set in, especially at menstrual periods. On account of the rapid recurrence of these fits, a vaginal examination was made, ulceration of the o diagnosed, and treatment adopted, with improv e ment in local condition. No improvement in the fits. Patient took to alcohol for relief, and at last became insane. In 1882 she was sent to the asylum, and entered as an incurable epileptic, with erratic symptoms. Dr. Midford of Portland, who saw the patient, recommended öophorectomy, but this Dr. Bucke did not think necessary. The patient was taken out of the asylum, womb and ovary reported contracted and ovary attached. Vaginal öophorectomy was performed on 10th April, 1883; one ovary was found cirrhosed. Recovery took place, and patient menstruated at usual time, and has continued to do so ever since. No improvement mentally or with the fits, the patient was returned to the asylum. It being considered essential that the tubes should also be removed in these cases, and by abdominal incision this was decided on. This was for the purpose of exploring the pelvis for any supernumerary ovary or remains of ovarian tissue, and if the uterus was diseased, to remove it also. The operation was performed April 23rd, 1884. There was no trace of an ovary or ovarian tissue. The uterus was enlarged and densely indurated, and tubes hypertrophied. The uterus and tubes were then removed. The operation lasted less than one hour, and was well borne by patient; vomiting was somewhat severe afterwards, the patient, however, apparently doing well for the first 36 hours. After this time patient steadily continued to fail; pulse 140, and temperature 102; death ensuing 59 hours after the operation. The report states that "ever since the operation, her fits (slight ones) have been very frequent, but at no time has there been a single unfavorable abdominal symptom, and on examination after death the wound seemed to have been almost healed by first intention. Cause of death, continued and progressive shock." In speaking of this case, Dr. Bucke told me the patient had a series of epileptic fits lasting for 11 hours almost continuously, and that as she had two such attacks while in the asylum, during each of which she nearly died, he felt convinced this last attack, coming on toward the close of the second after such a severe operation, "had a great deal to do with the fatal termination." The following points connected with the operation itself are perhaps worthy of note: 1. The abdominal walls were divided in the exact median line, so that the peritoneum was reached without dividing a single muscular fibre. 2. The uterus was carried upward and retained there by means of a large rectal bougie passed up the vagina and pressed against the os uteri. 3. The uterine arteries and other vessels were secured by fine hemp ligatures, which embraced the folds of the broad ligament corresponding to each tube and ovarian ligament. 4. The uterus was divided at the inner os by a V-shaped incision, and the amputated surfaces brought together by five catgut ligatures in such a way that a simple linear incision resulted. The deeper parts of the opposed surfaces were then more closely approximated by means of quilting them with catgut, about five double or shoemaker's stitches being thus employed. 5. The deep abdominal sutures were inserted so as to carefully avoid any portion of the muscular tissue. 6. No abdominal bandage or long plaster was employed with the object of strongly encasing the abdomen, a practice fraught with no possible good, and often potent for much evil.

Upon examination of the parts removed, the Fallopian tubes were found to be occluded for about an inch from the horns of the uterus, and also very firm to the finger. The uterus was hard and about twice as large as it should have been. The cavity of the body was almost entirely obliterated, admitting the point of the probe for about a quarter of an inch only. This condition prevented any communication whatever between the tubes and uterus. Menstruation must have been from the cavity of this neck.

I much regret the issue in this case, because some two months ago I removed the ovaries and tubes from a patient who had been suffering at her menstrual periods with increasing severity up to about six months before the operation, when suicidal mania supervened, and the monthly disappeared. I had a letter from her medical adviser a few days ago, in which he says; "Miss C. is doing well, and her mental condition much improved, though hardly up to par." It may be that there are few cases of insanity which would be cured by removal of uterine appendages, yet, doubtless, there are some cases where the cessation of all sexual activity holds out the only hope of ameliorating their sad fate. Two classes of cases would seem to warrant the performance of the operation, viz., 1st, those cases of *imperfect sexual development* where the nervous energy is diverted