(3) The clinical manifestations of hydatid infection are due in most cases to complications following upon rupture of the primary cyst.

(4) Frank rupture of a cyst results in an immediate anaphylactic reaction. Such a reaction was observed in this case.

(5) Intraperitoneal rupture of a cyst results in the development of numerous secondary cysts throughout the abdominal cavity. In this case 48 cysts were removed.

(6) 'Daughter cyst' formation is a true secondary echinococcosis. Like all secondary cyst formation, it is a sequel to rupture of a cyst. This rupture may be gross or minimal. In the case reported it followed operative interference.

(7) Secondary infection of a liver cyst usually follows intra-biliary rupture. The history of this case lends support to the view that pyogenic organisms gained access to the cyst in this way.

(8) A grave change in the clinical course and prognosis results from the introduction of secondary infection into the cyst. The indications for treatment in a secondarily infected cyst are quite different from those in an uncomplicated one.

A CASE OF RUPTURE OF THE VAGINA

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THE following case is reported because it is unique in my experience and in the experience of others with whom I have discussed it. There has been no opportunity for a search of the literature to determine the incidence of this type of case.

Haliman, a 28-year-old Muslim woman, was admitted on the 24th of February. She said she had been having labour pains for three days and that she was at full term. She had seven children, all of whom were born normally. Five are now living and two died in infancy. She admitted having been examined by only one *dai*. The labour pains had stopped shortly before admission to the hospital.

Physical examination (which was hastily and very inadequately done) revealed a very poorly nourished and poorly developed woman. She was very sallow and lethargic but conscious and showed no evidence of surgical shock. The pulse was weak but regular. The abdomen was small for a full-term pregnancy. No uterine contractions were felt. There was no presenting part at the brim of pelvis. In the right hypochondriac region was a movable round mass which in my haste I took to be the head through a very thin uterine wall. The pelvic measurements were: interspinous—7½ inches, intercrestal—8½ inches, and external conjugate—6 inches. No vaginal examination was done. Cæsarean section appeared advisable.

At the time of operation which had to be delayed because of another emergent section it was noticed that the shape of the abdomen had changed and the round movable lump was found in the right lower quadrant of the abdomen. Under ether anæsthesia a paramedian incision was made. When the peritoneum was opened a small amount of clotted blood was encountered and it was seen that the fœtus was free in the abdominal cavity. The cord was twice coiled very tightly around the neck and was so short that it had to be cut before the fœtus could be extracted. The fœtal head was not unusually large but was severely moulded. It was then seen that there was a rupture of the anterior vaginal wall. The placenta was extracted. No bleeding from the uterus followed the removal of the placenta. The ruptured vaginal wall was extremely œdematous and friable. The rupture extended across the vagina just below the cervix and down the left and right lateral margins of the vagina for a distance of about an inch and a half. The fully dilated cervix could be clearly identified and was intact as was the uterine wall. The endometrium was pale and granular and in distinct contrast to the smooth red epithelium of the vagina. The vaginal wall was repaired by a few light catgut sutures and a cigarette drain was inserted in the pelvis and the abdomen closed in layers.

The patient's general condition seemed little worse after the operation. Twenty-four hours after she developed a large bed sore, an incident in keeping with her general condition of malnutrition. She ran an irregular temperature, about 100°F., which after the ninth day subsided to 99° as a maximum. For a week there was a profuse vaginal discharge of very foul odour. The patient gradually improved and was discharged on the 24th post-operative day.

CONGENITAL OBSTRUCTION OF THE ANUS

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CLOSELY allied to the condition of imperforate anus is a condition, very rarely met with, which for want of a better term may be called congenital anal obstruction. The following two cases I have had in the last two years explain the condition :—

Patient A, a female child, aged ten months, was admitted into the hospital for difficulty in defæcation. The child was passing motions by herself, but with great straining, and the quantity passed was small and came as a flattened band.

On examination there was a small band of skin one inch long and half an inch broad extending from the posterior margin of the anus to the anterior margin, with a free rugose edge laterally. The little finger could be passed easily into the rectum to the right or left of the band. Whenever the child strained to pass motions, with the dilatation of the anus, this band also stretched, obstructing effectively the passage of the fæces, just in the same way as a rubber band stretched over the mouth of a bottle. With increased dilatation of the anus due to severe straining this band stretched more and more, and the fæces escaped by the sides of this band, and came as a flattened band.

Under local anæsthesia the band was removed by cutting it off from its connections to the anterior and posterior anal margins and there was a well-formed anus exposed with a perfect sphincter. The child, of course, was perfectly all right thereafter.

Patient B, a male child, aged one and a half years, was admitted into the hospital for stricture of the rectum. The child had to strain a lot in defæcation and the quantity passed was small and flattened.

On examination there was a piece of redundant skin about one inch long and half an inch wide attached to the posterior anal margin, the right anal margin and the anterior anal margin, but free along the whole of its left margin. In fact it looked like a hood over the anal aperture. About its attachment to the right anal margin there was less pigmentation, the band was much thinner and there was a dimple on the surface resembling very much the appearance of imperforate anus. The little finger could be passed up into the rectum along the left edge of the band. With the straining at defæcation and consequent anal dilatation