cordingly done on the 8th February. On opening the cavity a quantity of blood clot, of varying age, and bloody serum was revealed. On the right of the uterus, in the region of the ovary and tube, lay a ragged, granular mass. On attempting to raise this to apply a ligature to it, it was torn away. I made no further attempt to tie the torn base, but proceeded to scoop out what I could of blood clot, of which there lay a large quantity in the Douglas pouch. The cavity was then well washed out with a large quantity of warm water. In this part of the operation, the signal advantage of Lawson Tait's large ovariotomy trocar became very apparent. This tube measures about $\frac{7}{8}$ of an inch in diameter, and at its free end is a blunt beak, with two lateral openings. The large rubber tube attached to it was immersed in a pitcher of warm water held aloft by assistants. The water was then sucked through till it flowed from the trocar tube, which was then carried to all the deep parts of the pelvis, the powerful stream bringing away masses of clot and fibrine, an operation which could in no other way have been so effectually managed. The blunt beak of the instrument precludes all possibility of any injury to intestines or other structure. A glass drainage tube was carried to the bottom of the pelvis, where it was retained for a week. It will be observed that I applied no ligature to anything, yet the torn vessels yielded no more than a moderate amount of blood and bloody serum, as shown by the fluid sucked from the tube. The wound was closed as usual and the patient put to bed in rather an alarming condition, her pulse was 140° and small. Nothing was given by mouth for three days. She was fed per rectum with beef-tea and brandy. Under soap-suds and turpentine enemata, flatus was passed within sixteen hours, and a fæcal motion obtained in twenty hours. The distension was thus rapidly reduced and the pain soon relieved. Not a particle of morphia or opium was given at this stage. She made a tedious but complete recovery. The tedious nature of the convalescence was entirely due to a severe attack of cystitis.

At the time of operation no semblance of a fœtus was seen, but on careful examination afterwards of the mass removed, a blood stained fœtus about an inch in length, as well as characterstic chorionic villi were discovered by Dr. Johnston, the Pathologist to the Montreal General Hospital. From the appearance of the fœtus and parts when removed, I have no doubt that the vitality of the fœtus ceased at the time of the first serious symptoms, but that it did not escape. Such a condition of course shows that electricity would have been useless at any time after this patient was first seen by her physician.

The diagnosis of extra-uterine pregnancy is on all hands confessedly difficult, and yet it is probably not so difficult as imagined by the inexperienced. The first thing to be sure of is the possibility of pregnancy. If then the patient present the signs of abortion—pelvic pain and vaginal discharge—the pelvic pain being usually severe and attended with faintness or collapse, and the discharge containing fragments of, or a complete decidual cast of the endometrium; and if on examination we discover the characteristic softness, enlargement of the uterus and the violet discoloration of the genitals, but above all the rapidly growing tumour on one side and behind the uterus, the diagnosis is established with such a measure of certainty that we must act. The next question is, what shall we do? This part of the subject—the treatment—is by no means settled to the satisfaction of all parties, and some of the most recent discussions have indicated a wide difference of opinion on the part of high authorities as to what shall be done, or perhaps more correctly, what shall first be done. The treatment of extra-uterine fœtation may be spoken of under three heads: fœticide by electricity, abdominal section to remove the fœtation, and expectancy.

Electricity.—The form of electricity which has the greatest number of adherents is the faradic current; it is the simplest and most easily applied, and there must be very few medical men who do not possess the necessary apparatus. Certain eminent abdominal surgeons strongly oppose it, and yet there is a mass of evidence in its favor which seems to me to make its position unassailable. I grant that the evidence in some of the cases will not bear close scrutiny, but this is not the case as regards the bulk of it. I have published a case in which I take it the evidence as certainly proved the condition as anything short of seeing the fœtus or chorionic villi.

Abdominal Section.—Mr. Tait, Dr. Johnstone,