large I prefer to strip off the ligamentous capsule as far down as possible. If that can be done a portion of the cyst wall is then cut off, taking care to take away most on the sides, so that the central portion will come up to the abdominal wall without dragging. Bleeding vessels in the cyst wall are ligated or twisted. The detached portions of the capsule are folded into the cyst and united with a continuous suture, beginning on each side and continuing towards the centre, but leaving space enough between their meeting to admit the drainage tube. In doing this great care has to be taken to keep the hands and the instruments, which have touched the inside of the cyst, from coming in contact with the peritoneum or abdominal wound. Again, in fastening the partially closed capsule or cyst to the abdominal wall, it is necessary to pass the needle from the abdominal wall into the cyst, and not use that needle again, unless it is thoroughly cleansed. If, on the contrary, the sutures are passed from the inside of the cyst outward, septic material will surely be carried into the tissues of the abdominal wall and trouble will follow. One suture on each side of the opening in the cyst for the drainage tube will suffice to unite it to the abdominal wall, and one suture above and one below, carried through the sides of the abdominal wall and into the cyst wall, but not through, will complete the coaptation. If this much is accomplished without contaminating the normal tissues there is very little danger of septic peritonitis occuring, or septic inflammation of the abdominal walls. The drainage is so perfect that though suppuration in the remaining portion of the cyst may go on, there is not much danger of it extending outside of the sac. The drainage must be long continued and the convalesence is very slow, comparatively. In case the secreting surface of the cyst has been thoroughly destroyed by suppuration the recovery is usually not so long delayed. Contraction and closure of the cavity comes in a month or thereabout. If on the other hand a part of the secreting surface is left, the discharge may go on for months, but the patient meantime may regain her health and be able to attend to her duties comparatively. When a small pocket and sinus remain it will facilitate recovery to inject iodine or carbolic acid.

I may be prejudiced in favor of this mode of treating such cases, from the fact that I have had six, two intraligamentous cystomata and four adherent ordinary ovarian cystomata, which could not be removed, but were treated by drainage, and all of them recovered, while several cases of a similar character, treated by removal of the tumor, were lost.

Correspondence.

OUR PHILADELPHIA LETTER.

(From Our Own Correspondent.)

CLINIC BY WILLIAM OSLER.

A Case of Aortic Insufficiency, Interesting on Account of Influence of Treatment.

This case, a liquor dealer, presents the following history :—He has always been healthy, with the exception of rheumatism in 1861 ; he confesses to a chancre and bubo, although we lose all history of specific trouble beyond the starting point in this disease. These are the only conditions in his past history which we can bring out ; he has not been a hard drinker. His present condition is as following. His feet, legs and scrotum are œdematous ; he is in the condition of orthopnœa, his respirations are 48 to the minute ; his pulse is 96, regular, but feeble and collapsing. The cardiac apex beat is diffused in the fifth and sixth interspace, an inch outside of the nipple line, the impulse is not strong, but impresses one as being fluttering and ineffective. Dullness begins at the upper border of the fourth rib, beyond the nipple, to the left, and the sternum to the right. On auscultation we detect, at the aortic cartilage, a double second murmur. The sounds at the apex are very feeble. Watching the patient's breathing, shows that he has a Cheyne-Stokes breathing —the gradual increasing and decreasing rhythmical respiration.

This is this man's third attack of his heart trouble. The first was in '83, the second in '86, and the third in '89. In '83 he had shortness of breath on exertion ; in '86 he had it while at rest in bed. Under careful treatment, over which we will go again, he was relieved each time and enabled to perform his duties with more or less satisfaction to himself. In this attack we will give him eight to ten ounces of whisky daily, with