

it has ended, or may arise from the emptying of pus into the peritoneum from inflammatory action. The importance of not only preventing the entrance of such elements into the peritoneum, and of removing them before closing the abdominal opening; but also of giving them free vent during the period of convalescence, has attracted the attention of many ovariologists. It is my uniform habit to insert a glass drainage tube eight inches long, and varying in diameter from half to three-quarters of an inch, just above the pedicle and into the depths of Douglas's pouch, in every case except where there is absolutely no fluid left in the peritoneum. Should no fluid be left in the abdominal cavity, this tube should not be inserted, or if the operator be in doubt it should be placed in position and kept tightly corked. If fluid accumulation exist, or its occurrence be rendered probable by slight oozing from broken adhesions, the tube should be left uncorked, that serum and blood may drain away. If no increase of temperature mark the occurrence of septic absorption, nothing more is necessary than to keep this in place until all danger has passed away. Should septicæmia show itself, a gum-elastic catheter cut off near its end should be inserted as far as possible, the glass tube drawn up for an inch, and a stream of warm water containing one drachm of chloride of sodium and sixteen grains of the crystals of carbolic acid to the pint, gently injected by means of a Davidson's, or fountain syringe. No force whatever should be employed, but a free supply of water should be thrown in, until the return current come forth clear. When the temperature or pulse rises, and the other symptoms of septicæmia develop, such an injection should be practised once in eight hours. But without the tube is left from the time of the operation, it is difficult and sometimes impossible to reach the most dependent part of the peritoneum. In no instance have I seen evil result from this course, and hence I urge its employment."

"Septicæmia which I believe will in time be admitted to be the most frequent cause of death after ovariectomy, when once fully established, a most dangerous state. It is ushered in by dizziness; excessive muscular prostration; anorexia; great pallor; high temperature; small, rapid, and very weak pulse; sometimes a low delirium; dry tongue; and a sweetish odor of the breath. It is probably this condition which is so often alluded to as a 'typhoid state' after operations, and one cannot but suspect that many, if not most, of those cases quoted in Dr. Clay's tables as shock or collapse, occurring as late as the fifth, sixth, seventh, and tenth days, were really instances of this affection. The development of peritonitis and septicæmia should be carefully looked for. All the vital and physical signs which mark them should be constantly investigated, and their inception be met by appropriate therapeutic means. Septicæmia

being the result, first, of the decomposition, and second, of the absorption, of fluids in the peritoneum, is not likely to occur for several days, but it may take place in two or three weeks after the operation. If at any time the temperature should gradually or suddenly advance to 103°, 104°, or 105°, except just as the patient rallies from the immediate effects of anæsthesia and operation, fears should be entertained that peritonitis or septicæmia is developing. If it occur within four days after operation, it is likely to be the former. If after that time, the probabilities are greatly in favour of the latter. The pulse will usually become rapid at the same time whichever morbid condition is developing, and it must not be forgotten that the two are often combined. Let no one suppose that septicæmia once established becomes irremediable. Experience disproves this; it is the prolongation of exposure to absorption of septic elements that constitutes the great danger of the condition. This method of meeting in an efficient and satisfactory manner, the most fruitful source of danger after ovariectomy, I regard as second in importance to no other improvement which has been introduced since the discovery of the operation itself. It emanated from Dr. E. R. Peaslee, and has even now, I think, not assumed its legitimate position in the scale of importance."

This practice has not been very warmly accepted in Great Britain. English surgeons, proverbial for their slowness to adopt any new recommendation, have practised drainage only in cases regarded as desperate, or likely to prove such. On the Continent, however, it has been received with considerable enthusiasm, especially by the thoughtful German. But it is due to Prof. Carl Schröder, to say, that he doubts the utility of resorting to the use of the drainage-tube in many cases where it is now used. In a recent article upon this subject he remarks:

"Let me once more state my views precisely, that the exudation after ovariectomy is not in itself the cause of the septicæmia, but is on the contrary perfectly harmless unless it decompose; but that decomposition only occurs after infection, and that consequently the important point is not the removal of the exudation, but the avoidance of the infection. I should therefore decide upon drainage during the operation, only in case I believed—a state of things which of course should not happen—that the patient had become infected, or, in case decomposing masses from some suppurating cyst, e. g., had found their way into the abdominal cavity. Drainage of the abdominal cavity assumes a very different position as a therapeutic measure, against a septic peritonitis which already exists. For, although the exudation be neither the original