Joseph Price, who, as I have said, has recently reported a run of 26 consecutive cases, without a death, and who, at a recent meeting of the American Association of Gynecologists, stated that when he was in doubt, he always drained, and significantly adds he always tried to believe himself in doubt.

Some objections have been made to the use of the drainage tube, but they are mostly theoretical, and easily disposed of, the principal one being the risk of hernia following removal of the tube. This can easily be guarded against, by placing an extra loose suture in the middle of the space to be occupied by the tube, and which on the removal of the tube can be drawn tight and tied. I have never seen hernia follow a case in which the drainage tube was used for a few days, while I have seen several cases of hernia in cases in which it was not used at all.

The other objection is, that it may cause injury to the intestines, especially the rectum by the pressure upon it, but if care is taken to use a tube just long enough to dip into Douglas' cul-de-sac and no more, and to use no compression upon the external extremity, but, on the contrary, to leave the tube floating freely in the cul-de-sac, there will be no danger from this source. In some cases, I believe, death has followed the removal of the drainage tube while oozing was still going on.

The rule to follow is: As long as the amount of fluid pumped from the tube exceeds one drachm for four hours, the drainage tube should be left in.

I see only one possible improvement on the extra peritoneal treatment of the stump, and that is to have no stump at all. Two or three methods have been suggested and put in actual practice of attaining this object. One consists in first removing the bulk of the tumor by abdominal section, after having placed an elastic ligature around the cervix; then dropping the stump into the pelvis and temporarily closing the abdominal wound; and then proceeding to remove the stump by vaginal hysterectomy, which, owing to the much smaller bulk to be removed, is very much easier than vaginal hysterectomy in any other condition. In doing this, lock compression forceps may be used to arrest hæmorrhage from the remains of the broad ligament, and considerably shorten the duration of the operation. This, I believe, is destined to become the ideal operation for the removal of large fibroids. It was first advocated, I believe, by Dr. A. Mary Dickson Jones, of Brooklyn, who recently sent a communication in which she reports several successful cases in which this method was followed. The operation has not been done, however, often enough to speak so decidedly about it as we can about the extra-peritoneal method, and, therefore, until the combined method of abdominal and vaginal hysterectomy has been more thoroughly tried, I urge upon any who do hysterectomy for fibroids at all, to use the safe and in every way satisfactory method of the extra-peritoneal treatment of the stump.

RHEUMATIC HYPERPYREXIA.*

BY J. GILLIES, M.D., TEESWATER, ONT.

My object in presenting the above subject to this Association is to show the great value that I found in the "cold pack treatment" in this most formidable complication of acute rheumatism. All cases of rheumatic fever that I had met with in my practice complicated with hyperpyrexia, had hitherto proved fatal previous to my adopting this mode of treatment—and this has induced me to bring this most dangerous complication before this Association. The symptoms of such a condition, which were usually supposed by the older writers to be a sudden metastasis of the rheumatic inflammation from the joints to the brain, are as follows:

The patient becomes restless, irritable, excited and wakeful; there is great thirst with a dry, brown tongue; the skin becomes dry and burning, or, more frequently accompanied by profuse perspiration. The joint pains may persist or may suddenly cease. There is acute delirium followed by stupor, coma, and sometimes by convulsions. The temperature rises rapidly towards a hyperpyrexial point and ranges from 104° to 110° or 112° in a few hours. As a rule the degree of pyrexia in rheumatic fever bears some proportion to the number of joints affected and to the intensity of the inflammation. The onset of complications is usually attended by a rise in the temperature, but this is never great unless the case turns out to be one of hyperpyrexia with delirium.

* Read before the Ontario Medical Association, June, 1890.