recommended are in the main correct, and are in accordance with the rules and suggestions laid down five or six years ago by Garrigures, Saenger and Leopold; these should be carried out in ideal cases, but unfortunately, we meet with many, complications which must be dealt with as they occur.

Having recently performed the operation myself, and looked up the literature and technique of the subject, I was surprised to find that we can to-day make but little improvement or change for the better.

In 1886, Saenger had operated four times, saving all the women and children. Dr. Leopold had operated nine times and lost one woman, saving all the children.

Dr. T. A. Ashby.—I wish to congratulate Dr. Kelly on his brilliant success with the Cæsarean section. This success is convincing proof of what can be done when the section is instituted under proper conditions, and at a proper time.

The future of the operation rests upon a proper and judicious selection of the case, and upon an immediate resort to the section before other methods of delivery has been attempted and abandoned. I doubt whether the Cæsarean section under such conditions, will give a higher mortality than the ovariotomy of ten or fifteen years ago.

The technique of the section is simple enough, and certainly its mechanical execution is not as difficult as that necessitated in the removal of many conditions of tubal and ovarian disease.

Hæmorrhage is not large, and it is easily controlled. Septic processes should not follow if strict aseptic precautions are observed.

The progress of the section as a substitute for other methods of delivery, rests upon an early and clear recognition of the pelvic measurements, and a prompt acceptance of the method as the proper procedure in the given case. When this is done the success of the section is not compromised by unfortunate interferences in other directions. When we have obtained the statistics of this class of cases, we are in a position to compare the mortality of the section with other operative methods.

Dr. W. P. Chunn.—I did not hear the first part of the history of the case, but think I would have removed the ovaries or tied the Fallopian tubes to prevent future conception. It is hard to say just what operation should be done.

Dr. Noble.—In doing a Cæsarean section, I would not touch the ovaries and tubes as Dr. Chunn speaks of doing, but would do nothing to prolong the operation. Tying the tubes would probably cause salpingitis. This objection is purely theoretical. So far as I know, this has been done only twice—once in England, and once in America.

Dr. Brinton.—I have been for some years interested in measuring the pelves of women. Very often we go to labor cases without knowing anything about the condition of the pelvis. With the hospital surgeon who has the best facilities, the Cæsarean operation will undoubtedly be the best in cases of extreme pelvic contraction. But with the average practitioner, what is best? I think that with these physicians craniotomy will hold the place. In speaking of craniotomy "holding its place," I referred to those cases of pelvic contraction where the child could be extracted without harm to the mother, say from $1\frac{3}{4}$ to 3 inches.

Dr. T. A. Ashby.—I must offer an apology for presenting a series of experiences which are familiar to all who have done much intra-abdominal work. I have brought these charred remnants of tubal and ovarian inflammation before the Society to invite discussion, not to exhibit anything original. They represent nearly every phase of intra-pelvic inflammation and illustrate the various degenerative conditions which are found in the pelvis after an inflammatory fire has passed over these tissues. Of the nine specimens here presented, removed from the same number of cases, no two are alike.

In one case the tube has received the brunt of the attack, in another the ovary is involved in abscess cavities, whilst in a third both tube and ovary are tied up in a knot by adhesive inflammation, and so on through the series.

The clinical histories of these cases would be exceedingly interesting did time admit of a recital, but I shall not tax your patience with details. We have the same old story in all of these cases save two—one the large specimen of a tubal sac of uncertain origin, probably an interrupted tubal pregnancy of long standing, and the other the remnants of a catarrhal salpingitis and ovaritis with intra-pelvic adhesions. Of the other seven specimens the origin of the condition is of chief interest in this connection, since they explain to my mind the essential factor in the production of the specimen here presented. Each of these women have borne one or more children; in each case the history of the intra-pelvic trouble dates from the last lying-in period, which was accompanied with mild or severe symptoms of child-bed fever. In each of these women there was an old lacerated cervix, in some more pronounced than in others. The histories of these cases, as far as they can be made out, and can be interpreted, tell the simple story. During labor a cervical tear occurred, in this wound septic material gained a lodgement, a septic process was established, which extended from the cervix to the cavity, from the cavity to the tubes, and from the tubes to the intra-pelvic peritoneum.

The severity of the symptoms in each case must have borne some relation to the septic process and to the tissues involved, though no way is offered for verifying this statement. We simply find the results in general destruction of the tube, or ovary,