all that could be desired. She left the hospital twenty-one days after the operation and travelled some forty miles home with but little fatigue.

CASE III.—Mrs. W., aged 28. Married seven years, no children. One miscarriage five years ago, followed by "inflammation." Since that time she had complained of pain in left side and back, but was able to do housework. Examination showed retroversion with adhesions. Anterior colpotomy (vaginal section) was done, the adhesions which bound the uterus to sacrum and rectum were broken down with the finger passed through the vaginal incision and over the uterus, the ovaries and tubes aside from adhesions were normal. The uterus was then antiverted and attached to the anterior vaginal wall (vagino-fixation). Patient left hospital on the tenth day.

CASE IV.—Mrs. C., aged 24. Nullipare. One year ago I removed a pustube and septic ovary through the posterior cul-de-sac. On account of the narrow and deep pelvis, with great muscular development, the operation was difficult, in fact it was a mistake to attempt vaginal work in this case. The right ovary and tube appeared normal and were not molested. The present sickness was a typical acute septic salpingitis. After waiting until the active stage had passed, I opened the abdomen and removed one-half of the ovary which was cystic and disinfected the tube as much as possible hoping to save it, but upon passing a probe through the funbriated end the tube was found impervious, and removal was decided upon. No drainage, convalescence normal, left hospital on ninth day.

CASE V.—Mrs. W., aged 26. Married, no children. One year ago she noticed an enlargement in lower abdomen, which gradually increased in size. Menses had been regular and painless with exception of one intra-menstrual hæmorrhage in July and an excessive menstruation in December. She had occasional discharges of large masses of thick mucus. Was examined by several medical men in an adjoining city, and the tumor pronounced non-removable but would probably become absorbed. Examination showed uterus crowded to the extreme right, pelvis and lower abdomen filled with a semi-fluctuating mass. The diagnosis lay between a cyst with thick tense walls, or a semi-solid fibroid. In either case, considering the age of the patient, operative measures were justifiable. Abdominal section showed the mass to be fibroid with immense varicocele of ligaments and enlarged and cystic ovaries. The whole mass was removed (pan-hysterectomy) and drains inserted through abdominal wound and into the vagina. Abdominal drain removed second day, vaginal drain on sixth day. Temperature did not exceed 100 2-5. Excellent convalescence, remained in hospital five weeks.

CASE VI.—Qui For, Chinese, aged 28. Married, no children. This patient, when a girl, was rescued from the slavery which exists among this race of people, and educated in the Methodist Mission school. Being subject to that common to all races, she married Cha Hong, also one of the "Mission," but alas for the frailty of poor humanity, the ubiquitous gonococcus found lodgment in both urethra and joints, and Cha Hong was rendered *hors de combat*. During his sickness he was supported by faithful Qui For until she too fell a victim to gonorrhœal infection. The patient complained of great pain in lower abdomen, increased under pressure, worse upon right side, with right rectus actively on guard. Constipation and vomiting. A vaginal examination gave no definite information. As the local indications were suggestive of appendicitis, I determined to open the abdomen at once. The appendix was but slightly congested, but was summarily disposed of. The pelvis was examined through the same opening and an acutely inflamed and distended pustube removed from the opposite side. The pelvis was thoroughly flushed and drain inserted. Patient made an excellent