liability to drafts from the opening of doors and windows prevented. The patient is then lifted from the bed and placed upon a narrow table, made comfortable with folded blankets and sheets, in front of a large window, transmitting an abundance of light. Her feet and legs should be kept warm by means of woollen stockings, flannel drawers, and a light blanket. The feet rest upon a stool or chair at the foot of the table. It is necessary to have five or six skillful, cool-headed assistants, free from all taint or suspicion of contamination, arising from dissections, *post mortems*, suppurations, or contagious diseases. The nurse must have in readiness, in the room, plenty of hot and cold water, carbolized water, (1 to 100) a tub, several pails, wash bowls, soap, towels, soft flannels and cotton cloths, napkins, &c. She should have three pairs of new sponges, readily distinguishable from each other: one pair for the external wound; the second, a large pair, for the contents of the tumor; and the third pair, extra soft and fine, for cleansing the peritoneum. Care must be taken to keep each pair in separate dishes, and the assistant who sponges the contents of the tumor must be careful not to touch the sponges reserved for the peritoneum.

The operator takes his place on the right of the patient, with his chief assistant directly opposite. The one in charge of the instruments should be familiar with his duties, and ready to anticipate the wants of the operator. The assistant in charge of the anæsthetic should be accustomed to its administration, and one who could be relied upon to faithfully discharge his duties regardless of the progress of the operation. The anæsthetic should be given in such quantity only as is necessary to maintain quietude. This is important, owing to the tendency to prolonged sickness and vomiting after ovariotomy. When chloroform, which I prefer, is used, it is astonishing how little is required to keep up complete anæsthesia, especially when sprinkled "guttatim" upon one thickness of a napkin covering the nose and mouth, held closely around the chin to prevent the loss of vapor, while the air is freely admitted from above on either side of the nose.*

*Perhaps the most systematic method of administering chloroform, is that adopted by Dr. A. M. Rosebrugh, of Toronto, in his Ophthalmic practice.—See CANADA LANCET, vol. 5, page 622.

All things being in readiness, the bladder should be evacuated with a catheter by an assistant, before commencing the operation.

THE ABDOMINAL INCISION.

The abdominal section is now always made in the median line, between the umbilicus and symphysis pubis, the length required depending somewhat upon the nature of the contents of the tumor. Even for explorative purposes the incision should be about five inches long, which will usually be found sufficient to allow of the extraction of the tumor after its size has been reduced, but if not, the incision can afterwards be lengthened. The section is made with a strong scalpel, commencing below the navel, at a point which will make a proper length of wound ending an inch above the pubic symphysis. Care must be taken to make the dissection along the median line, through the skin, areolar and adipose tissue, down to the *linea alba*. When this *tendinous line* has been reached, and uncovered throughout the extent of the external wound, it is picked up by a tenaculum, opened, a groved director passed underneath, and carefully avoiding the sheath of the rectus muscle on either side, the aponeurosis is divided along the linea alba, from end to end. One more structure—the fascia transversalis with some adipose tissue, having been opened in a similar manner, the peritoneum is exposed. A little time should now be taken to sponge the wound and arrest the hemorrhage. The peritoneum is then raised by the tenaculum, snipped, and divided upon the director. A small quantity of straw-colored serum now usually escapes from the lower end of the wound, and occasionally, if not prevented by an assistant controlling the upper end, a loop of intestine will protrude. The peritoneal cavity having been thus opened, the tumor is brought into view, and in most cases presents the bluish-white, glistening aspect characteristic of an ovarian tumor, but in some instances, especially compound cysts, the appearance is darker, redder and more vascular. In other cases a loop of intestine may first present itself: the great omentum readily recognizable by its characteristic adispose appearance, may, like an apron, extend over the tumor; or a very vascular membrane may cover it, which on investigation proves to be hypertrophied projections of the pedicle, containing large blood vessels.