Some of these unexpected complications are very embarrassing to some operators, in the excitement of the hour, but a cool, quiet investigation will soon serve to clear up the perplexity, and the experienced surgeon will prove himself equal to the emergency.

ADHESIONS.

The tumor having been exposed to view, search is made for adhesions. The hand is washed, plunged into warm carbolized water, and two or three fingers are passed around between the tumor and the abdominal parietes. If slight adhesions are met with, they are gently broken down with the fingers. I have found the large curved steel sound, recommended by Professor Thomas, an excellent instrument for a more extended search for adhesions. It is warmed, dipped in the disinfectant, and passed gently around the tumor as far as the pedicle. With the aid of this harmless instrument the operator can satisfactorily assure himself of the presence or absence of adhesions around every part of the tumor excepting posteriorly. The most serious adhesions met with, are strong attachments to the bladder, uterus, omentum, and intestines. These bands must not be cut, unless first secured by a silk ligature; and this, I believe to be a good and safe method. But it is usual to enucleate them from the tumor by the fingers or the handle of the knife. Another excellent method of separating strong adhesions, is by making use of the temporary clamp and actual cautery. When, however, the cyst is firmly adherent to the bladder, intestine, or uterus, a small portion of the cyst wall should be cut out and left adherent to the viscus, the secreting membrane being dissected away. In such cases great care must be exercised to avoid perforating the intestine, or rupturing the fragile wall of the cyst.

TAPPING THE CYST.

The operator having confirmed his diagnosis, and ascertained that the removal of the tumor is possible, proceeds to diminish its size by removing the fluid contents. The cyst is seized at the upper end of the abdominal incision by strong, toothed, or deeply grooved forceps, and steadied, while the large trocar is plunged into it. An excellent instrument for this purpose is the trocar, known as Spencer Wells'. It is an ingenious contrivance, self-retaining, and has a flexible tube attached, through which the fluid is conveyed into the receptacle below the table. When one of these trocars cannot be obtained in a country town, a large tube, sloped and pointed at one end, may be improvised for the occasion, an opening being made for it by a scalpel. In such an event, and indeed in all cases where there is danger of the contents escaping into the peritoneal cavity, it is best to turn the patient on her left side, while the fluid is flowing away, and every precaution must be taken with sponges and flannels to prevent the contents getting into the peritoneum. In the mean time, the assistant is keeping the cyst well into the wound, by steady traction with the forceps, while another compresses the abdominal walls against the tumor by one hand on each side of the incision. In compound tumors after the parent cyst has been evacuated, others come into view, and are, one after another tapped and emptied. The contents of some cysts are very gelatinous and tenacious, passing out through even a large tube very tardily. Under such circumstances, the patient being on her side, I have expedited their evacuation by laying them open freely with a scalpel. In other cases, the contents are semi-solid, or composed mostly of small cysts—honey-combed, which have to be incised, broken down with the hand inside, and scooped away before the cyst can be sufficiently reduced to be extracted through a fair sized opening.

REMOVAL OF THE TUMOR.

As the cyst is being emptied of its contents, the assistant, by continued traction with the forceps, gradually withdraws the lessened tumor through the incision, assisted, in most cases, by the hands of the operator. Care is now taken to have the tumor well supported by the assistants, to prevent its falling, or dragging injuriously upon the pedicle. When the length of the pedicle will permit, it is good practice to tie it tightly with whip-cord, near the tumor, make a loop with the cord, with which to manipulate the pedicle, and cut away the tumor. This may be now entrusted to a skillful and experienced assistant, who will attend to any unruptured adhesions, according to the methods previously described, while the operator gives his attention to the pedicle.

SECURING THE PEDICLE.

We come now to the most important step of the operation—the treatment of the pedicle. The