ing both tubes and ovaries in these cases, but considering that quite a number of women have had to have subsequent removal of the other tube for the same thing, and as both tubes appeared diseased, I felt it my duty to remove both tubes in these cases.

There were several other cases which looked very like tubal pregnancy, but as no chorionic villi could be found, they have been classed with other cases of diseased ovaries and tubes.

I have already stated that two of the cases of ventral hernia were very difficult. One was a case of seventeen years' standing, and the intestine was so adherent to the abdominal wall that it was found to be impossible to dissect it off without seriously injuring the bowel. The latter was therefore freed by cutting off a thin slice of the abdominal wall, and leaving it on the intestine, and the omentum was drawn down over the bowel. In this and in five other cases the abdominal parietes was split up into its constituent layers, and opposite sides united with layers of buried sutures; in the seventh case, in which the opening was small, it was closed by a buried purse-string suture which seemed to do well. The other difficult case did not follow abdominal section, but was congenital. She had also hip joint disease, and a sinus leading from the hip joint to the navel, discharging pus. When my hand was in the abdomen, I could trace this sinus like a rubber tube half an inch thick right down to the pelvic wall, in front of the peritoneum. She will shortly be handed over to a general surgeon for excision of the hip.

Before closing this paper, I wish to pay my tribute of gratitude to Bardenheuer, of Cologne, who first employed the principle in 1881, and to Trendelenburg, who afterwards brought it into general use of performing pelvic operations with the patient inverted, so that the intestines fall away from the pelvis, and allow us to see what we are doing. Some of my patients who died would now be living if I had known about it during my first years of operating, and without it I feel equally sure that some of those who are alive and well, would have now been dead. While we were operating in the dark amidst coils of intestine, our work was inevitably imperfect, and the drainage tube was necessary to make up for our deficiency, but with the advent of the Trendelenburg posture, we can do perfect work, covering over denuded surfaces with peritonem, and tying oozing vessels until there is nothing left to drain.

As far as the effect upon the sexual feelings of the women was concerned, these patients might be divided into three almost equal categories: first, those who after the operation gradually lost all sexual feeling which they had formerly possessed; second, those who never experienced it either before or after the operation; and third, those who had never known what sexual pleasure was before the operation, but gradually experienced it more and more after the diseased ovaries had been removed. About half of the latter have now a strong sexual appetite, several years after removal of both ovaries. I am strongly in favor of leaving in the silk worm gut sutures which close the abdomen for thirty days; since I have been doing this, now some three years, ventral hernia following operation has almost become a thing of the past. I attribute much of my increasing success and diminishing death rate first to the Trendelenburg posture as already explained; second, to the A. C. E. mixture and quick operating, requiring so much less anæsthetic; and third, to my assistants and nurses being better trained and more thorough believers, as I am myself, in *absolute asepsis* from beginning to end.

250 Bishop Street, Montreal.