to be hereinafter noted, must be adopted. Occasionally, though rarely, the cyst wall is so thin and fragile that the separation is difficult or impossible. Again, in case both ligaments are split up and the cyst lies between the uterus and the bladder, it is difficult to separate the cyst wall and the uterus, and the bleeding is often difficult to control, but in the majority of cases these are not insurmountable difficulties. In regard to the process of enucleation, I hope to be pardoned if I give some of the details with which you are familiar. They will be important in the way of making the description complete if nothing else.

In the first place, it is important to tap the cyst high up, in order to avoid wounding the thickest portion of the broad ligament. To do this it is sometimes necessary to extend the incision in the wall of the abdomen higher than may at first appear necessary. The cyst being emptied and drawn well out of the wound, the separation of the ligament and cyst wall should be begun at the point highest up, where the ligament is so thinned out as to be hardly noticeable. When the dissection is begun all round, the capsule can be lifted up and the separation continued by gently forcing a sponge between the tissues, and finally the deeper portions can be separated by the finger.

When the dissection has to be carried deep into the pelvis it is a great help to "pass one hand into the cyst as a guide, and continue the enucleation with the other" (Keith), the assistant making the necessary traction, which should be made upon the cyst wall, as the capsule is easily lacerated. If an opening is accidentally made in the capsule, it should be carefully closed with fine catgut sutures, applied upon the peritoneal side. The management of the ligamentous capsule after the cystoma is removed should first be directed to the control of hæmorrhage. In some cases a general oozing, which pressure will stop, is all that there is, but usually there are wounded vessels which need ligating. When the cyst extends deep down into the pelvis there is often very troublesome bleeding from veins. These should be ligated if possible, but this cannot be done in all cases. Pressure with a hot sponge should then be tried, and if that fails, styptics may be employed. The parts now present a pouch the inner surface of which is raw, and from which there will be some bleeding and much serous oozing. This calls for drainage and to do this the cavity should be closed, so as to cut it off from the peritoneum. The redundant tissue, which is frequently great, owing to the growth of the broad ligaments, should be treated as follows: The upper portion of the opposing sides should be folded in so as as to bring the peritoneal surfaces together and these should be united by a continuous cat-gut suture. The suturing should begin on both sides and close the parts, except at the points directly beneath the abdominal wound, where space should be left for the drainage tube. If the folds of the ligaments, thus held together by sutures, can be brought up to the lower angle of the wound, they should be fixed to the peritoneal surface of the abdominal wall by silk sutures, passed through the ligaments on each side of the opening for the drainage tube and through the wall of the abdomen. When the ligaments cannot be brought up to the wall of the abdomen, a drainage tube without side openings, should be carried down to the bottom of the cavity and fixed in the abdominal wall. The rule of practice has been to bring the whole mass of capsule into the abdominal wound and fasten it there in order to make sure of completely cutting off the sac in the ligaments from the peritoneal cavity. There are objections to this method, which more than outweigh the safety. It leaves a mass of tissue in the abdominal wound which inclines to break down and cause sepsis, and there is great liability to ventral hernia afterwards. I therefore, prefer the method described, believing it to be as safe and certainly more favorable to prompt healing and future results.

While this mode of treatment is perfectly satisfactory in suitable cases, there are difficulties attending the operation in exceptional circumstances and consequently certain dangers. The cyst wall may be easily torn and hence the danger of leaving a portion of it. When this happens it is necessary to destroy the secreting surface of that which is left. This may possibly be done by applying the cautery or pure carbolic acid, but it increases the liability to suppuration and renders the convalescence more tedious.

The next method of treatment is to remove the cyst and capsule together, by ligating the ligaments below the cyst.

This method is adapted to those cases in which the cyst is situated in one broad ligament, and