showing distinctly its sac and a point at which it had burst, with the contents free in the peritoneal cavity.

CASE 2. In one of my first operations of this kind I found that the anterior wall of the sac on the right side was composed, at one spot, of only a single layer of membrane, thin enough to be almost transparent, and which must have given way on the slightest pressure; such, for instance, as romping with a little child on the lap, etc., etc.

CASE 3. In a patient recently operated on, the left distention gave vent to a quantity of stinking pus immediately on my touching it with my fingers, using scarcely any pressure at all. Here, a very little external pressure, even examination by double palpation, might have caused a rupture.

The diagnosis of an enlarged and distended tube must be frequently to some extent presumptive, founded upon the clinical history and physical signs. There will be found a tumour of not very considerable size in the position of the Fallopian tube on one or both sides of the uterus or, if larger, it may be felt almost wholly in Douglas's space. A small ovarian cyst, a phlegmon in the broad ligament, or a small hæmatocele, are the affections which would most generally be taken for it; but I have been able in a certain number of cases to say beforehand that the tumour felt was most likely a distended tube, in which the result proved that I was correct. In the acute forms. the parts about the uterus may be felt to be boggy, with more or less fixation of that organ. In the more chronic forms, the uterus may be quite free and mobile; and the tube felt, more or less tender, as a small tumour, floating about apparently quite freely. If the tumour is large, say the size of a small orange or more, and is to some extent fixed by adhesions, the result of previous inflammatory attacks, the uterus is less free, and may be pushed to one or other side. With the patient lying on her back, and especially if thin with a lax abdominal wall, important aid may be also gained by the use of double palpation, *i.e.*, with the finger of one hand in the vagina, and the other hand exercising pressure outside through the abdominal wall. The clinical history, in addition, will give a considerable amount of aid in the diagnosis. In some instances, I feel sure there is nothing to be felt in the pelvis before operation, and we have nothing to guide us but the more or less constant pain and recurring attacks of inflammation; each attack making the adhesions stronger and more extensive, and rendering the subsequent removal by operation more dangerous.

In performing abdominal section for the removal of these tumors the incision may generally be, say two inches, or just enough to insert the fore and middle fingers of the left hand. It would seem as if an enlarged experience enabled the operator to separate the adhesions with greater facility, and that an increased "tactus eruditus" taught him the more easily to distinguish the line between ovary or tube and the surrounding parts. The omentum is sometimes found to be troublesome, getting entangled among the fingers. If there is any doubt in the surgeons's mind as to the exact relation of the parts, I think it is best to take the fundus uteri as a landmark, and by tracing outwards, on either side, the ovary, tube, and broad ligament can generally be accurately mapped out. If the tumour, after being separated from its bed of adhesions, is large and cannot be brought out through the short opening, it is often a good plan to aspirate it, especially if the contents are serous, when the collapsed tube comes outside readily. If any of the serum or pus escapes into the pelvis, especially the latter, it is of the utmost importance to make a most complete *toilette du peritoine:* in fact the patient's safety depends more upon this than perhaps all other datails in the operation put together. I would say, sponge, sponge, sponge! I do not think it necessary to wash out the pelvis; dry sponging is quite as effective. There need be no fear of too much sponging. If there has been no escape of pus, and if I am sure also of no blood being present, I make it a rule to close the abdominal wound completely: otherwise, I insert a glass drainage tube.

I have of late omitted the use of the spray in performing abdominal operations. This doctrine of cleanliness has doubtless been brought about very largely indeed, if not wholly, by the work which Lister has done; and I understand it to include many items, such as abundant use of water, most careful attention to sponging, arrest of hæmorrhage, and drainage where necessary. If there is the slightest doubt, before closing the wound, as to the presence of fluid or the likelihood of much future oozing of bloody serum, you must sponge very thoroughly indeed, and will probably require a drainage tube.

The remarkable and well-known frequency with which both tubes will be found affected with