conjunctiva, how its virulence depended upon the amount of invading poison, how the conjunctival secretion was inimical to the poison, and how the quickness with which the eye could close, making it difficult for the finger to touch the conjunctiva, was the reason it often escaped infection. He gave an elaborate description of the various symptoms, both of the earlier and later stages, and also of the sequelæ and complications. He advocated general, as well as local treatment. At first he would treat with antiseptic lotions with cold, and later by astringents, if called for. If the cornea became infiltrated centrally he would advise atropine: if circum-corneal eserine would do good. Opium should be given if the pain called for it. Antiseptic midwifery was doing much for the prevention of ophthalmia neonatorum. Its treatment was similar to that of the other. Prevention in both was better than cure. Doctors should advise all patients to be exceedingly careful as to cleanliness. The pregnant woman, if she has any discharge should be treated before delivery. This was the most fruitful cause of blindness. In the institution for the blind in Brantford, sixteen of all cases of blindness were traceable to ophthalmia neonatorum.

The next paper handed in was written by Dr. Gross of Fergus. It was a case of a young woman, her first confinement, under Dr. Chisholm, of Wingham. She had been in labor two days and two nights, when Dr. Groves arrived he found her much exhausted. A solid bony tumor filled the pelvis the anter-posterior diameter of which was less than an inch. An operation was decided upon, although the surroundings were unfavourable. They incised on the right side, paralled to pourpart's ligament, commencing close above the symphbsis pubis and extending six inches, a sound being passed through the urethra into the emptied bladder. The section was continued into the vagina, and the child, a strong healthy girl of average size extracted. The mother died, but the child lived. The doctor said this operation was much safer than Cæsarean section. He concluded by saying that it was never justifiable to deliberately destroy one human life when there was reasonable hope of saving both.

Dr. P. P. Burrows, of Lindsay, then read a paper on "Treatment of Talipes Varus by contin uous extension." It was unnecessary, he said, to enter into an anatomical description of this deformity, as he had entered fully into the question in a case reported in the "Canada Lancet," June 1887. In the case reported he divided the contracted tendans the plantar afscia and muscles. Next morning he applied a plaster Paris splint, with cotton batting padding. After ten days a small portion of the splint below the ankle joint was removed, the foot, over-corrected, and fresh plaster secured it in the new position. In thirty days he removed the splint and found the limb perfectly straight. He then had a laced boot put on, stiffened on its inner side.

Dr. Powell, of Ottawa, asked what age the child should be before the tendons should be cut.

Dr. Burrows said that in the child reported the age was four.

Dr. Bryans asked how long the plaster Paris splint should be left on in a marked case. Dr. Burrows replied that he left it on thirty days.

Dr. Sullivan, of Kingston, asked Dr. Burrows how many cases he had used traction on. He also wanted to know if he would operate before the fourth year. The doctor thought that great deformities could not be overcome before the fourth year by traction, nor could talipes varus be overcome, where there was contracture of the tendons, etc., without section. Dr. Burrows said that a moderate case of talipes, if left untreated, became much worse if left long, as a result of contraction. He thought counter extension rational treatment.

Dr. B. E. McKenzie then stated that different specialists had different modes of treatment. He thought no one line of treatment could be adopted for all cases. He said that in children he was cutting less than formerly, and that he never cut the tendo-acchilles under the one year. Often in talipes time was lost in extension when the knife should be used.

Dr. Temple's paper came next. "A few brief remarks on some of the details which lend success in Abdominal Surgery." One secret, he said, was attention to details, another was experience, another was a good knowledge of the peritoneum and more especially of its delicate epithelial coat. The instruments should be be sterilized, the surgeon's and his assistants and nurses hands should be carefully cleansed; the sponges should be boiled and the abdomen around the place for incision made aseptic. It was not necessary as was done formerly, to completely dry the peritoneal cavity, the sponging was often done too vigorously, causing inflammation of the delicate membrane. Where it was indicated, Dr. Temple would flush out the cavity with plain boiled water, moderately hot. This had not only a cleansing, but a general stimulating effect, as well as being helpful in arresting hæmorrhage. He advised the drainage tube in those cases where there had been adhesion with more or less oozing and to be removed within the next forty-eight hours, depending on the color of the fluid. He had not had a case of hernia follow its use. He was not in favor of giving opiates after the operation. No food should be given for twenty-four hours. To relieve thirst a couple of ounces of water with a little salt in it was useful as an enema. The patient should be kept warm. If tympanites appeared he would give calomel followed by mag. sulph.