cases of peptic ulcers treated by the Leube treatment are cured, 66 per cent. by the Lenhartz, 47 per cent. by the ambulatory treatment administering nitrate of silver, 50 per cent. with subnitrate of bismuth, and 40 per cent. with olive oil. Of the cases treated by the Leube cure, 74 per cent. remained permanently well, while 77 per cent. of those treated by the Lenhartz cure, likewise remained permanently well.

20. Seventy-one per cent. of the cases operated on are cured, 91 per cent. remaining permanently well.