ceased, when I passed the index finger through the incision and easily felt the ovary through the peritoneum. The point of the knife was again used to divide the peritoneal layer; after which the ovary was grasped by the finger and brought through the incision and external to the vulva, when it was ligated with hempen thread and separated with scissors from its ligaments.

The stump was returned, and a pledget of lint inserted into the wound to act as conductor of any fluid that might occupy the cavity of the pelvis. The patient quickly regained consciousness. Within two hours afier operation I removed the calico, as its presence was giving her trouble.

At 8 p.m., drew off 10 oz. normal urine. Ordered turpentine stupes to abdomen as she complained of pains over hypogastric region.

January 30th.—Very little pain in the abdomen- Removed urine morning and night. Slept well most of last night. Takes toast and tea, also gruel. Rests well on sides and stomach.

January 31st.—Slept most of the night. Got out of bed and passed a large quantity of urine. No pains. There is a little soreness about perineum and stomach.

February 1st.—Doing well. Gave an aperient to move the bowels.

February 2nd.—Patient felt very well. Examined vagina by the finger and found wound united, and not a trace of any effusion. From this date forward patient made rapid and perfect recovery from the effects of the operation, but her general health continues very feeble.

I have given a table shewing temperature and pulse. It is remarkable that the pulse never went above 88, while 99,5° is the highest point reached by the thermometer.

Subsequent History.—I have little more to add, and that little is unsatisfactory, inasmuch as the patient has experienced but little benefit from the operation. The only relief acknowledged is the removal of dyspareunia.

The general health of the patient, however, is so very poor, I am not without hope that, when her health has been established, she will be entirely relieved of her suffering.

32 Beaver Hall,

Montreal, May, 1876.

Conservative Surgery and Railroad Accidents. By WILLIAM FULLER, M.D., Professor of Anatomy, University of Bishop's College, Montreal.

(Read before the Medico-Chirurgical Society of Montreal, 16th June, 1876.

GENTLEMEN,—Having frequently observed men discharged from military hospitals with amputation performed in the thigh, within a very few inches of the hip, and even with both thighs amputated, I have been struck with the marked contrast in the success of military surgeons, compared with those engaged in ordinary practice, and dealing with the common accidents, which occur to men engaged in the trades, and on railways, the most fatal of all accidents. It is a notorious fact that very few surt vive a crush of the thigh by the wheels of a railway carriage, and a few thoughts which have occurred to me upon this important subject, I wish to present to the Society, with a view of obtaining the expression of its members upon a matter so vital to the interests of the largest and most useful portion of society, the workingmen. In order to arrive at a just conclusion as to this contrast, for I cannot admit that military surgeons are more skilled than we, we must examine first, carefully, into the different conditions of the accident, and, second, as to whether our treatment is modified to suit the varied conditions. In the accidents of war, though the instruments are blunt, the velocity is great, and the amount of shock sustained is in the inverse ratio to the velocity. I have often enquired of men injured in war of the sensation experienced upon being struck by a ball, and the invariable answer was that they knew nothing of it until the blood was discovered, or they had fallen on the stump of a limb carried away. At most, with a few only, a slight burning or sting was felt. The shock of the accident was comparatively slight. On the other hand, in railway and ordinary accidents, where the velocity of the force applied is slow, and parts are slowly crushed and bones ground in pieces, the shock is very great, and from frequent enquiry it was uniformly asserted by all, that the sensation was horrible at the moment of accident, and the mention of it recalled a terrible feeling which they could not describe. Even in some, a secondary shock was perceptible when the fearful moment was referred to. Experience has laid down certain rules by which military surgeons are guided in the necessities of amputation. The army surgeon amputates according to his rule, and though extensively injured, his patient survives, while, with equal skill on the part of the surgeon and equal con-