with signal defeat. Small pedicles submitted to such treatment, but the larger ones were not so tractable. They oozed, they bled, they sloughed, and refused to be so tenderly dealt with. A wire was then put about them and they were forced to remain outside of the abdomen. Many operators meet with remarkable success by this method, but the continued anxiety and worry of always looking, like Micawber, for something to turn up forced one of the most successful operators of this century to abandon operation and to again seek for palliative measures. The operation then received a blow from which it has not yet recovered. Other vaunted remedies were tried, as they were tried by our ancestors long years ago. Our ancestors failed, and we have failed to cure by these means. Enthusiasts stepped in, and the medical profession blindly followed. Anything to avoid the knife. An operator was avoided as if he had been a murderer, and he only received the crumbs that fell from the rich man's table. He was forced frequently to operate for glory or the love of humanity. It was an uphill fight. The fight was felt by many to be a fight against an unsurgical operation, an operation that left a dirty sloughing mass sitting on a dirt-abhorring cavity. On this continent, Eastman reported his success by the no-pedicle method. I had myself written up such an ideal operation, but had not as yet performed it. The trend of European thought was in the same direction. Krug then took up the operation, and he, with Eastman and myself, felt convinced that the pedicle must go. At Richmond I brought the subject up for discussion before the Southern Surgical and Gynecological Society in November, 1891. Those who had done well and brilliantly with the clamp remained conservative, but were interestedly awaiting developments. What I said before the Michigan State Medical Society last month, when invited to describe the no-pedicle method, I may repeat here: "I will never do another abdominal hysterectomy with an extra-abdominal pedicle as long as I live if I can operate by this other method. I feel that this operation will be the one generally adopted before another five years are over. I can heartily recommend it." For the purpose of analysis, I select three cases done by each method, and will endeavor to review the period of convalescence without prejudice.

Case 1. A fibro-myoma, the size of a man's head, with a pedicle formed by cornua of uterus after tying the broad ligament in which the tumor had developed with a chain suture on its outer side. The abdomen became distended shortly after the operation, but the flatus was expelled when the flatus tube was passed. This distension is evidently due to traction on the rectum by the pedicle. This distension disappeared on the fifth day. In this case a drainage tube was used above the point at which the pedicle was fixed, and was removed on the fourth day. Irritability of the bladder came on, and was troublesome. Clamp removed on the nineteenth day. In this case the temperature twice reached 100⅗, and the highest pulse was 86. The pulse usually ran at about 65, and was unusually slow.

Case 2. A case of pregnancy and fibroid; fibroid weighing about thirty-five pounds. Pregnancy of five months' duration. Clamp and pins placed in lower angles of wound. Symptoms of distension set in very soon after the completion of the operation. What appeared to me to be obstructive vomiting set in, and enormous quantities of fluid were thrown up. It seemed as if the whole intestinal tract took part in the reverse peristalsis. An enormous number of enemata were administered, together with calomel, Seidlitz powders, magnesia sulph., cathartic pills, but without effect. I began to despair; but with all this vomiting the pulse ran at 66 to 90, clearly indicating that it was not due to peritonitis. The temperature at about 99°. To me the temperature is but a poor indicator, but the rapid pulse always makes me feel uneasy on two points, viz., hemorrhage or sepsis. Obstruction is generally at first accompanied by a moderately slow pulse and a slight, if any, rise of temperature. Peritonitis is always ushered in by a rapid pulse, let the temperature be either high or low. No drainage tube was used in this case. The pedicle sloughed above and below the clamp, and left an enormous hole to granulate from the bottom after the clamp came off on the twenty-first day. As the stump became putrid the temperature began to rise, and with it the pulse. Septic diarrhœa, a septic gastritis and enteritis and passage of undi-