opposite their premises may be, but, as a rule, in gynecological discussions charges and counter charges mar the dignity of debate. It would seem to me, Sir, from my observations of the men of this continent having their field of work in the pelvis, that they can be classed under the two heads, surgeons and operators. Preserve, oh ye gods! any of my immediate lady friends from the uncontrolled clutches of the latter. The operator reigns supreme king of the ampitheatre. He washes his hands upon the completion of some pelvic brilliancy, before an admiring audience from the country, as a member of which I have myself left the operating room borne down by the sense of my own diminutiveness and conscious of the darkness of the fate that destined me to return to my hayseed practice, to minister to the needs of colicky infants and lumbagoed fathers. Is it provocative of sober deliberation to have such phrases thrown out in discussion as this from the no-drainage fanatic: "There is no need for drainage in abdominal work. The man who drains is a dirty operator." Or this from the soap and water man: "The operator who has need of corrosive poison to render himself fit for the operating table had better take a month's vacation to prepare himself." I hope I shall be pardoned for some digression, in view of the importance of the line of thought upon our subject.

Pelvic fluid collections can, I think, from such experience as I have had, be divided into two main classes:

(1). The septic.

(2). The non-septic, or simple.

These two large divisions I would subdivide into

(a) Those with adhesions.

(b) Those without adhesions.

So that we have then

(1). Septic collections with and without adhesions.

(2). Non-septic collections with and without adhesions.

In handling these conditions it appears to me that the first point to be determined is the extent of the adhesions, for I do not think I mis-state the facts when I say that in no class of cases does an operator feel the uncertainty of his post-operative prognosis so much as in abdominal excisions with extensive adhesions. There is no sign known to me whereby the friends downstairs can be assured that such a patient will live twenty-four or forty-eight hours after operation. With such a dreadfully dangerous proceeding before us, then, I maintain that it is but right that we weigh well the necessity of resurrecting from its intestinal grave the buried cyst. In malignancy we have a pathological basis for thorough excision, irrespective of injuries to adjacent organs, but in adherent sacs of pent up fluid, here, as in other parts of the body, why should excision be demanded before simple incision and drainage? Frequently have I heard the daring Joseph Price advise "the ploughing out of everything in sight" "Tear down adhesions, leave not one behind; if you open the bowel, never mind, sow it up again." Well, Sir, after we have ploughed out, left nothing behind, opened the bowel in two or three places and sewed it up again, what have we left but a raw space that engulfs all in sight the moment our sponges are removed; and the adhesions that we have taken so much trouble and time to break up, are replaced by fresh ones that will in time become as firm as the first set. Having before us, then, a case of diagnosed pelvic fluid collection, it would seem to behove us to adapt our treatment. Discriminative, or not dogmatic, action is to follow, and in selecting our lines of action it would appear to be our duty to realize that in the relief of the case in hand, incision, with evacuation of the pent up fluid, has its place at least in the same rank with excision.

Excision means a bold opening of the abdominal cavity, with all the attendant dangers of general infection; it means a breaking down of all adhesions interfering with the removal of the sac, a procedure attended, even in the most prudent hands, by ruptured viscera, and always followed by a grave shock. In short, the