I should greatly exceed my limit of time did I attempt to discuss the relative value of tracheotomy and intubation. The opportunity is given, however, to call attention again to what I believe to be an important addition to the ordinary procedure in tracheotomy—*i. e.*, to fill the larynx above the artificial opening with a pledget of cotton or small sponge saturated with an antiseptic solution, to prevent, if possible, the extent of the local disease by continuity of surface.

Let me repeat these thoughts: 1. Diphtheria is in its incipiency a local disease. 2. Local treatment is important, an aid to, but never a substitute for, the careful general medication and cure. 3. The exact means used in local treatment may not be important, but the end to be accomplished is the speedy sterilizing and disintregation of the diphtheritic exudation, without injury to the adjacent tissues. 4. The local treatment must be conducted promptly, persistently, and carefully.—Dr. Porter, in N. Y. *Med. Jour.*

ABDOMINAL SECTION FOR DISEASE OF THE UTERINE APPENDAGES.

Dr. Charles B. Penrose read a paper on this subject, founded on eleven cases, all successful. The operations had all been performed in 1887, and the patients were at present well and able to attend their various duties.

In five of the cases the appendages were removed on only one side. In one of these (a case of pyosalpinx and cystic ovaries) the author had found it impossible to remove the left tube and ovary. They were firmly adherent in a knot on the side of the uterus, and the uterus was bound down in the hollow of the sacrum. In the other cases of unilateral removal he had intentionally left the appendages upon one side. Except in the case of dermoid cyst, the women were young and desirous of having children; and at the time of operation he could discover no sign of any pathological condition in either the tube or ovary. He was aware of the fact that in cases of tubal disease it was often unwise to perform a unilateral operation and to leave even an apparently healthy tube, as, in many cases, it subsequently became diseased from an infecting focus in the uterus.

Though sufficient length of time has not yet elapsed to come to any definite conclusion with regard to his cases, yet so far he had had no cause to regret having left the sound tubes; and in one case the patient had become pregnant since the operation.

A point of interest in connection with the first case (salpingitis and cirrhotic ovaries) was the length of time during which the patient was fed by the rectum. She began to vomit as she recovered from the influence of the ether, and she continued to vomit everything which was administered by the mouth for thirty-six days after the operation. There was no apparent cause for this excessive vomiting. The operation was simple, and was not followed by any obvious symptoms of peritonitis. The rectal injections, by means of which this woman was nourished for over a month, consisted of pancreatized milk, eggs, and whiskey. Two-thirds of a quart of milk, one egg, and three ounces of whiskey were administered in four or five doses during the twenty-four hours. During this prolonged course of rectal feeding she lost many pounds in weight. No food at all was taken by the mouth; the very small quantities which were occasionally administered experimentally, were always rejected immediately. When she finally became able to take food by the mouth it was necessary to give it in the form of twenty-drop doses of soup or beef tea. In the table he had made no distinction among the different forms of non-purulent inflammation of the Fallopian tubes. All thickened, enlarged, adherent tubes which did not contain pus he had put down as cases of salpingitis.

In all the cases of pyosalpinx there was a history of repeated attacks of pelvic pain and inflammation, which often confined the patient to bed for several weeks. In two of the cases of pyosalpinx there was also ovarian abscess. In these cases the abscess cavity in the tube communicated directly with the abscess cavity in the ovary, and the origin of the ovarian abscess was obvious. In case VII (salpingitis and abscess of the ovary), however, there was no pus in the tube. The tube was enlarged and adherent, and its fimbriated extremity was closed; and it did not communicate with the cavity of the ovarian abscess. The ovarian abscess contained about half an ounce of pus and had a distinct pyogenic membrane. The author thought that abscess of the ovary was of more frequent occurrence than works upon gynecology admitted And, though it probably was in general due to oöphoritis caused by inflammation of the tube, yet it was not always associated with pyosalpinx. In two cases of double pyosalpinx (cases V and IX) a thin purulent fluid was found in the peritoneal cavity, and the intestines were found to be deeply congested when the abdomen was opened. The patients had probably been suffering for some time with general chronic peritonitis, the patients having only complained of pelvic pain and pain in the back. The chance that such a condition might occur in connection with pyosalpinx was a strong argument in favor of removing these abscesses by abdominal section, instead of evacuating them by the vagina, as was so often done.

The danger of assuming any case of peritonitis in a woman to be idiopathic, without a thorough vaginal examination, was obvious. He had the