laparotomy done, but, as she told me afterwards, with the sincere hope that she would die under it. After a few days in the hospital she became so lonely that she insisted upon my attending her at her own house.

Preparations were made for the operation, with every aseptic precaution, the patient having taken a hot bath on several successive nights, and the instruments, silk and silk worm gut, all having been boiled in plain water. On the morning of the 16th January, assisted by Drs. Trenholme, Reddy, Spendlove and Gaherty, I removed the tubes and ovaries through a two inch incision, and without any difficulty. There was so little oozing that I did not deem it necessary to either irrigate or to insert a drainage tube, but in future I intend always to use the irrigator instead of sponging, which latter is apt to hurt the intestines. Shoemaker's thread was tried for ligatures, but, although very strong before being wet, it seemed to lose its strength afterwards, and broke, so that I had to fall back on silk, which held well. The incision was closed with four silk worm gut sutures, which I took care to pass through the peritoneum, fascia and skin only, and not including the recti muscles. The wound was dressed with dry boracic acid, and healed by first intention all through, and more than three months after the operation there was not the slightest sign of hernia. Nothing whatever passed her lips for the first twenty-four hours except hot water, and as little as possible of that. No morphia was used at any time after the operation. The bowels were moved on the third day with a saturated saline solution, and the vomiting was controlled by means of one-grain doses of calomel every hour, after everything else had failed.

Now, if I were to close this case by saying that the patient made an uninterrupted recovery, it would be telling the truth, but not the whole truth. The vomiting after the operation was most distressing and continued for several days, preventing her from obtaining any sleep. Very hot water failed to relieve it during the first day, and milk and lime water, soda water, cocaine, and a mixture of pepsin, bismuth, hydrocyanic acid, and spirits of chloroform, all failed in turn the second day. It was not till I tried the calomel on the third day that it was controlled. Is there any way in which this difficulty can be prevented? If so, it would be well to know it; the vomiting is not only so distressing but also adds greatly to the pain of the incision. I have noticed several times that when the patient was carefully prepared by semi-starvation for at least three days before hand, there was absolutely no vomiting whatever. There is another advantage in having the intestines collapsed before the operation, and that is the saving of them from exposure and manipulation to which they are very liable, if distended with food or even with gas. One might think that because the bowels had been well moved previous to the operation, that the whole intestine would therefore be empty, but it is well known that a patient may have a very copious evacuation and yet have a large residue in the upper bowel.

Tympanitis or wind was another troublesome complication, which is met with more or less in every case, and which is probably due to paresis of the muscular fibres of the intestines. For this I tried assafœtida in pill form without much benefit, as also enemas of turpentine. What seemed to give most relief in this case was a tablet of soda mint every hour, and the application to the abdomen over the dressing of towels wrung out of hot water, hotter than the hand could stand. I also found that the patient experienced considerable relief from lying on her right side with her head low, so that the gas could float up into the sigmoid flexure and thus escape into the rectum. Another hint worth having is that Rochelle salt, as a saline purge, has the ad-