with some difficulty. In lifting up the mass, I broke into an encysted collection of dark fluid blood and clots behind broad ligament. The distended tube coiled around an enlarged, degenerated, cystic ovary was then lifted up and ligated close to uterus and cut away. After tying several bleeding points in omentum the pelvic cavity was carefully sponged out, and abdominal wound closed by through and through silk worm gut sutures, after splitting recti and turning out flaps so as to bring together from each side a broad, raw, muscular surface. The abdomen was closed without flushing or drainage. Recovery was uninterrupted. The abdominal sutures were left in over two weeks, and there was no sign of irritation about any of them when removed. There has been no recurrence of the ventral hernia since. The tube was found on examination to be distended with dark fluid blood; its fimbriated end closed, but uterine orifice open.

Remarks.—Although neither fœtus nor placenta were found at my operation, and though Dr. Howitt did not state in his letter to me that either fœtus or placenta had been found at his operation, yet I am inclined to think that the condition of things found at each operation was the result of ruptured tubal pregnancy. The encysted collection of blood behind broad ligament in my operation is, I think, strongly in favor of this view.

It is interesting to notice, that when Dr. Howitt operated for removal of right tube, the left ovary and tube were apparently healthy; and this brings up the question which has frequently been under discussion before, as to whether, in an operation for removal of ruptured tubal pregnancy of one side, it is right to leave behind in the pelvis the opposite apparently healthy appendage. I think it is generally acknowledged that tubal pregnancy is likely to recur in the opposite tube if left. In one case, reported by Tait, with which most of you are familiar, a normal pregnancy in uterus intervened between operation for ruptured tubal pregnancy on one side and interstitial pregnancy on the other. With this experience before him I have seen Tait leave the opposite tube in a case in which I assisted in the operation for ruptured tubal pregnancy.

In the case I have reported, the patient was very anxious for children and did not wish, if it could be avoided, to be deprived of the possibility of becoming pregnant, so that under these circumstances, I think Dr. Howitt was justified in leaving the opposite tube and ovary.

In connection with this case, I have just one word to say on the subject of flushing and drainage. A few years ago I would have considered it unsafe to close the abdomen in such a case without drainage, but it is just such cases that teach us that the closed peritoneum can dispose of a little blood, etc., that may be left, much better than if we should flush and drain. Drainage in this case would probably have interfered with the result desired, viz., cure of the ventral hernia.

Case III.—Suppurative appendicitis and peritonitis acute. Incision and drainage, followed twenty-three days later by discharge of gangrenous appendix through abdominal wound.

On Saturday, January 13th, 1894, I was called by Dr. Cline, of Belmont, to operate on a case of suppurative appendicitis. Patient, young lady æt. nineteen years, living on a farm near Belmont, was taken ill on Tuesday previous with abdominal pain and vomiting. Dr. Cline saw her on Wednesday and gave her a laxative dose of castor oil and opiates to ease pain. Bowels moved well from oil, and next day, Thursday, she felt very much better and got out of bed. Friday she was worse again with more pain, and rising pulse and temperature. Saturday, a.m., temperature 102° F., pulse 120.

With Dr. J. B. Campbell, of London, I arrived at house about 3.30 p.m., and found temperature 102° F., pulse 160; sick stomach. She was partly under the influence of opiates so that she was not at the time suffering much pain. Abdomen was distended and tympanitic. An indistinct thickening could be felt in region of appendix. From condition of patient immediate operative interference was called for. Chloroform administered by Dr. J. B. Campbell, and assisted by Dr. Cline, I again examined under anæsthesia before operating. Through abdominal wall thickening could be felt somewhat more distinctly.

Per Vaginam.—A mass could be felt to right of retroverted uterus in location of right Fallopian tube. I made an incision through abdominal wall just inside of spine of ilium about three inches long, down through muscles and fascia to peritoneum.

Before going further, I again examined with