

to determine the condition was allowable. It was not allowable in pelvic neuroses. As to the choice of site for the incision, the essayist had shown a preference for the linea alba and semi-lunares. He (the speaker) rather chose to have more liberty. In many cases he preferred to cut through the abdominal muscles. A small incision to be afterward enlarged if necessary, through the external oblique, then an incision through the internal oblique (especially in appendix cases) in a line with the aponeurotic fibres, which are intimately connected with the transversales. Practically one could not distinguish between the two. In closing up, where the abdominal wall was thick with adipose tissue the layer suture was preferable, first stitching the edges of the peritoneum with cat gut; next the two inseparable layers of the transversalis and internal oblique also with cat gut, using a mattress suture; and, most important of all, the external oblique aponeurosis with a mattress suture. This made a very strong abdominal wall, and there was little or no danger from hernia.

Dr. Carstens said it was never right to remove healthy ovaries, as in hysterio-epilepsy. Ovariectomy would not cure epilepsy. He had to refuse such cases every day, but it did no good, because somebody else would do the job. Regarding the social aspect of the question, he held there were two sides. Those who held the side opposite view to Dr. Hingston argued that "this sort of woman was no good. Better to take em out, anyhow. Don't want this kind to breed, would breed epilepsy, hysteria, drunkenness, insanity." However, he drew the line on disease. He did nearly two hundred abdominal sections in a year, and had yet to see a single case of pelvic cellulitis. His contention for the exploratory incision was that it should only be used as a last resort for diagnosis. But he considered it a perfectly justifiable proceeding, the risk being comparatively small. There was some risk about any operation in which an anæsthetic was used. He disagreed that a general surgeon could do all sorts of surgery. He (the speaker) found his time completely taken up in this one line of work and reading the literature of the subject in three languages. As to his relation to the general practitioner the specialist could not divorce himself from him, as his own work depended entirely on the general practitioner.

Sir William Hingston then delivered the address in Surgery. He said that not being aware, till he arrived in the city, that he was to address full-fledged medical men instead of students, he was somewhat taken aback, and much that he had intended to say would not be *apropos*. He would, therefore, ask to be pardoned if he were somewhat rambling in his remarks on the progress of surgery. Much of what he had decided on saying had come out in the previous discussions, as, for

example, the question of operation for diagnostic purposes, and the question, when to operate.

While literature, philosophy and general science had advanced with accelerated movements, giant strides were those of surgery. Its exponents had performed operations of dazing moment, they had become bold and reckless. They enter every cavity and every viscus of the body. And who would say we had reached the *ne plus ultra* limit yet? It was within memory that injury of the brain could not be located. Brain lesions then wrapped in mystery, are to-day appreciable and curable. As Kepler predicated the existence of another heavenly body, by its effects on others, before it had been discovered by the telescope, in like manner, lesions within the cranium, not seen before, could be located by their effect on remoter parts of the body. A catalogue of the pathological conditions of the brain and nerve centres could be fully established. In that department alone we were able to see that surgery was beginning to be a science. Hitherto it had been an art. But when we saw an affection of the wrist, ankle, shoulder or elbow, and could say precisely what part of the brain was affected, we had left the region of conjecture for that of absolute precision, as much so as Kepler, who, when he saw no planet, foretold there must be one there because it disturbed the whole, and later a powerful telescope brought the heavenly body into view. Such men as Ferrier and Horsley, had raised the art of surgery to a science, so far as brain surgery was concerned.

Sir William then spoke of other changes in other departments of surgery. As to epitheliomata of the face, there was a time when these were removed completely with the knife. For many years it had been his practice not to treat them in this way. He had kept them under control twenty-five or thirty years. There was epithelioma and epthelioma. For certain forms the knife must cut at once, otherwise life would be lost. As to cancer of the tongue, he was surprised from time to time to hear the enquiry made as to how much should be removed. Syme laid down years ago that the partial removal of the tongue was wrong in principle, and that view he (the speaker) had endorsed. This was the rule no matter how small a part of the tongue was affected. In some cases, it was difficult to tell whether the disease was malignant or syphilitic; but a few weeks of specific treatment would determine the condition. Formerly it was the custom to remove the tonsils. Experience has now shown that this was unnecessary. These organs enlarged and diminished with the hygrometric conditions of the atmosphere. He had noticed this particularly in one family. He rarely removed tonsils now.

Regarding empyæma he considered surgical interference necessary. Some favored aspirating,