be easily turned out. It has been my practice to open the cyst and evacuate its contents so that it then can be pulled out of a small opening, and any vessels which bleed can be easily seized as they are torn in separating the cyst. In some cases of adherent cyst the separation is very difficult, but in fluid cysts the vascularity is not so great, nor is there so apt to be an adherent capsule. In the solid, colloid, encysted growths the enucleation is more difficult owing to the greater vascularity. It is important here to get into the proper capsule, preferably the deeper one, for the superficial one is often covered with the ramifications of blood-vessels. Even in these cases, before enucleating I open the tumour and remove some of its contents; when this is done, the subsequent extraction is much less difficult. In diffuse cases or interstitial cases and the true vascular thyroid of Graves' disease, in malignant disease or where the cysts are multiple and small, or where the growth is very large, I prefer now to excise the gland. In Graves' and the interstitial cases only one lobe is excised. In these cases I make use of an incision along the inner border of the sternomastoid to near the upper border of the sternum, and then continue the incision transversely as far as necessary. Here the most important point is the free opening of the capsule of the gland. As soon as the capsule is divided the gland can be delivered and the vessels tied without much difficulty. The superior thyroid artery should first be secured, then the gland thrown up and over to the opposite side. The inferior thyroid artery should be tied and not cut, and then recurrent laryngeal nerve looked for and carefully separated. It runs up the posterior part of the gland, when the gland is enlarged it appears as if it entered it. The branches of the inferior thyroid artery with which it entwines should be cut near the gland, and also the veins which accompany these branches. I have cut the nerve once, and it was immediately sutured; the function has been partially recovered since.

The After Treatment. In the cases where enucleation has been performed there may be free oozing from the bed in which the cyst lay, and to prevent extensive oozing I pack this with strips of aseptic gauze, which I remove on the second day. In the cases where a portion of the gland has been removed a drain is inserted for 24 hours. The wound is closed with horse-hair sutures, and ordinary dry dressings applied. Usually the enucleation cases are discharged from hospital in a week or ten days.

The advantage of the enucleation method in suitable cases is the ease with which the operation is performed, the absence of risk of myxœdema and the fact that the recurrent laryngeal nerve is never injured. The disadvantages are the chance of recurrence of the growth, the tendency to oozing after operation, this oozing occasionally going on to secondary