by skilful hands and all necessary precautions, a perfectly safe operation.

The remaining tube should not be removed—*i.e.*, the tube not the seat of fetation—as has been recommended by some to prevent a recurrence of pregnancy in that tube, unless it is markedly diseased. Removal of it became necessary only once in the four cases operated on for ectopic gestation by him. Two cases subsequently became pregnant, one has been delivered of two living children, and another is now in her seventh month of pregnancy.

Dr. Florian Krug, of New York, gave a short historical sketch of the employment of

TRENDELENBURG'S POSTURE IN GYNECOLOGY.

Dr. Krug witnessed a suprapubic cystotomy done in this position by Dr. Willy Meyer, formerly Prof. Trendelenburg's assistant. He was immediately impressed with the great advantages this method offered for abdominal work and at once set out to make use of it. He has since done over one hundred and fifty laparotomies in this posture, and has induced a great many operators on this side of the Atlantic to adopt it.

Dr. Krug claimed the following advantages for the method: If the patient's pelvis is raised up so that the symphysis forms the highest point and the body comes on an incline of at least 45° to the horizontal, all the viscera of the abdominal cavity will gravitate towards the diaphragm and the pelvis become free and easy of access. The small intestines will hardly come into view and never trouble the operator during the operation. The operator is enabled to see everything that he is doing and need not grope about in the dark. All bleeding points are readily detected and tied. In weak and anæmic patients the posture is a great advantage, preventing shock from acute anæmia of the brain. In all his operations he had never found any objectionable point or disadvantage in this posture. There are different ways of putting the patient in this position, very simple and very complicated ones. In most of his operations he had used the head-rest of an operating table, to which cushions were fastened with straps. Trendelenburg himself has had a very complicated operating chair constructed which answers all requirements. Several new devices have been brought out in New York lately.

Dr. Krug had lately constructed a frame of galvanized iron which can be screwed to any laundry or operating table. The upper part of this frame is covered with sailing canvas, a material which is durable, easily sterilized, and cheap. Straps are provided for the knees and ankles of the patient, whose pelvis can, by a simple mechanical arrangement, be elevated to an angle of 45° to 60°, and lowered again if required. The frame can easily be carried or taken along in a street car, and can be used on any kind of a table; it is easily cleaned and sterilized, and it is cheap.

Dr. R. T. Morris, of New York, said that those who had once seen an operation in this position would appreciate fully the great value of Trendelenburg's invention.

Dr. H. O. Marcy, of Boston, presented photographs showing a modification of the Trendelenburg chair.

Dr. J. H. Carstens, of Detroit, spoke of the danger of atmospheric infection from the air rushing into the abdominal cavity, as had been stated was the case as soon as the abdominal walls were opened. He considered that that would be a decided objection to the Trendelenburg position.

Dr. Willy Meyer, of New York, replied to Dr. Carsten's objection that the danger from atmospheric infection would be very slight, certainly no greater than in amputations and similar open work, in which cases he always expected union by first intention. He then gave a demonstration of the Trendelenburg posture on a table after Trendelenburg's original model that he had imported.

Dr. Krug, in closing the discussion, said that ever since he had used the Trendelenburg posture he wondered how he ever got along before. He considered that it would be a pretty fine distinction between the amount of air which entered the abdominal cavity in this posture and that which enters in ordinary operations. He had used the operation in from one hundred and fifty to two hundred laparotomies, and was willing to match his results with those of anybody else who operates in a horizontal position.

Dr. Rufus B. Hall, of Cincinnati, read an essay upon

SUPPURATING CYSTS DEVELOPED FROM ADHERENT OVARIES AFTER REPEATED ATTACKS OF INFLAMMATION; AND SECONDARY OPERATIONS FOR REMOVAL OF DOUBLE INTRALIGAMENTOUS CYST.

His conclusions were to the effect that, if these cases were operated upon early, just as soon as the physician was certain that nothing but an operation could bring the hoped-for relief, the operator would not be called upon to treat such desperate cases as those reported. No operator is justified in leaving an abdominal operation incomplete, except in malignant desease, for the reason that all other growths can be removed, and it should be done when once attempted. As long as the general practitioner persists in pursuing what he pleases to call conservative treatment in these cases, and keeps the patients under his care just as long as he can keep breath in them, and surgeons of the older class turn these patients from their consulting rooms as non-operative cases and thus defer it, or the cases made still more complicated by incomplete operations, men engaged in this special work will continue to see just such desperate cases. While this state of affairs exists, what can we hope for other than a high mortality in these delayed cases, and who should be held responsible for the deaths? (See page 470, THE CANADIAN PRACTITIONER.)

Dr. M. Rosenwasser, of Cleveland, wished to protest against the assertion that these intestinal adhesions were due to the first operation. Intestinal adhesions are common to the broad ligament, and not to the cyst, and will be found there whether you operate the first time or the second time. He also wished to contradict the assertion that these cysts ought to be removed. It is better occasionally not to attempt removal. In some cases it is better to stitch the cyst to the abdominal wall and drain, leaving the cyst wall alone.

Dr. H. O. Marcy, of Boston, said that in a certain class of cases he had felt that we must stitch and drain. In another class of cases you can