not easy, and still a diagnosis must be made upon a rapid inspection and palpation. Moreover, upon a prompt decision, regarding the exact conditions and how to manage them, depends the success of the surgeon in incomplicated cases. To do all this promptly, considerable training is required which can only be obtained by seeing and handling such morbid growths. This is the opinion that I have formed after having had my share of trials and vexations. I have also seen, in the practice of others, much confusion and delay in making a diagnosis and in deciding how to proceed with the treatment, all of which, increases the risk to the patient.

I am not confident that I have seen or carefully thought of all the conditions which may simulate intraligamentous ovarian cystomata, as seen after the abdomen is opened, but I have encountered a number and shall briefly state what I have observed and how they may be differentiated.

(*To be continued.*)

EARLY OPERATIONS IN DISEASES OF THE ABDOMEN OF DOUBTFUL DIAGNOSIS.*

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The number of fatal cases variously diagnosed as Peritonitis, Intussusception, Volvulus, Perityphylitis, etc., that at different times have come under my notice, induces me to bring this subject before the Association.

In the majority of these cases the diagnosis was not verified either by operation or post-mortem examinations. Nearly all were treated in the orthodox way without any operation having been attempted.

Our leading surgeons at the present time do not hesitate to open the abdominal cavity in nearly all cases where the diagnosis is not clear, and a very large percentage of their reported operations are attended with success ; but in the country, and probably in some towns and cities, many patients still die without having even the chance for recovery that an operation might give them. The statement was made at this Association last year in one of the discussions, that no one should attempt a laparotomy, or any similar operation, without previous experience, so that in every case a man skilled in that branch of surgery should be called to operate. This statement should no doubt stand unchallenged for cities and large towns where experienced surgeons are at hand, but in country districts, especially among the poorer classes, if the necessity for such an operation presented itself, the attending practitioner or some convenient consultant must undertake the operation.

The diagnosis of the exact anatomical cause of acute obstruction is seldom possible, and where it is persistent if an operation were at once performed the chances of success would be increased. I will relate two cases of obscure abdominal disease which although resulting fatally from too long delay in operating may, I hope, draw forth some expressions of opinion from those who have had experience in abdominal surgery; and may encourage my fellow country practitioners so that some fellow-being suffering from a similar disease may be given that chance to recover.

CASE I.—Mrs. S., aged 62, an active little woman, mother of a large family, had a femoral hernia of right side and had suffered occasionally from intestinal colic, for both of which troubles she received medical treatment. She was taken ill Dec. 29th, '87, with moderate abdominal pains; on the 30th inst. I was called in and found her suffering considerable pain, chiefly in the right inguinal region; pulse and temperature almost normal, bowels inactive, no flatus passing; bowels usually constipated. The abdomen not distended, not tender, hernia, causing no trouble, tongue coated a dirty yellow, some nausea. I administered the usual remedies and found her more comfortable in the evening ; nausea however increasing with some vomiting.

31st inst. Persistent pain, bilious vomiting, quickness of pulse and slight elevation of temperature, no movement of bowels although enemata were administered and other treatment faithfully carried out. Sunday, Jan. 1st, '88, symptoms aggravated ; she began vomiting fæcal matter ; the heart, which in health had been intermittent, became more irregular in action, and pulse feeble.

Jan. 2nd.—Vomiting profuse and stercoraceous, pulse intermittent and weak, temperature 100°. Dr. McLaughlin, of Bowmanville, saw the case with me, and was fully agreed as to treatment and

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