right ovarian and the right uterine vesssls were secured in the same way as those on the left side. A posterior peritoneal flap was reflected back. An assistant now passed his finger well up in the anterior vaginal fornix, and using this as a guide the vaginal vault was punctured with sharp pointed scissors close to the cervix.

Taking this as a starting point the vaginal vault was gradually, by means of scissors, separated from its connection with the uterus. This was the most awkward part of the operation, and during its performance the right uterine artery was nicked below its point of ligature. It spurted for a few times in a manner sufficiently alarming for those concerned. It was, however, fortunately quickly secured with forceps and again ligated. As it was necessary to include a certain amount of tissue in the ligature, some fear was felt that the ureter might possibly be injured, but subsequent events showed that this was not the case.

Throughout the operation the ureters were not seen to be recognized as such. Several small vessels around the divided edge of the vault of the vagina bleed freely, and some of these were secured with long fine silk ligatures. The uterine vessels on both sides and the ovarian on one side were also secured with long silk ligatures, it being thought best not to trust to the catgut alone. All the silk ligatures were now brought down through the vagina and the peritoneal flaps were allowed to fall together, but the edges were not sutured. The vagina was packed with iodoform gauze, one strand being placed slightly through the opening in the vaginal vault. The intestines and omentum were replaced in position and the abdominal wound was closed, the peritoneum by a continuous catgut suture and the muscular aponeurosis and skin by interrupted sildworm sutures. The patient was put back to bed and was in very good condition considering that she had been under chloroform four hours. Although the operation was for various reasons a long one, the amount of blood lost was very small. The subsequent management of the case was left in the hands of Drs. Fraser and Deacon. The recovery after the operation was very satisfactory. The highest temperature recorded was 100 1-5°. Shortly after the patient was put to bed one hypodermic injection of 1-8 gr. of morph. sulph. was given, but no anodyne was subsequently needed. There was a slight vaginal discharge, but the gauze did not require changing until the fifth day. An evacuation of the bowels was secured about the same time. The abdominal sutures were removed about the tenth day. About the same time the first silk ligature came away from the vagina. The last one did not come away until the end of the fifth week, and to cause it to come away some elastic traction was necessary. The patient was able to sit up out of bed at the end of the fourth week.

At the present time, seven months after the operation, the patient expresses herself as feeling well. She is able to do a fair day's work. Has no pain, excepting a slight backache if she is on her feet most of the day, but a short rest in the recumbent posture soon relieves this. She has the hot flushes which are generally present after removal of the ovaries. The brownish pigmentation spots have mostly left her face; the abdominal cicatrix is firm. A digital examination shows the vagina to be closed in at its upper part by a slightly puckered cicatrix; there is, however, no perceptible shortening of the canal. There is no tenderness, nor signs of pelvic exudation, nor any tendency to prolapse of the vaginal vault. With the exception of a few doses of a laxative she has taken no medicine since leaving the hospital.

The specimen which I present for your examination consists of the enlarged uterus, the fibroid growth and the uterine appendages. It has been preserved in a solution of formalin, and as a result has become changed from a dark red