method that could not be done by the abdominal alone; consequently it seemed to him that to open the abdomen after beginning an operation through the the vagina was practically a confession of failure, it meant that the operator had found himself unable to carry out his original intention.

It was not his experience that abdominal operations for pyosalphix had a specially high mortality, for it happened that a rather large proportion of his cases of abdominal section had been for pyosalphix and so far there had been no death among them. I might add that my own experience agrees with Dr. Giles, as I have often been agreeably surprised to see patients recover from the most serious operations for pus tubes when neither the assistant or myself has thought it hardly possible.

Conservatism in Gynaecology has been receiving a good deal of attention during the last few months. Up to within a year or two ago it was the custom to remove both tubes and ovaries whenever one tube was diseased, even though the other tube and both ovaries were apparently healthy. When this was done in young women the artificial menopause brought on so suddenly was accompanied with great inconveniences, so much so that many of these young women declared that they regretted having had the operation performed. This led to remove only the tube and the ovary on the affected side and although we occassional were reproached for not making a complete cure by removing both, mostly in cases of sclerotie ovaries, yet these cases were much fewer than those who complained of the miseries of the premature menopause. More attention was then directed to the matter and now we frequently leave both ovaries in even where we have to remove both tubes for suppuration. Nearly a year ago such a case came under my care; a young lady who was infected by her fiancee with gnorhoea leading to two very large pus tubes. He so regretted his crime that he was anxious to make amends by marrying her and she begged that I might leave her ovaries. The pus tubes were therefore removed without tying the ovarian artery or otherwise hurting the ovaries except that the adhesions were stripped off them and they were carefully cleaned. This patient made a splendid recovery and is now very happily married. She menstruates regularly and normally and has all her womanly feelings and attributes. As I used catgut to tie off the tubes at the corner I would not be surprised to learn that she had become pregnant. In many other cases I have removed three-quarters of one or both ovaries and and a part of one tube with very satisfactory results. As many of these were done during the last few months it is too soon to expect them to become pregnant, but there is no reason why this should not occur. Since beginning this article I have operated on a lady for retroversion with fixation who was most anxious to have children. I found both tubes closed and imbedded in adhesions, the result of a severe attack of pelvic peritonitis from which she nearly died eight years ago. Both ovaries and tubes were torn almost to shreds by the enudations and nearly an hour was spent in patching them up with fine silk; but finally a good tube was left through which a prob could be pressed into the uterus. She is making a remarkably pleasant recovery from the operation and I have yet hopes of her becoming pregnant.—250 Bishop Street, Montreal.