who were moribund with obstruction of the bowels of nearly nine days' duration, one of whom died on the table and the other the same night.

In the first case, I felt at the time that her chances were *nil*, but after consultation with my colleagues, it was deemed right to give her the benefit of the doubt. As I only opened the abdomen 12 times in that year, that one case made my mortality 17, instead of 8½%. In the second case, which occurred the following year, the patient was a very old woman in the country, who had a strangulated femoral hernia for nine days. The bowel was gangrenous and broke at the slightest touch, and I opened the abdomen in order to remove enough of it to sew healthy intestine to the incision and so make an artificial anus. But her death had nothing to do with the operation. That case raised my mortality that year from 9 to 13%.

Where the operations were performed.—I have come to the conclusion that this makes very little difference, as far as the result is concerned, although the trouble and anxiety for the operator are very much greater in a private house. Of the 8 cases operated on in private houses, all of whom recovered with the exception of the strangulated femoral hernia case, above referred to, there were one abdominal hysterectomy, two very bad tubo-ovarian abscesses, one large hydrosalpinx, one ventrofixation, accompanied with curetting and amputation of the cervix and removal of large cirrhotic ovaries, one removal of very small sclerosed ovaries. Of the two performed at Strong's Hospital, both of whom recovered, one was a hysterectomy for a large fibroid, and the other the removal of a large cystic kidney by the abdomen. Among the 23 who recovered at the Samaritan, were one large fibroid of uterus, one large cyst of the ovary, three Trenholme operations, *i.e.*, removal of the appendages for fibroid tumors, two desperate cases of ventral hernia, and five cases in which, there being menorrhagia and a lacerated cervix and perineum and the uterus being retroverted and fixed by exudation, which at the same time cemented the tubes and ovaries into Douglas' *cul-de-sac*, it was thought best to remedy all these conditions at once, and the uterus was therefore dilated, curetted, the cervix and perineum repaired, the ovaries and tubes removed, and the uterus stitched to the abdominal wall. The highest death rate was at the Western, but that can easily be accounted for; first, because my earliest operations were performed there, and, second, because the worst cases happened to come there. The lowest death rate was at Strong's Hospital, and the next lowest at the Samaritan.

I have honestly tried my best to reduce my death rate, but not by selecting cases. If I had done so, my list would not have had to carry the two cases of obstruction of the bowel. But if this report is to be of any use, it must be absolutely accurate and reliable, and I have therefore put down every case of death. I have here a list containing the name and address of every woman whose abdomen I have opened, as I think it the duty of every one to throw his records open for inspection and verification.

In view of the constant efforts to reduce the death rate which the abdominal and pelvic surgeons are making, an examination of the causes of death has always been of the greatest interest to me. I would like therefore to analyze these 11 deaths, and see how many of them could have been prevented. My first death was a case of very large multilocular ovarian cyst, filled with colloid material and completely filling the abdomen, and adherent to nearly all the viscera. The pedicle was ten inches wide and had to be tied and cut in many segments. There was much oozing from the parietal and visceral peritoneum, which was however arrested by hot sponges. A drainage tube was inserted and a few hours afterwards, when the pulse had gained some strength, red blood began to come from the tube. It was hoped that it would soon stop, but as it continued next day, the incision was re-opened, when a tiny jet of blood was seen to be coming from a tear in the broad ligament between two ligatures. It was easily tied and the abdomen was washed out, but she was too weak to rally and died next day. This accident would probably have not occurred, had we then possessed the Trendelenburg posture, by the aid of which we can inspect every part of the broad ligament and place sutures on oozing points. The operation would hardly have been a serious one if it had been performed early enough.