success, and had it been done at the start, it is highly probable that she would now be living and in good health.

One more case and I am done.

Mrs. W. had a history of recurring pelvic inflammation for six years, each attack followed by an imperfect recovery. In July last, her family physician went out of town and left her in my charge, she being at the time suffering from an acute recurrent attack of pyosalpinx. Unfortunate circumstances prevented my answering numerous urgent messages from this lady until evening. When I got there I found evidence of a ruptured tube and consequent beginning of peritonitis. No time was lost in getting instruments and assistants, opening the abdomen and cleaning out a quantity of escaped pus, securing and removing the tube, together with this fibroma of the right ovary. Fortunately here the operation was in time, before the inflammatory process had extended very far, that is, while it was yet localized and before paresis of the intestinal wall had occurred, and the result was all that could be desired.

These cases are primarily in the hands of general practitioners, and I believe it to be the duty of the family physician to thoroughly inform himself of the natural history of this disease, and not to discharge a patient suffering from salpingitis as soon as she can sit up and join her family at dinner, but to watch carefully over her for months and years if necessary, and to keep informed of the condition of the tubes, and thus discharge one of the highest functions of the family physician. And I believe that in recurrent cases of salpingitis, as in recurrent cases of appendicitis, the question of operation is a legitimate one for serious consideration.