on gonorrhœa in women. The disease is much more frequent than is generally supposed. It nearly always leads to pelvic peritonitis and closing of the tube. As to treatment of cystic gonorrhœal salpingitis or pus tubes, he thinks that the appendages from both sides should be removed when the woman is near the menopause or has already had several children, even if one side is apparently healthy.

Hanks (Ibid) gives the following rules to be followed in order to prevent secondary hemorrhage from the pedicle after ovariotomy: Separate and ligate the arteries, and then quilt the pedicle with strong ligature. In smaller pedicles the needle is to be passed to one side of the artery, care being taken not to split the vessel. In tying with catgut the first turn should be single and the second double; but with silk the procedure should be reversed, the first twist being made double and the second single.

Grandin (Ibid) brought forward the advantages of *accouchement forcé* in certain obstetrical complications, notably in uræmia. Where care as to cleanliness has been taken, he claims there is no risk about it. It has been urged against it that it endangers the cervix, but he thinks that the advantages of a rapidly terminated labor with a live child and mother safe would warrant some risk to the cervix.

Dr. B. F. Baer, at the last meeting of the Gynæcological Society, read a paper on supra-vaginal hysterectomy without ligature of the cervix in operating for uterine fibroids. The mode of procedure in the new method is as follows: the abdomen is opened, and the tumor, freed of all adhesions, is lifted out of the abdomen. The patient is then placed in Treudelenburg's posture. A single silk ligature is passed through the broad ligament near the cervix and again through near the outer side to prevent slipping, and tied. A pedicle forceps is placed on tube and ovary. The ligament is then cut near the forceps close to the tumor. Both sides are thus treated and the knife run around the tumor making a light cut. The peritoneum is then stripped down and the uterine arteries located and tied. This should be done near the cervix. The tumor is removed and all the supra-vaginal portion of the cervix cut away. The stump drops deep into the pelvic cavity covered by the peritoneal flaps which are joined by Lembert suture. He claims that there is no hemorrhage and no sloughing for there is no tissue constricted to slough.

The chances of contamination of the abdominal cavity are reduced to a minimum, as are also the dangers of hernia.

Dr. Palmer read a paper at the same meeting on inter-menstrual pain coming on from 16 to 18 days after menstruation with an average duration of 9 days. He thought it was due to some obstacle in the way of the discharge of a Graafian follicle due in most cases to thickening of the cortex or outer layer of the ovary. If other means failed, removal of the ovary was advised. Nothing was said about either fine wire faradism or galvanism with which most of these cases can be cured.

Gusserow (Archiv fur Gynäcologie) divides cases of ascites which come under the observation of the abdominal surgeon into four classes—those due to tuberculosis, to papilloma of the ovaries, to malignant disease of the ovaries and peritoneum, and to non malignant disease of the genital organs. He is strongly in favor of exploratory incision, not puncture, as he says it is impossible to distinguish them otherwise, while many of them will be found to be due to causes which can be removed and a cure effected.

[I recently reported a case to the Medico-Chirurgical Society of Montreal of enormous ascites in a woman of fifty-six who was dying from the pressure of the fluid interfering with the heart's action. About