has never had any accident attending the operation. Although he has had no experience with Treves's cautery puncture, he does not think it suitable for glands deeply placed. In sinuses and scrofulous ulcers, he has had most excellent results from scraping out the parts with Volkmann's spoon.

Dr. Trenholme, of Montreal, read a paper on "Some Details of Uterine and Ovarian Operations." After describing the usual precautions that should be taken regarding the cleanliness of hands, sponges and instruments, he said that he prefers No. 1-20 shoemakers' thread to any other form of ligature. Before use the thread should be immersed for twenty-four hours in pure carbolic acid, and not put into water at all. In closing the abdominal wound, he uses silver wire for the deep sutures and horsehair for the superficial. He laid great stress on the importance of not enclosing any muscular tissue in the suture. He advised short incisions of two or two and a half inches. Muscle should never be cut in the incision, as it gave great trouble afterwards. The pedicle of the tumor should be ligated in small segments, and the large vessels should be ligatured separately and the ligature cut short. The cavity of the abdomen should be thoroughly cleansed with sponges, and drained when necessary. He allows his patient after the operation to move freely in bed; this favors the reposition of the bowels In uterine fibroids, when large, he always divides the mass in the median line, then each half is enucleated. The stump should be cut in shape of a V, and the edges brought together with a running suture and quilted with the shoemakers' stitch. He has found linseed-tea enemata of great service after operation; fomentations to the abdomen were also very beneficial. No after medicinal treatment is needed, except when there is vomiting; in this he has found sipping hot water useful, and also ipecacuanha in homœopathic doses. He uses the third dilution.

Dr. Macfarlane, of Toronto, would have liked to hear Dr. Trenholme say more about dietetics. In his operation he had found vomiting to be a very troublesome complication; warm water with a flavoring of brandy he had found of great services in these cases, also frequent small doses of Epsom salts as recommended by Lawson Tait. He never gave any medicine at all when there was any threatening of peritoneal trouble. He never used drainage unless the adhesions were extensive.

Dr. Kerr would like to know why Dr. Trenholme objected to including muscle in his sutures.

Dr. Shepherd, of Montreal, did not understand why an abominal wound should heal so differently from wounds in other parts. So far as he himself was concerned, in performing abdominal section he treated his incision as an ordinary wound. He used silk or catgut sutures, and passed them through the whole thickness of the wall of the abodomen; union invariably took place by first intention.

Dr. Fenwick agreed with the remarks of the last speaker. He always used silk sutures, and objected to horsehair, because knots made in it did not hold well. In treating the pedicle he first clamped it, and then tied all the large vessels; afterward, he tied the pedicle with the Staffordshire knot and removed the clamp. He had used hot water occasionally to cleanse the abdomen.

Dr Trenholme, in reply, said he spoke of interstitial fibroids. He formed the pedicle out of the labial borders of the uterus in such a way that he left the broad ligaments to sustain the pelvic viscera. He used the shoemaker's stitch to secure primary union. With regard to the external wound, he thought that the conditions found in the abdominal cavity existed nowhere else. It is of the greatest importance to secure primary union so that there shall be no subsequent hernia. For vomiting he used hot water over the wound, and ipecac in minute doses. In preparing the patient he avoided purgatives as much as possible. In cold he weather kept the extremities of the patient wrapped up in cotton-wool.

Dr. Shepherd, of Montreal, next read a paper on "Excision of the Tarsus in Tuberculous Disease of the Bone." He remarked that in cases of tuberculous and carious disease of the bones the necessity for amputation is not immediate, and it is the duty of the surgeon to endeavor first to remove the local disease before sacrificing the foot. The reader of the paper illustrated this principle by giving the histories of several cases. In one case, where there was disease of both feet, he removed on the right foot the cuneiform, scaphoid, cuboid, and bases of the metatarsal bones, and on the left, the lower end of the tibia, astragalus, part of the os calcis, the scaphoid, and cuboid. The result was excellent, and the patient, a girl aged seventeen, was able to walk about comfortably. In children amputation is hardly ever required.

Dr. Macfarlane believed this is the proper method of treatment and should be extended to caries of the spine. In dressing the wound left after excising tarsal bones he never stuffed the wounds with anything, but placed the foot in a good position and left the rest to nature.

Dr. Kerr, of Winnipeg, said that patients, after operation, should not be allowed to walk about too soon, as they are apt to have a splay foot.

Dr. Fenwick said he could mention a number of cases in which he had resected the tarsus with the happiest results. He related the case of a gentleman (a medical man) who had been wounded at the battle of Alma, and had carried the bullet in his heel for nearly thirty years. The os calcis was trephined, and the bullet removed, with result of a rapid closure of the cavity and a useful foot.

Dr. Kerr, of Winnipeg, read a paper on the