led, but through which the urine could not find its way if blocked. This blocked condition produced a distention of the ureter and pelvis above the obstruction and gave rise to the pain.

The specimens shown by Dr. Joseph Price were of very great interest. Myomata sloughing, as a result of electrolytic puncture, were shown. Dr. Price showed many specimens and plates of pyosalpinx, matted ovaries and tubes, from patients in whose pelvis electricity had been given a fair trial by the most skilled electrical operators. He thought that if these electricians knew more of gynæcology and less of electricity the patients would be better off. A veil of mystery had been thrown around the use of electricity, and before a man was looked upon as fit to use it he must spend half a lifetime in his preliminary education. The general consensus of opinion was that the result of electrical treatment were disappointing, and that the cases came into the hands of the abdominal surgeon eventually; that electricity is a good caustic; that it will temporarily relieve hemorrhage in some cases of uterine fibroids; that it is useless in tubal disease or disease of the ovaries, or in ectopic gestation. As to its power of relieving pelvic pain, not much was said. Many reported results of the use of electricity were useless, owing to the impossibility of making a correct diagnosis without opening the abdomen. A suppositious diagnosis may be made, but it is not and cannot be verified without exploratory operation. To exemplify this point, Dr. Price showed a specimen removed before many of the members in the forenoon. He thought the woman had had a miscarriage and was suffering from puerperal pyosalpinx. He would defy any member present to diagnose the case even now with the specimen in his hand. Was it pyosalpinx or was it tubal pregnancy? He then opened it with a scalpel and it proved to be a tubal pregnancy. The fœtus was easily made out.

He held that Tait's idea of rupture into the broad ligament was not correct. He had seen many cases (and the one just shown proved the fact) in which no rupture had taken place into the broad ligament, but the tube had simply gone on dilating as it does in pyosalpinx, hæmatosalpinx, and hydrosalpinx.

A discussion of the supposed virtues of the Staffordshire knot took place. A case having been mentioned in which hemorrhage had taken place after the most careful use of the knot, Dr. Price said that he had long since given up using it and had returned to the simple old knot used by many celebrated ovariotomists of the past. The simple transfixion, crossing of the ligatures, and tying in halves, would not allow bleeding any more than any other kind of knot. It was not so much the knot as the man who tied it.

There can be no doubt that hemorrhage may occur after using any kind of knot, no matter how well applied. All of the best operators have had this experience.

The question of drainage after abdominal operations was discussed. Some thought drainage should be used in every case. Others that it should be used very seldom. The general weight of opinion seemed to be that drainage should be used whenever the abdomen was washed out, where there was danger of subsequent hemorrhage from adhesions, or a thick pedicle where there was much handling of the peritoneum.

The question of the necessity of drainage after washing out a tuberculous or an inflamed peritoneum was not discussed.

The wonderful record of Dr. Joseph Price, of twenty-six consecutive abdominal hysterrectomies without a death, was presented to the meeting in an informal way.

The report will no doubt be published before long in detail. This is the best record yet published.

The question of the advisability of performing vaginal hysterrectomy for cancer was discussed, and opinion still remains divided. The statistics on both sides have not yet been collated to the satisfaction of those holding neutral ground. Many are waiting to be convinced. The main questions seem to be: 1. Do the cases live longer after (*a*) vaginal hysterrectomy, (*b*) after high or low amputation of the cervix, or (*c*) after being left practically alone, or occasionally cauterized to relieve the hemorrhage?

2. Is the suffering greater up to the time of death (*a*) if they are simply occasionally cauterized; (*b*) if the disease returns after vaginal hysterrectomy; or (*c*) if the disease returns after amputation of the cervix?

3. In how many cases can we be sure (*a*) that if the uterus is removed the surrounding struct-