SURGICAL TREATMENT OF CANCER OF THE BREAST.—Sanderson says: It is a matter of fact that efferent lymphatic vessels run from the axillary glands through the apex of the axilla into the posterior triangle, and, after forming connections with the glands therein, finally enter the thoracic duct on the left side and the right thoracic duct on the right side. Moreover, superficial lymphatics from the skin covering the mamma track up over the clavicle to these same glands in the posterior triangle. It is laid down that in primary malignant disease of the breast the axilla should be cleared out (after removal of the breast), whether the glands be visibly infected or not. Why? Because the fact that they are not affected macroscopically is no proof that they are not affected microscopically. And yet, in the face of the anatomical facts quoted above, it is not the usual custom or practice to go further. If it is wrong to assume that the axilla is free from disease because it shows no sign to the naked eye or finger, it is equally wrong to assume that the posterior triangle has escaped. If it is right and peremptory to clear the axilla, it is also right and peremptory to clear the posterior triangle. Still more is it inconceivable how the triangle can be left untouched if the axillary glands are found to be clearly affected at the time of operation. It may possibly be objected that it is not feasible or is difficult to clear the posterior triangle. To this it can be replied that by a flap operation, done a week or ten days after the primary operation, a clean dissection can be made of the whole posterior triangle, that it is not difficult, and that it is quite feasible. A flap formed by a long incision down the sterno-mastoid muscle meeting an incision along the clavicle is detached as far back as the anterior border of the trapezius; this exposes the triangle, and the contents can be systematically removed with a little care and patience. By such means the acknowledged principle would be carried out as far as possible, and if the principle is right it seems incumbent upon the surgeon to strive to apply it thoroughly in practice and not to be content with stopping half-way.

THE EXTRAVASATION OF BLOOD IN TUBAL PREGNANCY.—James Oliver states that during the evolution of a natural pregnancy there results not only an augmentation in the size of the blood vessels of the uterus, but a hypertrophy of the tissues of this organ generally. When, however, the fecundated ovum develops in the Fallopian tube it seldom happens that any vigorous local growth is excited by its presence, although the blood vessels in the involved tube become greatly enlarged. Apart from any intrinsic disease, the integrity of a blood vessel depends greatly upon the manner in which it is supported by the surrounding tissues. When, therefore, the pressure exerted by the Fallopian tube against a growing ovum is insufficient to support the correlatively enlarged blood vessels, they rapidly become thinned, and rupture with extravasation of blood takes place on the slightest provocation. When the developing ovum is located in the cavity of the uterus we are accustomed to believe that accidental hemorrhage from the maternal vessels never takes place until after the fourth week of pregnancy. Whether this belief be correct or not, it is evident that in tubal pregnancy accidental hemorrhage from the vessels in the mucous lining of the Fallopian tube may occur as early as the seventh or the tenth day after impregnation. In ectopic pregnancy, therefore, blood may be extravasated from the maternal vessels before the chorionic villi become vascular—a phenomenon which happens during the third week of pregnancy when the chorion becomes incorporated with the allantois. The paroxysmal attacks of severe pain which are sometimes experienced in cases of tubal pregnancy are due to these effusions of blood, and, although the primary hemorrhage occurs always whilst the ovum is living, subsequent hemorrhage may nevertheless happen after this body has died. Rupture of the Fallopian tube itself, which has gradually become more and more thinned, may be induced by the first or any succeeding extravasion of blood; and as this accident may occur as early as the fourth week of pregnancy, before the chorionic villi have begun to participate in the formation of a true placenta —for the ovum is everywhere placental at this period—the breach in the continuity of the tube is not, in all cases at least, attributable to a thinning at the placental site or to a penetration of the tube by the villous processes. A portion of the external hemorrhagic discharge—vaginal—which is observed in the early days of some tubal pregnancies comes directly from the ruptured vessels in the tube.

DELIRIUM AFTER GYNÆCOLOGICAL OPERATIONS. —Doleris (*Nouvelles Archives d'Obstet. et de Gynec.*) has prepared an instructive memoir on the appearance of acute more or less maniacal delirium after "minor" gynæcological operations and plastic surgical proceedings. In one case no operation was performed, but the patient worried continually about surgical relief, till a maniacal attack came on. Two fatal cases occurred in Doleris' experience. In both the patient was vicious, plethoric, alcoholic, and syphilitic. One was very rich and luxurious; she took great quantities of ether. After an operation from the uterine side for the cure of suppurating tubes, violent delirium set in with icterus and no fever. Death occurred on the sixth day; complete asepsis was proved at the necropsy. The second patient was a servant at a beershop. Very large sclerosed ovaries were removed. Fatal delirium ensued; neither vomit-