were several interesting papers on the proper time for removing pus tubes and the general feeling was that it was safer to operate during the interval than during the attack as is also the case in appendicitis. There was also a very warm discussion as to the relative advantages of the abdominal and vaginal routes for removing pus tubes and the general feeling was that it was easier and safer to remove them by the abdomen. As disease of the vermiform appendix frequently complicates pus tubes it was pointed out that the possibility of having to remove it in any case was a sufficient reason of itself to induce us to operate by the abdomen. Dr. Macan, of Dublin, laid great stress on the importance of making a careful bimanual examination under narcosis before deciding upon the vaginal route. Landau of Berlin was strongly in favor of the vaginal route even for bad pus cases and he has the courage of his convictions for I saw him removing the uterus and both tubes and ovaries by the vagina in a very bad case while I was in Berlin. One thing was very evident on this occasion, that while it is difficult to remove large pus tubes even after the splitting of the uterus in two and consequently sacrificing it, it is well nigh impossible to remove them through an opening in either the anterior or posterior vaginal vault without removing the uterus. Some years ago I attempted to do this and was compelled to abandon it by the vagina and to complete the operation by the abdomen. This combined operation by the vaginal and abdominal route was the subject of a long discussion at the December meeting of the British Gynæcological Society. Dr. Arthur Giles summed up the general opinion very concisely by saying that the *raison d' etre* of the vaginal operation was to obviate the necessity of opening the abdomen, and that there was nothing that was done by the combined method that could not be done by the abdominal alone; consequently it seemed to him that to open the abdomen after beginning an operation through the vagina was practically a confession of failure, it meant that the operator had found himself unable to carry out his original intention. It was not his experience that abdominal operations for pyosalpinx had a specially high mortality, for it happened that a rather large proportion of his cases of abdominal section had been for pyosalpinx and so far there had been no death among them. I might add that my own experience agrees with Dr. Giles, as I have often been agreeably surprised to see patients recover from the most serious operation for pus tubes when neither the assistant nor myself had thought it hardly possible.

Conservatism in gynæcology has been receiving a good deal of attention during the last few months. Up to within a year or two ago it was