of the opinion that the mortality after operation for strangulated hernia had decreased. He had operated with good results on a patient 89 years of age. As to gangrene, no law could be laid down; each case must be judged on its merits. There were fewer cases of gangrene now than formerly, because the strangulation was sooner recognized. He cited a case he had had, where gangrene was present to a small extent, which he stitched up with a Lambert suture, returned the gut, and recovery followed.

Dr. Peters said Mr. Hutchinson was certainly very pronounced in his view regarding the use of taxis, not by gentle manipulation, but by using all the force he possibly could, and after he was tired, of getting an assistant to continue the process. Notwithstanding the statistical reports, he thought the results were exceedingly good, because if these cases were left to themselves, they would certainly in most instances end fatally; while under operation, thirty or forty per cent. of successes was a good record.

Dr. Toskey said that the maxim as laid down by the leader of the discussion were correct enough, but the difficulty was in knowing how to apply them. A great deal of judgment was required. In regard to taxis, he could understand, in a large hernia which would fill the hollow of his two hands, how one's whole strength might be placed upon it to reduce it, but this same rule would not apply to a very small hernia. With regard to the increased hospital mortality statistics in this operation, he suggested that it might be due to the fact that the ordinary outside medical man was now so well trained that he undertook these operations himself with success, and sent only the worst cases to the hospitals.

Dr. Wishart did not agree that this was an easy operation and lightly to be undertaken. There was always danger in opening the abomen. He believed that in case a country practitioner, far removed from help, met such a case, he should give chloroform and try to reduce at once, as delay was very serious. He had never seen in the cases where taxis had been used, even to a considerable extent, any damage done to the bowel when he had opened up. The speakers agreed that where the knife had to be used the radical operation should be done, as a rule.

Drs. G. W. Fox, of New York, and Coonyn, of Buffalo, were invited during the session, to seats on the platform.

The Association then divided into sections.

SURGICAL SECTION.

Dr Bruce Smith was appointed to the chair.

"McGill's Operation for Prostatic Enlargement," was the next paper, by Dr. A. McKinnon, of Guelph. The reader of the paper gave the history of several cases he had had of prostatic hypertrophy accompanied by urethral stricture, cystitis and severe bladder spasms. The operation consisted in a suprapubic cystotomy and removal of a portion of the prostate with very gratifying results. He outlined the technique of the operation fully, and of subsequent drainage. He quoted statistics furnished by Bellfield, of Chicago, of 41 such cases where 32 had made recoveries, the patients having regained the power of voluntary micturition.

Dr. Primrose discussed the question of the use of Peterson's bag, and the dilitation of the bladder, how this would enable the operator upon completion of the abdominal incision, of stitching the bladder wall, and holding it by means of the stitches while it was being opened, instead of cutting down upon a sound, as Dr. McKinnon had advised. He asked also, how hæmorrhage was controlled in view of the vascularity of the prostate. He advocated the advisability of perineal drainage, as in high drainage there was danger of infection of the cellular tissue in front of the bladder.

Dr. Grasett said his experience was limited in this line of work, having done, but one and that a partial prostatectomy. The result in this case was good. He thought a combination of the suprapubic and the perineal method to be the best, so as to avoid the necessity of incising the mucous membranes of the prostate; the sections being scooped out from below, the opening above enabling the operator to exert pressure downwards on the gland from above.

Dr. McKinnon said that he had found hot water would control the hæmorrhage, but if necessary the opening might be plugged.

Dr. R. Whiteman, of Shakespeare, followed by a paper on "Cholocysthomy." He described the history of a case of obstructive jaundice. It was difficult to decide whether it was due to gall stone or malignant disease, but the diagnosis inclined to the latter. Cholocystotomy was performed in the usual manner with success. As all of the bile passed out of the abdominal incision, a number of interesting features were observed in connection therewith. On the administration of calomel, the flow was lessened, but increased on the giving of salicylate of bismuth. It was also noted that when the bile decreased the urine increased, and vice versa. On post mortem it was found that an opithelial cancer occupied the region of the duodeum at the junction of the bile duct.

Dr. Graham said he was very much interested in this case, as he had seen it in consultation. The diagnosis was comparatively easy, as the distended gall-bladder was in the position one would expect it to be, and the accompanying symptoms pointed in the direction of obstruction to the outflow of bile, but he had seen cases where the diagnosis was exceedingly difficult, the gall-bladder