dermically, and also two or three half-drachm doses of tinct. opeii. Has swallowed a small quantity of iced brandy and milk, and has had brandy and oatmeal gruel (strained) per rectum. Pulse 144, feeble. Extremities fairly warm. Urine drawn; is smoky. As there was some show of discharge on dressings, these were changed under spray. Also vagina was washed out with 1 in 40 of carbolic acid solution, there having been some bloody serous flow from that part. Quarter-grain of morphine given hypodermically.

11 p.m.—Has had a good deal of eructation of wind and vomiting through the day. Three or four enemata of brandy, with beef tea and gruel alternately, have been given. Pulse 148. Another quarter-grain of morphia as before.

June 28, 8 a.m.—Rested pretty well. Urine has been natural in color since first passage after operation. Some slight bloody discharge continues from vagina. Pulse 148; temp. 100·5°.

6 p.m.—Severe vomiting began at 9 a.m., and continued every few minutes up to the present. Vomited matters presented the coffee-ground character. Patient is very restless, and countenance is somewhat hippocratic. Not much pain. Had quarter-grain morphine subcutaneously about 3 p.m. Pulse 152.

Thinking that some benefit might accrue from transfusion, I cut down upon left median cephalic vein, and, after isolating it, it was raised upon a probe and a small trocar thrust into it through the canula, of which 14 oz. of the following solution was introduced :—

Chloride of sodium	6	parts.
Carbonate of sodium	1	"
Distilled water 100		"

This, after having been filtered, was heated in a clean bottle to 110° F., and then conducted through clean rubber tube of aspirator, by force of gravity, into vein—care, of course, being taken to have no air in tube. Immediately after the transfusion the pulse improved in strength, and fell to 136 in the minute.

June 29, 2 a.m.—Patient felt more comfortable for three or four hours after transfusion, but since then vomiting and distress have returned as bad as ever. Only one or two nutrient enemata have been administered during the last twenty-four hours, as they seemed to produce quite severe pain. Pulse very rapid and feeble. Glass drainage tube removed and rubber one substituted.

3 p.m.—Countenance grows worse. Considerable swelling of abdomen. Pulse 144; temp. 102°. Dressing changed. Abdominal cavity washed out with 1 in 40 solution of carbolic acid.

June 30, 3 p.m.—Vomiting continues, though nothing is now taken but small bits of ice. No enema since last report, because it causes much increase of pain. One-sixth grain morphine hypodermatis is required twice a day for relief of pain. Wound dressed. Considerable dirty watery discharge, having a gangrenous odor. Pulse scarcely perceptible.

July 1, 3.30 a.m.—Patient died.

11 a.m.—Autopsy. Small intestines found considerably distended, but not much inflamed. There were one or two dark, gangrenous patches on the sigmoid flexure and rectum. The whole raw surface of posterior pelvic cavity was dark and foul-looking, while the free cut edge of peritoneum near this part presented the same appearance. The uterine stump looked well, and no hemorrhage had occurred from it.

Remarks.—There are several points of interest in the last case reported which are worthy of notice. It will be observed, in the first place, that no hemorrhage of the slightest consequence occurred while the elastic cord was held tightly around the stump of tumor. It is therefore evident, I think, that, seeing it was so efficient in the case of a tumor with so large a base, it will prove in all such operations equally successful in controlling bleeding. The fact that so much blood was lost before the completion of the operation was undoubtedly my own fault, in not making sure of the peritoneal wound at least, near posterior pelvis, before relaxing the constricting rubber. I may say, however, in slight extenuation of this error, that in loosening the tourniquet, the edge of peritoneum slipped rather suddenly and somewhat unexpectedly from beneath the grasp of the rubber coils.

It would have probably been better to have dissected back a longer flap of peritoneum pos-