combed. He was interested from the fact that he had had one or two cases where he probably would have succeeded better by doing this operation. It is a difficult matter to cut through the abdominal wall into the true pelvis and find out the exact condition Though we very quickly get a view of the parts, we cannot manipulate easily.

Dr. W. H. Wathen, of Louisville, congratulated Dr. Montgomery upon his courage, his tact, and his excellent technique.

Dr. A. Vander Veer, of Albany.—I would not be willing to abandon vaginal hysterectomy for removal of the uterus and ovaries. The technique of vaginal hysterectomy is so perfect it is one of the most brilliant operations we have to perform at the present time, and the results are satisfactory. In regard to colotomy, I never had a patient who was thoroughly satisfied with the result of the operation. All were dissatisfied with the fecal discharge. But in the five or six cases in which I have operated for the removal of the lower segment of the rectum, it mattered not if there was some leakage, some trouble in keeping a pad there and receiving the feces; they always said, "Doctor, it comes out at the right place. It feels more natural."

Dr. Ap Morgan Vance, of Louisville.—The performance of primary colotomy would bring about a difficulty from the fact that a good deal of the gut was to be removed; and if there is cancer there, the more removed the better. If it was tied, anchored, at the point of ordinary colotomy, we would have difficulty in bringing it down to get approximation.

Dr. J. F. W. Ross, of Toronto, read a paper entitled

HOW SHOULD WE PROCEED WHEN ABDOMINAL TUMORS ARE COMPLICATED BY PREGNANCY?

He emphasized the point that there was nothing of malpractice in the opening of an abdomen during the existence of a concealed pregnancy, before proceeding to discuss cases in which pregnancy had been recognized. Cases of ovarian tumor and fibroid tumor of the uterus were reported, and a request was made for reports from members of the association, so that a foundation might be laid on which to build up a few fixed rules for future guidance. Ovarian and myomatous tumors were the only two forms taken into consideration.

*Ovarian Tumors.*—He said that the methods of treatment to be discussed were:

1. To allow the pregnancy to go to full term, or until the uterus throws off its product.
2. Puncture of the cyst until delivery is completed.
3. Induction of premature labor.
4. Ovariotomy—the uterus left to abort or go to term.
5. Ovariotomy—the uterus emptied of its contents by incision.
6. Ovariotomy and abdominal hysterectomy.

The author advocated early ovariotomy, but supported cyst puncture in certain favorable cases, if the patients objected to other operation or wished to have a living child. If at any time bad symptoms arose, he insisted on immediate abdominal section.

In advanced cases, where injury or much handling of the uterus is unavoidable, the organ should be emptied to forestall the almost inevitable abortion or premature labor.

*Myomatous Tumors.*—1. Induction of premature labor.

2. Early myomotomy or abdominal hysterectomy.
3. Late hysterectomy or Cæsarean section.
4. Tentative measures, as:

(*a*) Enucleation of cervical tumor to permit labor completion.

(*b*) Enucleation of a sloughing tumor following labor.

(*c*) Abdominal hysterectomy for a sloughing tumor or uncontrollable hemorrhage following labor.

(*d*) Abdominal hysterectomy for septic infection from retention of discharges in the non-contractile uterus.

(*e*) Abdominal hysterectomy or Cæsarean section to end a labor that will require long forceps, version, or craniotomy.

He finally concluded that the tentative measures were the best.

Dr. H. T. Hanks, of New York.—I have been interested for many years in the subject of uterine and ovarian tumors. We not only want to consider the patient but the surroundings, and when you know that you have got a unilocular cyst, that you can tap and remove the fluid and the patient can go on to term, or at least to eight and a half months, you are justified in doing it. But if the pregnancy is complicated with fibroid tumors, the case is different. They grow very rapidly from the first month up to the fifth or sixth month, but do not from the seventh to the ninth month. If the tumor is situated in the cervix you should enucleate it, because you cannot deliver through a cervix of which two-thirds is a fibroid. If you cannot do that, you are justified in producing premature labor or an abortion at the second or third month. If the tumor is the size of your fist, and you can push the cervix above the brim, and you have two-thirds of the cervical tissue healthy, you are justified in delaying. If the tumor is above the middle zone, the child can be delivered quite easily at term.

Dr. A. Vander Veer, of Albany.—The difficulty of diagnosis in a case of fibroid of the uterus or ovarian tumor is one of the problems of surgery. The subject is being handled with much greater clearness and more satisfaction, but it is essential to make a diagnosis, and in making the diagnosis we have very little that helps us in the history given by the patient. A condition which Dr. Ross did not touch upon is this, that in most cases where a patient who has a uterine fibroid becomes pregnant the tumor will take on a certain amount of growth, more in some cases than others. Occasionally it undergoes a sarcomatous change. Again, a patient may have a fibroid, go through pregnancy and a safe delivery, after which the fibroid will disappear. The medico-legal point of this question has been touched upon by two or three of the decisions that have occurred in court. We should be thoroughly united and thorough in our emphasis that in these cases the fibroid does sometimes disappear under the influence of pregnancy. In the treatment of ovarian tumors coincident with pregnancy, we should tap and carry the patient along as near as possible to the full time.

Dr. I. H. Cameron, of Toronto.—I am strongly in accord with the opinions expressed that no