

three or four hours, in quantities of about four ounce sat a time. Brandy and medicines, when necessary, may be added to the injections. The nutritive material should be strained and warmed previous to being administered, after which, the anus must be supported for a time by firm pressure with a napkin. After three or four days, when all tendency to vomiting has ceased, or as soon as the stomach begins to crave food, small quantities of light nourishment may be tried, A spoonful of milk, beef tea, or oyster broth, may be given at frequent intervals, and if such nutriment agree with the stomach, other articles of similar diet, and small portions of solid food can be permitted.

If the patient appear to be doing well, as indicated by the general symptoms—pulse, temperature, respiration, and freedom from pain—the wound need not be examined until the third or fourth day, when it should be cleansed and dressed with fresh materials. Should suppuration be then commencing in any part of the wound, or around the pedicle, this must be carefully sponged twice or thrice a day, after which, the wound is each time dressed with lint soaked with carbolic oil. The upper part of the incision usually unites immediately by first intention, and the whole wound in four or five days; but the sutures are not removed until the seventh or eighth, unless some of them become a source of irritation. When the clamp has been employed, it is left undisturbed until it become loose and ready to be removed without any traction; the time varies with the thickness of the pedicle, but it usually falls off about the eighth day.

After the sutures and clamp have been removed, the abdomen must be supported by adhesive plaster, pads of cotton wool and an abdominal bandage. Even when the patient leaves for home, she should be enjoined to continue the support by the elastic bandage, corsets or some other abdominal supporter.

SHOCK.

Occasionally, however, ovariectomy cases do not get on so favorably as above indicated. It not unfrequently happens that the nervous prostration we are accustomed to speak of as exhaustion, shock, or collapse, continues after the usual time expected from the effects of anæsthesia and the operation. The patient does not rally, but gradually sinks in spite of our best endeavours to revive her failing powers. With this depression of

the vital forces most of us are familiar, as occurring after capital surgical operations, and railway and other severe accidents. In reference to this condition, Dr. Barnes makes the following original and pertinent observations: "A considerable proportion of all the deaths, I am convinced, occurs from *shock*. Recovery from this is greatly a question of individual power of endurance. We can hardly foretell what this power is in any particular case. Women recover from the severest operations attended by all the complications considered the most formidable; others sink after the easiest and simplest operations. Women comparatively robust, succumb, whilst the apparently fragile recover. In many cases the unexpected result is not due, at least appreciably, to difference in skill.

"It can only be referred to difference in innate power of resistance. This is an unknown quantity, and is the chief cause of the uncertainty which surrounds the operation. No doubt the shock can be lessened by care and skill during the operation, and the patient can be to some extent supported through it."

Vigilant supervision and good management by the operator, personally, at this critical time, may succeed in reviving the sinking powers. Warmth, even in hot weather, must be kept constantly to the feet, legs, axillæ and cardiac region. When the stomach will retain stimulants, iced brandy or iced champagne, can be given by the mouth. But, when obstinate vomiting persists, the stimulants must be administered per rectum; and if necessary, ammonia hypodermically. The patient must be kept quiet on her back, and free from pain by morphine subcutaneously, or laudanum added to the enemata. In other desperate cases, when the patient does not sink from exhaustion, we scarcely expect she will survive the secondary dangers of hemorrhage, peritonitis and septicæmia.

HEMORRHAGE.

Should internal hemorrhage occur, indicated by progressive faintness, and a feeble, frequent pulse, the wound must be re-opened, the bleeding vessel secured, and the peritoneal cavity again cleansed. This appears a desperate undertaking, but the condition is an extreme one, as the patient, if left alone, will bleed to death. The above procedure offers the only hope of arresting the hemorrhage. During all this time, the operator must be on the constant watch for symptoms of