Abdominal hysterectomy, with three deaths.—One of these was a case so difficult, that I should have abandoned total extirpation of the uterus and been content with removal of the appendages, which in the four cases above mentioned proved so satisfactory. The uterus was squeezed in between two solid masses of fibrous tissue, which completely filled the pelvis, the right ureter running over the front of it. The two ovarian arteries were tied, but it was impossible to tie the uterine ones until the tumor was first extracted—with the greatest difficulty—so they were clamped and afterwards tied. The peritoneum was sewed over the stumps. The patient reacted nicely and was apparently making a good recovery during the first four days, with a pulse and temperature under 100. At my morning visit she was asking what she could have for dinner. An hour later her condition suddenly changed, her pulse jumping up to 140, with a normal temperature. I was tempted to open her and look for hæmorrhage. But her pulse came down several times under digitalis and strychnine.

She died on the sixth day, and on opening the incision the peritoneum was found clean and nicely healed in both places, and no explanation could be given. There is little doubt, however, that she would have been alive to-day, if I had simply removed the appendages, when the tumor would probably have given no further trouble. But I thought at that time that it was dishonorable to back down on an operation. Since then I have seen the best operators in the United States perform a safer operation than they had started to do, and even sew the patient up without doing anything, and I feel convinced that they are right.

One of the other deaths was due to sepsis, the only explanation for which was that the patient was disobedient and jumped out of bed to use the chamber when the nurse was out of the room, and that while she had a serre noeud and pins on the stump of a large fibroid tumor.

The third death was due to the operation having to be abandoned, owing to the intimate connection of the large fibrocystic tumor with the bladder, rectum and large vessels of the pelvis, in which it was deeply imbedded.

It is interesting to note that, in one of the cases of obstruction of the bowels, the cause of the trouble was the adhesion of a loop of small intestine to the stump of an ovarian tumor which had been removed four years before, thus causing a kinking of the bowel. This is an argument in favor of covering over the stump in all such cases with peritoneum, which since then I have generally done.

The seventh death was of interest for several reasons. She was a lady who had had four miscarriages, and, being anxious to have children, I placed her on viburnum prunifolium, with the happiest results, going on to full time. She then had several children at full time, never having the least trouble either with her miscarriages or labors. Then she sent for me to attend her for a miscarriage, and as I found the temperature high, I advised her to come to my private hospital for curetting. This was done, but with no improvement; the temperature continued to rise and the pulse to get faster, and a tender spot made its appearance in the McBurney region.

Suspecting appendicitis, the abdomen was opened that night at midnight. The uterus, ovaries and tubes and appendix were all bathed in pus. Not knowing which was the original cause of the trouble, the vermiform appendix, as well as the ovaries and tubes, was removed. There was a general suppurative lymphangitis, as pus could be squeezed out of the cut edges of the broad ligament, and also there was pus and flaky lymph all over the peritoneum, which was carefully wiped out. After this she had no more pain, but she died the next day.

We now come to the three deaths in 42 cases of pus tubes. These have generally been considered very dangerous cases, but I have not found them so bad as they have been painted. In many of the cases which recovered, the tube has burst, and the abdomen has been flooded with bad smelling pus which was carefully washed away. In one case the pus tube had burst into the broad ligament, setting up cellulitis, and then had been opened into the vagina; a fistula from the tube to the vagina ensuing, which continued to discharge foul smelling pus for six months, when the patient demanded an operation. The latter proved a formidable undertaking, necessitating the tying off of nearly the whole of the broad ligament on one side. Although great difficulty