there was in all probability a latent infection lurking in the tubes, although no pus was detected at the time of the primary operation. The operation was a simple one, and had I performed a hysterectomy recovery would, in all probability, have followed.

After satisfying ourselves that the appendages are normal, and that there is no offensive vaginal discharge indicative of a submucous myoma or of carcinoma, we should carefully examine the uterus to see if it be feasible to do a myomectomy. Where the nodules are few in number and situated at accessible points, the uterus should be saved. In a few instances we have removed interstitial myomata larger than an adult head, and yet been able to preserve the uterus. If, however, the uterus is everywhere studded with small or medium-sized myomata, there is a great probability that some would be left behind and a subsequent hysterectomy become necessary.

It is not advisable to do a myomectomy where the nodule is situated in the broad ligament or deep down laterally in the pelvis. In these situations it is impossible to obliterate the resultant spaces, and blood is bound to accumulate. These difficulties might be overcome by abdominal drainage, but here hysterectomy is preferable. Several years ago I removed a nodule, the size of a small cocoanut, from the left broad ligament. The lower portion of this nodule extended far down beside the vagina. There was little hemorrhage, and the tissue apparently fell together nicely. In a few days, however, the temperature rose to 104. Shortly after this there was a free discharge of pus from the bladder, and on examination much induration of the left side of the vagina was found. The abscess had opened into the bladder. After several weeks the abscess cavity closed and the patient is now, six years after operation, in perfect health. A similar case was noted by a colleague of mine; in this instance, however, the bladder was not implicated.

Should we decide on myomectomy, the easiest method of controlling bleeding is by means of a gauze rope applied around the cervix and clamped with artery forceps, thus avoiding the necessity of tying. If the myoma be small, the incision is made directly over it and as soon as the nodule is exposed it is grasped with a meso-forceps and twisted or shelled out. Where the nodule is large and partially sub-peritoneal, a lozenge-shaped piece of muscle is usually excised with the tumor. Care should be taken not to sacrifice too much muscle, as so much contraction may occur that it will be found almost impossible to bring the margins of the cavity together. After careful palpating the uterine walls, to be sure that no other nodules remain and having turned in the mucosa and sutured with cat-gut, should