slit remaining in the vaginal mucus membrane. The vagina is repacked every three days until healed. Many patients may be allowed out of bed in a week, and return home in ten to fourteen days, when the opening is usually closed entirely.

Abdominal section is frequently followed by stitch abscess hernia and troublesome adhesions, and always has an ugly scar to fret nervous patients. The vaginal method is followed by no untoward sequelæ.

The extra-peritoneal method of relieving pelvic inflammations.—When an infecting organism enters a Fallopian tube it usually sets up a reactionary inflammation which tends to close the fimbriated end and thicken the tube. In some cases it invades the intra-ligamentary cellular tissue and the peritoneum, especially that part forming the folds of the broad ligament becomes hypertrophied. In most cases pus accumulates in the tube, and as it is distended it tends to separate the folds of the ligament so that a considerable space is found between them, and the tube may eventually rupture into the ligament. Not infrequently tubal pregnancy works outward into the broad ligament and ruptures into it. In cases where these pathological processes occur, and we are called upon to operate either before or after rupture, an extra-peritoneal dissection gives the best results. Since 1896 I have practised the following method in such cases:

The patient is prepared for vaginal, and also for abdominal section, as in the cul-de-sac operation. The uterine artery is located, and the mucus membrane beneath it is opened with forceps and scissors and a dissection made with the fingers through the cellular tissue toward the seat of disease. If one keeps close to the uterine artery there is little danger of puncturing the folds of the broad ligament and opening the abdominal cavity. In this way I have exposed the under surface of pus-tubes, and an ectopic gestation. A small electric light, such as is used with the male urethroscope, can be inserted and a visual inspection made, but "finger sight" is all that is needed to recognize the under surface of the tube. When the tube is reached an assistant holds the tumor down by pressure from above, and the index finger is inserted so that the tip touches the tube. Along this finger, as a guide a long sharp pointed scissors is passed to the tube, and by gentle pressure is forced into it. When the tube is punctured that fact is recognized by sudden diminished resistance. The scissors are opened in the tube and withdrawn, tearing the opening wide enough for drainage. After the contents have been forced out by pressure upon the lower abdominal wall and irrigation used if necessary, a gauze packer is introduced and an iodoform gauze drain put in. This is changed as