most effectual methods of securing the pedicle is certainly the most important, and the most anxious question the operator has to consider. He is impressed with the recollection that in his management of this step of the operation, he is required not only to effectually and permanently secure the stump against hemorrhage, but this must be done so delicately as not to drag or twist the uterus, nor inflict the slightest injury upon the parts which are to remain within the peritoneal cavity, so that there shall be no tissue likely to decompose or give rise to septic absorption; for it is obvious, the success of the operation in no small measure depends upon how these objects are accomplished---what risk is run of hemorrhage, shock, peritonitis, and septicæmia—the four great sources of mortality after ovariotomy. It is, therefore, not surprising that this question has been anxiously discussed among ovariotomists, and various methods of procedure warmly advocated.

The various methods practiced and recommended by their advocates, may be classified thus:

1. *The Extra Peritoneal,*
2. *The Intra Peritoneal.*

*Extra-peritoneal.*—("without" the peritoneum). Under this division may be included the various modes of securing the pedicle outside of the peritoneum. This object is generally accomplished by either bringing the pedicle through the lower part of the incision, and fixing it outside with a clamp before dividing it, or first ligaturing the pedicle with silk, catgut, wire, or some other agent, and then either transfixing it outside, or with the abdominal parietes while closing the wound. The various plans resorted to for this purpose, have the same object in view—to keep the stump of the pedicle securely in, or outside of the abdominal wound so that it cannot drop into the peritoneal cavity, and there become the source of mischief. For the sake of brevity, I shall include all methods having the above objects in view, under the designation of *the clamp method*, as I believe the fixation of the pedicle externally can best be accomplished by a good, strong clamp—such as used by Mr. Spencer Wells. It should be borne in mind that some pedicles are very large and vascular, two or three inches in breadth, and containing the following structures: the broad ligament, the Fallopian tube, the ovarian ligament, sometimes the round ligament, several very large arteries, and a number of greatly developed veins; and all this mass must be firmly and effectually secured, if possible, against the perils already mentioned.

The *clamp method* consists in embracing the whole pedicle, outside the abdominal wound, with a strong metallic constricting instrument, capable of being screwed together very tightly, and cutting away the tumor about half-an-inch outside of the clamp. The abdominal wound is then neatly closed around the pedicle, under the clamp, and the stump thus firmly held, is so treated as to prevent any septic matter from finding its way into the peritoneal cavity.

This, it is claimed, possesses advantages over the intra-peritoneal method, where the stump of that large vascular mass, whether severed by the actual cautery, "tied and dropped," or treated by any other plan, remains within the peritoneal cavity, where it is liable to become the source of septic decomposition, and hazard the patient's life.

The clamp method has been, and still is, the one most generally practiced; it was introduced by Mr. Jonathan Hutchinson, and is nearly always employed by Mr. Spencer Wells—that prince of ovariotomists, who himself has performed the operation nearly one thousand times, thus adding, according to the calculation of Lord Selborne, 20,000 years to the lives of European women.

*Intra-peritoneal.*—("within" the peritoneum). Under this shall be included all modes which leave the stump of the pedicle within the peritoneal cavity: the actual cautery, the galvano-cautery, the *écraseur* acupressure, deligation by various ligatures, torsion, and enucleation.

Several members of this association, in attendance at the International Medical Congress, in Philadelphia, had the pleasure of hearing Dr. Miner, of Buffalo, describe in plain, lucid language, his plan of performing "ovariotomy by enucleation," and were deeply impressed with the conviction that his procedure is a capital method, in some cases at least, especially where the pedicle is so broad and short that it is impossible to apply a clamp, and hazardous to attempt to secure it by ligature, or divide it by the actual cautery. In a recent operation, where the pedicle was of this description, I availed myself of the method of enucleation, to separate the pedicle several inches from the tumor, in order to get sufficient length to