5. Vaginal myomectomy and hysterectomy should be performed by simple or V-shaped anterior median section of the uterus.

6. Large interstitial tumors are scooped out by the cutting-tube (tube tranchant) and extirpated by morcellation in "lozenges."

7. The ablation of large pedunculated fibromata by laparotomy presents its special indications. Abdominal myomectomy is only rarely indicated.

8. The operation of choice for multiple and large interstitial fibromata is total abdominal hysterectomy by subserous decortication of the inferior segment of the uterus, with closure of the pelvic peritoneum.

Differential Diagnosis of Pelvic Peritonitis and Pelvic Cellulitis.

Ely Van de Warker, in the *American Gynecological and Obstetrical Journal* for March, 1899, gives the following differentiating points:

PELVIC PERITONITIS.	PELVIC CELLULITIS.
Following labor or abortion in a few days.	Eighteen to twenty days after.
Beginning in a rigor.	No rigor (Bernutz).
Severe fever, face pinched, prostration.	Less fever, no facial or general reaction.
Pain acute, sharp.	Pain dull, throbbing-like, beginning abscess.
Great tenderness of abdomen.	Lesser tenderness.
Tumor generally behind pubis.	Tumor usually in iliac fossa.
Tumor, as a rule, not above pelvic brim.	Tumor at or above brim.
In early stage more evident in vaginal cul-de-sac.	In early stage less evident in cul-de-sac.
Suppuration rare.	Suppuration very frequent in phlegmons (Bernutz).
Purulent pelvic peritonitis attended with symptoms of peritonitis.	No symptoms of peritonitis.
Purulent mass, intra-abdominal.	Purulent mass in iliac fossa, subperitoneal.
Pus confined.	Pus often diffused and burrowing.
Pus tends towards viscera, or encysted.	Pus tends toward abdominal wall or deep iliac fossa.
No retraction of thigh.	Retraction of thigh.
When mass extends into the iliac fossa it is not well defined.	In cellulitis always well defined.
Tumor elastic or fluctuating.	Tumor more solid.
Always uterine displacement with peri-uterine mass.	May be absent with very large pelvic mass.
Never involves abdominal wall.	Often involves abdominal wall.
Relapses from slight causes frequent.	Relapses rare.
Sometimes an intestinal percussion note over mass.	Dull on percussion.
Never extends to vaginal wall.	Extension of cellulitis from broad ligament or iliac fossa into vaginal wall.
Often associated with specific infection of vagina.	Usually no specific infection.
Occurring without lesion of genitalia.	Often following lesion.
Pain always intrapelvic.	In addition, pain in anterior and inner side of thigh to leg and foot.
Phlebitis not observed.	Phlebitis an occasional complication.

—*Medicine.*

Repair of Injuries of the Pelvic Floor.

Charles Jewett, M.D.

For some time most of the extensive pelvic-floor injuries in my service at the Long Island College Hospital have been repaired at intervals of one or two days to a week or more