a sufficient extent to make a cuff, which is sutured to the lower angle of the wound, uniting peritoneum to peritoneum, after which the uterine arteries are tied separately, no use is made of elastic constriction. After the uterus has been brought forward into the lower angle of the incision the upper part of the wound is closed by suturing, which renders the part of the uterus to be removed extraperitoneal before the amputation is effected. If the cervix is left after the amputation of the uterus, the cervical canal is closed by one row of buried catgut sutures. Hæmorrhage after ligation of the uterine arteries is very moderate, and is consequently very readily controlled by a number of rows of buried sutures, for which chromicised catgut is invariably used. This leaves a funnel shaped depression in which rests the cervical stump of the uterus. About twenty-four hours after the operation the gauze is removed and the secondary sutures tied, after which, as a rule, primary union of the wound takes place.—*Med. News.*

When Should We Operate on Uterine Fibroids?—There was a time, within the memory of living gynæcologists, when uterine fibroids were regarded as wholly benign and almost sure to cease growing, if not to diminish in size, after the menopause. Contemporaneous with these views of twenty-five or more years ago, the mortality of abdominal hysterectomy was eighty per cent. These considerations had an important bearing on the question of when to operate for uterine fibroids. Now that the mortality has been reduced to one or two per cent., and it is known that uterine fibroids frequently cause the death of the patient either from repeated hæmorrhage, exhaustion, pressure, renal complications, malignant or necrotic degeneration of the fibroid itself, and that often times the tumors do not cease growing with the menopause, etc., the views regarding early operations have materially changed. Martin, of Berlin, records one hundred and ninety-six cases of fibromata in which thirty-eight were found to have undergone retrograde changes. In two hundred and five cases of extirpation of myomatous uteri, Martin found nine cases which showed carcinomatous, and six cases sarcomatous, degeneration. Leopold claims that fibromata may become fibrosarcomata, and in one of his cases he observed carcinomatous formation within the myoma. Erendorfer holds that the mucose of a fibroid uterus may become carcinomatous. Emmet states that in several instances under his observation fibroids underwent sarcomatous metamorphosis. Professor Klebs and Sir James Y. Simpson mention several similar cases. I would advise the removal of uterine fibromata whenever they cause any of the following symptoms: 1. Severe menorrhagia or metrorrhagia. 2. Severe pain from pressure. 3. Repeated attacks of pelvic peritonitis. 4. Malignant or necrotic degeneration. 5. Size of tumor so large as to interfere with the patient's movements and usefulness. 6. Cystitis, dysuria, hydronephrosis from pressure on the ureters, severe hæmorrhoids, varicosities of the lower extremities, uncontrollable reflex nervous and nutritive disturbances. 7. Repeated miscarriages, tubal and extra-uterine pregnancies, and where the tumor seriously complicates the labor. In these cases I believe operation is imperative, whether the tumor be the size of a walnut or as large as a fœtal head. To allow these symptoms to continue from month to month and from year to year, in the vain hope that the menopause will bring about a desirable result, is merely to reduce your patient's strength and remove her chances of recovery. To wait for a fibroid to grow to the size of a child's head before its removal may mean the death of your patient, either before or immediately after the operation. Dr. Irish records, in the *Amer. Journal of Gynæcology and Obstetrics* for December, 1894, ninety-four cases of fibroids, in which forty-three of them "developed dangerous and formidable symptoms, in patients between the ages of forty-two and fifty." Calcerous, necrotic, pus-forming, cystic, sarcomatous and carcinomatous degeneration may occur while waiting for the *vis medicatrix naturæ*. Abdominal surgeons are agreed that the dangers of the operation increase *pari passu* with the size of the tumor, the age of the patient, the reduction of her vitality, and the nutritive disturbances, etc, and that fatal cases are usually the neglected ones. Repeated severe hæmorrhages, attacks of inflammation and adhesions, salpingitis, ovarian degeneration, incarceration of the tumor in the pelvis, pressure on the ureters, hydronephrosis, extra uterine pregnancy, degeneration of the tumor, or malignant new-formation, are symptoms and complications that