go with her physician to consult Dr. Goodel about a very large ovarian tumor, which had been tapped several times, and which consequently was very adherent to the abdominal parietes. After confirming the diagnosis, Dr. Goodel recommended immediate removal. Her family physician then said that he always made a point of allowing his patients to choose the operator, and in this case the patient had chosen him, her family doctor, to perform it. Dr. Goodel wished him success, but what he came back for was to ask Dr. Goodel if they used the clamp now. As this was his first case, no wonder that Dr. Goodel was indignant. In a recent paper by Dr. Matthew D. Mann, of Buffalo, he gives his record, which alone is an answer to my question. In his first fifty cases he lost eleven, in his second fifty only five, and in his third fifty he only lost one. This is the experience of nearly all operators, and such being the case, I maintain that a man who in all probability would never have occasion to perform abdominal sections more than two or three times in his life is not justified in doing it at all. It cost eleven lives in Dr. Mann's first fifty, and five in his second fifty, in order to save forty-nine out of the third fifty.

I hope I will not be misunderstood; I do not wish to prevent anyone from becoming a laparotomist. I would only prevent those who have no intention of becoming laparotomists from doing laparotomy. This consideration has prevented me from doing at least a dozen operations, which consequently passed into other hands, because I had not decided to devote myself specially to this work.

To resume the report of my cases. My second was Mrs. M., æt. 28. First began to menstruate at 15, always regular till marriage at 20. No children. Contracted syphilis soon after marriage. One of the results of this was ulceration and stricture of the rectum. For this she was treated with constitutional remedies, and on several occasions the stricture was dilated under an anæsthetic by Dr. Perrigo, who kindly sent her into the Western Hospital under my care Jan. 15. After one of these dilatations he told me that she imprudently exposed herself and caught cold, accompanied with pelvic peritonitis, which confined her to bed for several weeks. On examination I found a stricture which would not admit the tip of the finger, but besides that there was a swelling in the left broad ligament, which was painful on pressure, and there were daily evacuations of fetid pus from the rectum, and high temperature every night. She was unable to eat or sleep. She was unable to do her work, the slightest exertion causing her so much suffering that she was obliged to go to bed. I came to the conclusion that there was a pelvic abscess communicating with the rectum. Several interesting questions come up in such cases. Was the stricture of the rectum the cause of the abscess? or was the abscess the cause of the stricture? What is the best thing to do? Shall we try to find the opening into the rectum and enlarge it and drain and wash out with iodine and water? Is it any use washing out the rectum with solutions of iodised phenol? Shall we dilate the stricture first and attend to the pelvic abscess afterwards? Or shall we leave the stricture alone for the present and attend to the abscess? Then, again, how shall we treat the abscess? By drainage into the rectum? By drainage into the vagina? Or by drainage through the abdomen? These are questions I have been asked by former students now in practice, and my answer invariably is: Attack the abscess from the abdomen, because by that means we are best able to get at it. It is impossible to keep an abscess in communication with the bowels aseptic, so the sooner that connection is severed the better. It would seem at first as though the vagina offered good facilities for drainage, because it could possibly be