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REPORT OF ONE HUNDRED AND FORTY-FIVE OPERATIONS DONE FOR THE REMOVAL OF OVARIAN TUMORS AND PATHOLOGICAL CONDITIONS ASSOCIATED WITH THE OVARIES AND UTERINE APPENDAGES ONLY.

BY A. VANDER VEER, M. D.,

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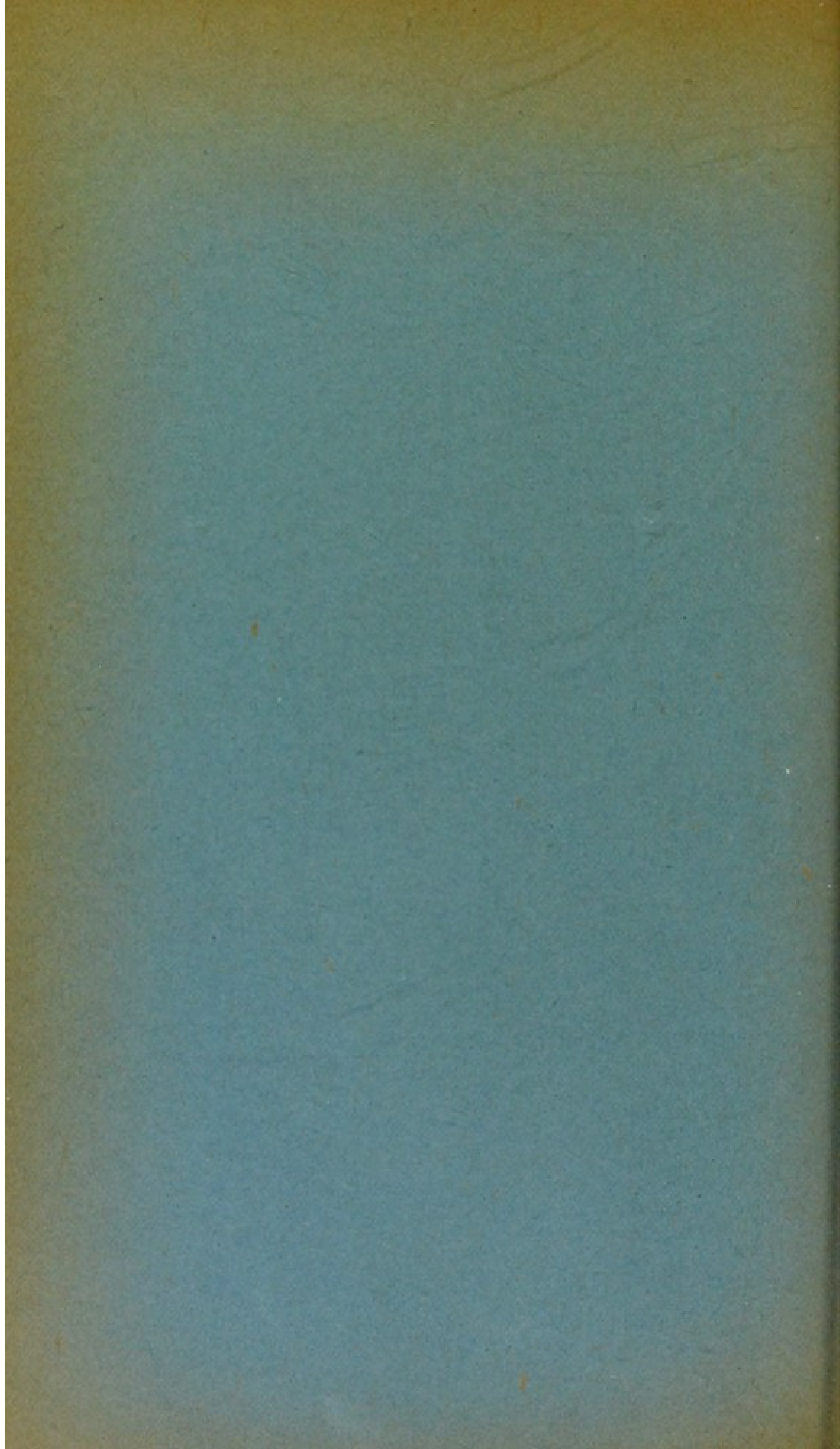

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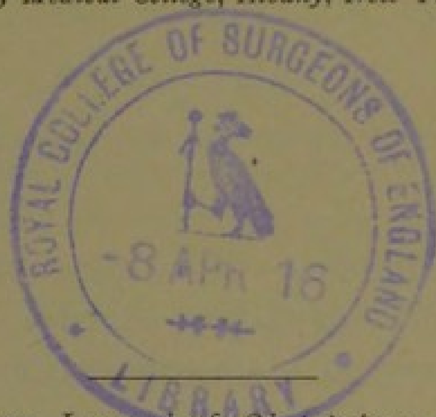

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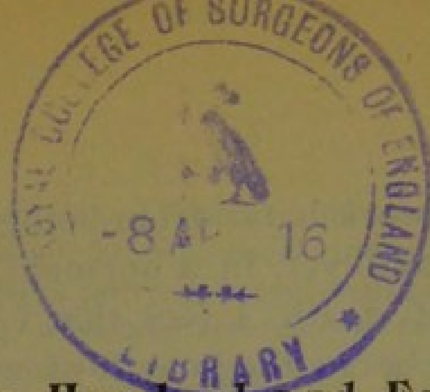

Report of One Hundred and Forty-Five Operations Done for Removal of Ovarian Tumors and Pathological Conditions Associated with the Ovaries and Uterine Appendages Only.

By

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An abstract of this paper was read at the meeting of the American Association of Obstetricians and Gynecologists, Toronto, Canada, September 19th, 1894.

In presenting this report in abdominal surgery, with accompanying table, I desire to state that the one hundred and forty-five cases do not include any of my work in supravaginal hysterectomy, excepting Nos. 112 and 114, cases complicated with ovarian tumors, or solid tumors of the ovaries or broad ligaments, cases of hystero-epilepsy, cases of tubercular peritonitis, of gall-bladder surgery, of appendicitis; or of any operations whatever within the peritoneal cavity, previously reported by myself in former papers, with one exception, case 42. The operations here reported were done for removal of ovarian tumors and pathological conditions associated with the ovaries and uterine appendages. It is true that some of the cases were simple tubercular peritonitis, in which the appendages were not removed, but the history of the case, in each instance, and direct physical examination, gave some little question as to whether there might not be an ovarian complication with the suspected tubercular trouble.

I realize that my work is far from being as successful as I could have wished, and yet, in a personal, critical retrospection of the causes of death, I feel that I have gathered an experience that will be to the benefit of my future patients, and I trust somewhat to those of my associates and successors who may continue to do this line of work.

CASE I.—Mrs. C. C., duration disease two years; history of several attacks localized peritonitis, accompanied by vomiting.

Operation February 20, '88, revealed multilocular ovarian cyst, papillomatous in character; some adhesions; broad pedicle; Tait knot. Patient did well for forty-eight hours, then began to vomit, showing marked evidence of intestinal obstruction, which continued unrelieved. Died on third day. Autopsy revealed obstruction due to loop of small intestine having attached itself to stump of pedicle.

CASE III.—Mrs. F. C., operation April 9, '88, revealed multilocular ovarian cyst, with sarcoma of mesentery—latter ligated separately and removed. Uterine appendages also removed. Drainage. Patient in good condition of health six months after operation.

CASE IV.—Miss C. D., maternal grandfather died of cancer. Menstruated at fourteen; scanty and painful; severe amenorrhœa and dysmenorrhœa since. Four years previous, after a severe fall and cold, had pelvic peritonitis. Leucorrhœa always very severe. Suffered from general pelvic pain, and unable to perform household duties, much of the time being a confirmed invalid. Operation May 31, '88, showed adhesions quite marked, right ovary enlarged, and tube much thickened, left ovary undergoing cystic degeneration, tube not so much diseased as right one. Stitch-hole abscess on sixth day. Finally good union, patient discharged on twenty-fourth day after operation.

CASE VI.—Mrs. A. M., mother, two paternal and two maternal aunts died of phthisis; maternal cousin had abdominal tumor. Personal history very good. Married at sixteen; two children; one miscarriage; youngest child twenty-eight years old. Seven years previous to operation noticed some trouble in left iliac region; dull pain and soon after side began to enlarge. Five years later menstrual periods became irregular and later still legs became œdematous. Examination urine showed no disease of kidneys. Abdomen measured forty-two inches in circumference about umbilicus. Operation May 31, '88. No adhesions. Weight of cyst and fluid thirty-five pounds. Patient in much pain after operation and given one-quarter grain morphia, hypodermatically, every six hours for first day, after which it was discontinued. Bowels moved second day; superficial stitches removed fourth day; deep ones fifth day; wound healed by primary union. Without any assignable cause temperature third day rose to 102½°, within few hours returning to nearly normal, after which patient made uninterrupted recovery, and discharged on twenty-third day.

CASE VII.—Mrs. A. O'C., family history good. Never had severe illness; menstruated at twelve, which was and always has been painful, but normal in quantity and general appearance. During September, '87, first noticed pain and tenderness in right iliac region. Pain dull, burning variety, and seemed

to extend gradually upwards. Four months later noticed enlargement left side, gradually increasing in size, patient measuring thirty-four inches in circumference. Two week previous to operation had severe, paroxysmal pain in left inguinal region, especially severe upon deep inspiration—continuing for ten days. Menstrual periods regular during growth of tumor and less painful than before. Bowels habitually constipated, except two weeks previous to operation. Operation May 31, '88, revealed large, multilocular ovarian cyst, connected with left ovary and tube, having many adhesions to bladder and intestines, which were relieved without great difficulty by means of pressure of hot sponge, proving them to be of recent origin, probably outgrowth of recent peritonitis. To deliver cyst required breaking up of very many smaller cysts through original opening in larger cyst. Right ovary undergoing cystic degeneration and removed. Abdomen thoroughly flushed with hot water. Weight cyst and fluid twenty pounds. Fluid thick and gelatinous; and portions escaping into abdominal cavity made irrigation necessary. Patient given few hypodermic injections of morphia first twenty-four hours to relieve pain. Superficial stitches removed third day, deep on fifth, wound thoroughly healed. Evening eight day, after evacuation bowels, patient had severe chill, followed by temperature 102° with profuse sweating. No abdominal tenderness, but hard, indurated mass could be felt about lower end incision. Warm applications used, and five grain doses quinine given every four hours. On evening of tenth day about one ounce of black, tarry fetid substance discharged per vaginam, vaginal douches being used after that each day. Temperature fluctuated between 102° and 104 4-5° degrees for thirty-six hours, but decreased on eleventh day, and on twelfth normal—no suppuration of wound. Indurated mass in region incision entirely disappeared and from this time on patient made an uninterrupted recovery, being discharged on twenty-fourth day.

CASE VIII.—Mrs. P. A. R., paternal grandfather died of cancer; paternal aunt of phthisis pulmonalis, otherwise family history good. Menstruated at thirteen, regular up to fifty-two, except during pregnancy and when nursing children. Two children; two miscarriages. Patient first noticed small enlargement left side abdomen two years previous to operation, painless and increased in size very slowly until April, '88, when it grew rapidly and became somewhat painful; much inconvenience in getting about; circumference at navel forty-one and one-half inches. Operation July 5, '88, revealed double ovarian cyst; right nearly unilocular, tapped, removed without much difficulty, although some adhesions to intestines. Cyst left ovary adherent to omentum, giving rise to considerable hemorrhage, requiring several ligatures; weight, cysts and fluid, forty-two pounds. Patient had quite severe mitral stenosis, but bore anæsthetic very well. Stitches removed fifth day; patient made good recovery and discharged on twenty-first day.

CASE IX.—Miss E. B., family history very good. Patient suffered many attacks of pelvic peritonitis. Operation October 1, '88, revealed double pyosalpinx; many and firm adhesions; operation very difficult; removal uterine appendages. Good recovery. Two years later patient died from what, at that time, was supposed to be sarcoma of cavity of pelvis.

CASE X.—Miss M. W., aet twenty, good family history. Unilocular cyst; uncompleted operation. After operation no symptoms presented to cause

anxiety, except as to pulse rate, not going below 100, tenth day increasing in frequency, and patient showed a nervous, agitated state, although bowels had moved properly, etc., but she gradually sank and died on fourteenth day. Autopsy revealed large number of clots in pelvis, same condition had extended up into abdominal cavity, particularly in right lumbar region, clots undergoing septic change, but no pus present; ligature was found loosened and discovered to have come from stock of imperfectly prepared silk, none of it being used afterwards. In this case I believe had there been no internal hemorrhage, or, when it presented, had I opened up, washed out, thoroughly controlled bleeding vessels and drained, she might have recovered; yet at no time was there shock enough to indicate this procedure warrantable.

Case XI.—Mrs C. W., family history of phthisis. No children; one miscarriage 1880. Regular menstruation until August 4, '88, when it ceased. May '88, after hard day's work, taken with severe pain, crest right ilium, lasting fifteen hours; enlargement presented afterward. Diagnosis of ovarian tumor; tumor enlarged rapidly—tapped October '88; patient afterward suffered from occasional attacks biliary colic and swelling of right leg. Operation, November 19, '88, revealed large multilocular cyst, from left ovary, containing variety of colored fluids, ranging from light to dark, dirty greenish appearance. Cyst contained papillomatous growth; right ovary healthy, not removed. Opeation protracted, as hard, solid portions of tumor rested over right kidney and iliac vessels, undoubtedly, from pressure, causing swelling of leg on that side; drainage for about forty-eight hours. Excellent recovery and patient discharged twenty-second day.

Case XII. — Mrs. H. T. T., family history decidedly cancerous. Four children; one miscarriage, seventh month. Menstruation normal. After birth second child, solid tumor, size of cocoanut, developed in left lumbar region, disappeared under treatment, appearing again at birth of third child, disappearing after delivery; patient at this time very ill; constant vomiting for a week, with suppression of urine; however, made very good recovery. No trouble fourth pregnancy; at fifth, had post partum hemorrhage. Three years previous to operation began to enlarge slowly for eight months, when on rising one morning, growth had disappeared, doing this several times since. About that time tapped twice, at intervals of a week. Operation, December 21, '88, revealed tumor springing from left ovary, cyst holding twelve quarts of fluid. Many adhesions. Operation difficult. Several silk ligatures applied within abdominal cavity. Right ovary also removed. Uninterrupted recovery, discharged on twentieth day.

Case XIII.—Mrs. H. M. R., family history of phthisis. Six years previous to operation delivered of still-born child. Health not good since. Menstruation regular, but always painful. Took fifteen to twenty grains chloral nightly. Three years previous to operation treated fifteen weeks by Dr. Emmett, in Woman's Hospital, for ovarian trouble and anteversion. After return home husband continued use of tampons, cotton and glycerine, but no improvement, and patient confined to bed four months. Diagnosis, double salpingitis, confirmed by operation December 22, '88. Some vomiting and continued pain in back after operation, otherwise good recovery, and discharged thirtieth day.

Case XV.—Mrs. N. M., family history good. Menstruation normal. One child, three years old; one miscarriage. First noticed distension of abdomen one year previous to operation, and was treated for ovarian dropsy and lung trouble by Dr. Woodward, of Vermont, for some time. Operation revealed ascitic fluid, peritoneum studded with small papillæ, giving somewhat the appearance of warts on a toad's back. Condition concluded to be one of tubercular peritonitis. Right ovary enlarged and removed. Masses afterwards proved to be tubercular in character. Glass drainage, which gave her much discomfort, was removed on fourth day and replaced by soft rubber tube. This removed on twelfth day, drainage having ceased entirely. Patient made an uninterrupted recovery and remained in good condition afterwards. One point of interest presented in her case, i. e. regarding glass drainage tube not being turned and raised each day by the nurse, its becoming quite firmly attached in position and removed with some difficulty. Patient discharged on twentieth day.

Case XVI.—Miss I. R., aet twenty-six. Family history only fairly good. Suffered from dysmenorrhœa, and severe, well marked attacks pelvic peritonitis. Feeble and emaciated when I saw her with family physician, with great effort continuing her work, that of bookkeeper in large store. Had continued indigestion with vomiting. Case evidently one of salpingitis, and probably double pyosalpinx. Cœliotomy April 5, '89. Many firm adhesions, difficult to separate, but removal appendages completed. Pelvis left in good dry condition. Patient vomited from time of operation, at last a spinach-like substance. No distension abdomen; bowels moved safely, no symptoms obstruction, but patient died from inanition on eleventh day. Autopsy showed evidence general peritonitis. Careful going over of technique of operation and surroundings failed to show any evidence of error.

Case XIX.—Mrs. F. W., family history good. Menstruated at fourteen; married at fifteen; fourteen months later delivered of living child at seventh month; premature delivery caused by boy jumping on abdomen; second delivery normal and child still living; one miscarriage since at third month; menopause at forty-eight. Oct. '88, operated on by Dr. Boyd for prolapse of uterus; no evidence of tumor at that time; thinks growth since to have been occasioned by resting filled coal scuttle upon left ovary at times for past six years. Dec. '88, observed aching pain in this region; some bloating and felt ill all winter; blisters and hot applications used; first noticed enlargement, size of goose egg, in Feb. '89; examination in May gave all the symptoms of ovarian cyst. Operation June 15, '89; diagnosis confirmed; cyst removed; quite a number of adhesions; drainage; recovery, followed by hernia some six months afterwards.

Case XX.—Mrs. B. A., aet twenty-two, family history of phthisis. Met with injury May, 1888, following October abdomen enlarged; tapped April 18, '89, fifty pounds of fluid drawn; circumference at umbilicus forty-four inches; though desperately ill yet she and her friends were very anxious for an operation. Cœliotomy August 22, '89; time required one hour and thirteen minutes; very extensive and firm adhesions of sac to peritoneum; much hemorrhage; multilocular cyst, left ovary removed; right ovary enlarged, with evidence of another cyst developing, also removed; glass drainage; every effort made to bring patient out from condition of shock, but she died four

P. M., August 30. Autopsy revealed no hemorrhage within peritoneal cavity. Case probably hopeless from beginning and illustrates the seriousness of delay and evil results of tapping.

CASE XXI.—Mrs. E. B., widow, aunt died cancer of tongue, otherwise history good. Menstruated at sixteen; regular without pain; married at seventeen; three children; two miscarriages; menopause at forty. One year previous to operation abdomen began to enlarge and gave some distress on motion. Jan. '89, could feel good sized tumor in left side which she could steady with hand when turning in bed. March, '89, tumor tapped but no fluid withdrawn. Six weeks previous to operation tumor grew more rapidly. Twelve days before operation Dr. Fuller aspirated left side and drew off small quantity of what seemed to be purulent fluid. Weighed 135 pounds year before operation. Emaciated, anæmic, bowels regular, appetite very good, urine scanty, pulse 128, temperature 99, measured 47 inches about navel. Diagnosis multilocular ovarian cyst. Operation Sept. 23, '89; diagnosis confirmed; scarcely any adhesions; large cyst filled with colloid material; ovaries removed; drainage; patient making good recovery.

CASE XXII.—Mrs. C. L., family history of phthisis; mother three children; one miscarriage; strong and healthy as a girl; menopause at forty-five. March, '89, after very hard work noticed enlargement left side abdomen; filled rapidly and tapped in July; one half gallon fluid removed; tapped again August 16, nearly same amount fluid. First tapping fluid had bloody appearance, second purulent. Had attack of what was called bilious vomiting Sept. 28. Appetite good, bowels inclined to diarrhœa; legs enormously swollen, at times discharging serum. Operation Oct. 14, '89; adhesions of sac to peritoneum very decided. When trocar was introduced there escaped a greenish looking fluid. Introduction of hand into opening of sac became necessary and a material looking like custard or omelette was scooped out; sac carefully separated from peritoneum, such vessels ligated as became necessary, peritoneal cavity irrigated with hot water, drainage tube inserted, and incision closed; patient vomited almost constantly for first forty-eight hours, finally ceased; drainage quite free, glass tube removed end fifth day, rubber substituted, left in but few days longer; patient made excellent recovery.

CASE XXIV.—Mrs. M. B., patient has three living children, youngest eleven years old. Menstruation regular from fourteen up to forty-three, when she flowed every two or three weeks. In Dec. '88, first noticed slight enlargement on left side; during last six months has enlarged more rapidly, pelvic cavity free from deposits; uterus freely movable. Operation Oct. 29, '89; ovarian cyst tapped and mucilaginous dark-colored fluid drawn off. Several adhesions found on left side; as sac was drawn out it was found to be multilocular; sac lifted out en masse and small pedicle ligated; patient recovered rapidly.

CASE XXV.—Mrs. R. H., family history good. Menstruated at fourteen; two children, no miscarriages; youngest child ten and oldest eighteen years old; since birth of first child suffered from pelvic pain, especially severe at menstrual epoch; pain feels as if bands were being tightened around the intestines. Not free from pain for eighteen years. Operation Mar. 4, '89, showed both ovaries bound down by strong adhesions; nothing further done

than to loosen adhesions as much as possible; impossible to isolate ovaries; abdominal wound sutured in usual manner, glass drainage; patient made good recovery.

CASE XXVII.—Mrs. D. S., mistaken diagnosis; supposed large ovarian cyst. Cœliotomy November 14, 1889, revealed tubercular peritonitis; ascites; one ovary removed; improved; patient died later on of return of peritoneal dropsy.

CASE XXVIII. — Mrs. S. N., menstruated at eleven. Not regular. Flow would cease for seven weeks or two months. Has five children. Three miscarriages. Youngest child three years old. Two years ago noticed enlargement in right ovarian region. April, '89, began to flow excessively, and on one occasion flowed steadily for two months. Enlargement gradually increased. Operation Dec. 5, '89. Ovarian tumor. Chill on fourth day, controlled by quinine. Cyst fluid twenty-two pounds. Uninterrupted recovery.

CASE XXIX.—Mrs. H. N., family history good; delicate as a girl. Menstruated at twelve; dysmenorrhœa always; three children; no miscarriages. Flowed excessively at times, more since marriage; suffered every month during pregnancy. Since birth last child — two and one half years old — pain more or less daily, sharp, stabbing, radiating from ovarian regions, down thighs and through back. Bowels regular; appetite good. Operation Jan. 27, '90. Left ovary, with tube, enlarged and removed. Right also removed. No drainage. Vomited once after operation. With exception of sharp pain and nausea no untoward symptoms. Stitches removed on fourth day; no suppuration. Partook regular diet fourth day. Uneventful recovery.

CASE XXX. — Mrs. A. McK., first trouble two years ago, thrown from carriage, followed by constant pain in dorsal, lumbar and sacral regions. Urination painful. Inflammation of uterus diagnosed. Severe pain pelvis and hip. Confined to bed. Improved somewhat but unable to walk. Recurrence of trouble in August. Physician diagnosticated cystitis and washed out bladder but attended with such severe pain, discontinued. Improved sufficiently to be brought to hospital Dec. 2, '89. Galvanism applied, pain decreased somewhat but back became so sensitive, current discontinued. First menstruated at thirteen — exposed to cold shortly before second menstrual epoch due and flow absent one year. On return, so painful, often confined to bed. Between August 4 and December 9, flow absent. Paroxysms of pain at time when flow would have naturally appeared. Since December up to date nothing appeared. Laparotomy and double oöphorectomy February 23, '90. Extensive adhesions of ovaries and tubes, small cyst on right side. Patient did well, received two hypodermics of morphia up to Friday night when was taken with severe attack resembling hysteria — husband had been visiting patient — did not rally for several days and kept under the influence of morphia at times. After this recovery uneventful. Stitches removed March 5.

CASE XXXI.—Mrs. E. H., always delicate as a child. Menstruated at twenty. Monthly pains previously, but no flow. Menstruation painful, patient having to go to bed. Flow sometimes lasted ten days, at times occurring every three weeks. Two living children—seven or eight miscarriages. First child born at seventh month. Second at full term, but labor difficult—instrumental. All miscarriages occurred after this labor and all without any known cause;

patient treated for some uterine trouble for past twelve years; in '89 fell on sidewalk hurting left side quite badly; after fall lost flesh rapidly—eighteen pounds in one month; before this felt quite well; one month later noticed enlargenent in left ovarian region, about size of an orange; painful for about two months, then pain ceased for a time, but is now present; growth not rapid; at times sensation like fluid moving from side to side of tumor when in bed. Operation for ovarian cyst performed April 22, '90. Cyst removed, drainage—recovery.

CASE XXXII.—Mrs. J. V., cœliotomy April 30, '90. Multilocular ovarian cyst; previous peritonitis; removal cyst and both ovaries. The adhesions in this case were so severe that on separating them with wet sponge and fingers the hemorrhage was quite constant and considerable. Several vessels in omentum and abdominal walls were tied with silk. The abdominal walls, owing to the great size of tumor, were after the operation, very lax and admitted of being folded over on themselves afterward; peritoneal surfaces sutured with deep sutures to control hemorrhage, and which had a good effect. These sutures were removed after forty-eight hours; sponge lost in cavity; found after prolonged search; drainage. Recovery.

CASE XXXIV.—Mrs. E. C., father died of heart disease, otherwise family history good. Patient had scarlet fever when child; leaving her with some kidney trouble. Menstruated twelve; first child born nine years previous to operation; delivered of five children; last she thinks at eighth month, living only one week. Since birth third child noticed irregularity in menstrual flow—more frequent and profuse. Lessened, however, two or three months prior to operation. September, '89, patient tapped for supposed ascites; four gallons removed. January, '90, again tapped; quart fluid obtained. Pregnant at time with last child. End February, '90, tapped again—amount fluid only few quarts. Fourth and last tapping August, '90, three gallons fluid. Child born between third and fourth tapping (March, '90). Punctures for tapping, one, two, four in linea alba, three almost in right hypochondrium. August, '90, patient noticed enlargement in right inguinal region, but noticed distension early as birth of third child; disappearing for a time, then re-appearing. Treated at time for ovaritis and enlargement of uterus—temporary relief. Enlargement in left side, but different from other. Leucorrhœa since birth first child. Abdominal section September 22, '90. Multilocular ovarian cyst, right side, left side, parovarian cyst; no adhesions; patient troubled with catarrhal inflammation intestines, which kept up diarrhœa for some time. Course recovery uneventful and otherwise uninterrupted.

CASES XXXV and LIX constitute the same patient.—Miss L. McC., aet twenty-three; menstruation painful, vomiting at times. Injured, and treated long time for spinal trouble, also retroverted uterus. Slipped on ice and afterward vomited for four weeks. Alexander operation for relief of retroversion, March, '89, by Dr. Pilcher, of Brooklyn. Menstruation more painful after operation. Entered Albany hospital April, '90; uterus carefully curetted, after rapid dilatation; no improvement. Cœliotomy October 7, '90. Right ovary enlarged, size turkey's egg, tube much thickened, both removed. Left ovary and tube apparently healthy; not disturbed. Recovery uneventful; discharged November 3, '90. No permanent relief from operation. Various kinds of treatment tried without benefit. Second cœliotomy November 9, '91.

Left ovary, size small orange, undergoing cystic degeneration, tube enlarged; both removed. Good recovery; patient in excellent health September 1, '94.

CASE XXXVI.—Miss M. G., mother died of pneumonia, otherwise family history good. Health never good; menstruated at thirteen; first day of flow always accompanied by dysmenorrhœa,—lasting five days,—fluid dark and liquid. About four years ago patient noticed enlargement in abdomen, does not remember where it began. Gradually increased until tumor began to interfere with respiration, when, fluid being suspected, patient tapped February, '88. Ten quarts removed, but necessary to tap again in August, '89, four quarts being obtained this time. Both punctures low down and in linea alba. Never any pain about location of punctures. Since last tapping abdomen enlarged until about as large as first tapping. Operation October 10, '90. One large, and several small cysts removed, some very slight adhesions broken. Left ovary healthy—not removed. Recovery uninterrupted. Apposition at lower angle not perfect—silk-worm gut—exuberant granulations.

CASE XXXVII.—Mrs. E. W., family history good; personal good until two years previous to operation; menstruated at thirteen; married eight years; has two children; two miscarriages; oldest child five and youngest two years old; first miscarriage April, '88; second, September, '88. Cause of first, fall; second, indefinite; both supposed to have been advanced to third month. Summer of '89 patient had pain over site of right ovary, which grew steadily worse until in November, she was forced to her bed for some time. Blisters and hot applications had no effect. During winter had attacks of unconsciousness. Operation, October 21, '90, revealed enlargement of tube and ovary on right side, due to chronic inflammation. Left ovary could not be found, apparently thoroughly atrophied and covered by firm adhesions. Right ovary and tube removed in usual manner after tearing away numerous adhesions. Glass drainage, packed with iodoform gauze. Drainage very bloody for some time—gradually cleared. Glass tube removed October 24. Rubber tube substituted; removed 27th. Further course uneventful. Discharged the sixteenth day.

CASE XXXVIII.—Mrs. S. K., four years previous to operation had severe brownish-looking, offensive discharge from vagina. Steady pain in ovarian and across lumbar regions. Husband admitted having had specific urethritis. Diagosis, pyosalpinx. Cœliotomy, October 30, '90. Bi-lateral pyosalpinx, double parovarian cyst and small fibroid, size English walnut, on fundus uterus. Uterine appendages removed, then fibroid. Latter carefully dissected from fundus, but bleeding very severe, controlled by use of thermo cautery. Glass drainage; discharge free for forty-eight hours; rubber tube substituted and kept in for five days. Recovery uneventful; discharged eighteenth day. Eight weeks after operation small abscess formed in sinus left by drainage tube, through which escaped one of the silk ligatures.

CASE XXXIX.—Mrs. F. M., menstruated at thirteen—had severe fall at same time; sick two weeks from this—perfectly helpless; two years after ill again in same way—did not leave room for three years. Ever since menstruating pain in back—much increased during first two or three days of monthly periods. Married ten years; one child; no miscarriages. Diagnosis of ovarian trouble made. Oöphorectomy November 29, '90; left ovary cirrhotic, right in condition fibro-cystic degeneration; both removed. Day

following operation severe pain over spine of right scapula — darting down back of arm even to tips of fingers; joints tender for some time; this lasted for three days, recurring at intervals afterwards in spite of counter-irritants and galvanism; third day usual attempt was made to move bowels with enema without success; was continued during the whole week, sulphate of magnesia and one-sixth grain calomel administered, without any result until seventh day when small movement. December 9, bowels moving daily. Cystitis with frequent desire to urinate was an annoying complication; her symptoms finally improved, she leaving the hospital January 5, 91; patient from letters received later made a slow but good recovery.

CASE XLI.—Miss E. K., aet thirty-three. Abdominal trouble at eleven, diagnosed as dropsical, which disappeared under treatment; multiple abscesses about left leg; Dr. A. March operated removing necrosed portions bone; later old cicatrices opened up partially. March, '90, felt sharp, sudden pain in each groin, after lifting heavy washing; enlargement on both sides, corresponding to double femoral hernia, followed, abdomen now enlarged. Operation advised, but advice not followed, patient enlarging rapidly in meantime. I advised operation December 1890. Cœliotomy January 3, 1891; cyst of right ovary had ruptured. Multilocular cyst, left ovary, with uterine appendages, removed; both cysts contained viscid, glairy mass, some remaining and being agglutinated to intestine; thorough irrigation; drainage — removed third day; severe diarrhœa controlled; tenth day lower angle wound opened, discharging four to five ounces fetid pus, after which patient made good recovery, discharged April 29, fistula almost healed.

CASE XLII.—Miss M. G., family history good with exception of one uncle dying of phthisis. Personal health good up to '89, when patient had attack anæmia; recovered wholly from this. Menstruation twelve, painful but regular. Noticed hard enlargement abdomen in '90; growth slow at first, but during two months previous to operation rapid. Diagnosis tubercular peritonitis. Cœliotomy January 14, '91. Profuse discharge fluid; peritoneum studded with tubercles; left ovary enlarged, cystic and studded with tubercles —removed; glass drainage, removed thirteenth day, rubber substituted; discharge gradually lessened; at end of second week drainage tube forced out, could not be re-inserted; gauze packing for ten days; discharged forty-second day, recovery complete — no ascites.

CASE XLIII.—Miss J. S., aet nineteen, family and personal history good. Tumor developed fifteen months previous to entering Albany hospital, February 27, '91. Diagnosis unilocular ovarian cyst. Cœliotomy February 28, '91, eleven A. M. Unilocular cyst from left ovary found, two gallons clear-looking fluid removed, and pedicle secured with Staffordshire knot; cyst, size of ordinary walnut, surface of right ovary; opened and curetted; edges of this incision sutured with iron-dyed silk; ovary and tube returned to pelvic cavity. Saw patient at one P. M., when all seemed to be going well; was called out of town, not returning until 7:30 P. M., when on visiting patient with house physician, internal hemorrhage was evidently going on. Pulse one hundred and forty-two, and sighing respiration; wound immediately re-opened, pelvis and abdominal cavity found filled with clotted blood; vessels had slipped from ligature, or knot loosened, evidently within an hour previous, from record of nurse. Pedicle re-ligated; no hemorrhage from incision in right ovary; two

pints saline solution poured into peritoneal cavity, wound closed and drainage introduced. Everything possible to bring on reaction was done; patient rallied slightly at first, and it seemed possible for her to re-act, but her mental condition was seriously shocked; she was alarmed, gradually sank and died March 1, at 8:10 P. M.

CASE XLIV.—Mrs. A. E., family and personal history good. Rapid enlargement right side near spine of ilium from December, '90; solid growth left side. Cœliotomy March 3, '91. Papillomatous cyst from left ovary; three gallons of fluid, some adhesions; another cyst connected with right ovary, closely adherent to surrounding tissues; this tapped and emptied of a viscid fluid—dirty, brownish color; in bottom of this cyst was another papillomatous growth; adhesions such it was impossible to remove this entire, cyst walls stitched to abdominal wound, and rubber drainage introduced; left side, pelvic cavity, glass drainage tube placed; patient recovered quickly and discharged May 18, '91; slight sinus of cyst right side, still existed. Re-admitted June 3, '91, with partial obstruction of bowels. Yielded to calomel, salines and enemas; sinus closed, but showed disposition to open and mass could be felt connected with right side of pelvis; improved slowly and finally discharged August 12, '91, having gained in flesh and strength. In good health until January, '93, when there was a return of intestinal obstruction, and patient re-admitted to hospital. Great distension of abdomen; lower portion old cicatrix incised; immediate presentation old, papillomatous mass filling right side pelvis. In attempting to enucleate mass, small intestine was opened into; gauze packing introduced, supposing that patient could scarcely recover, but by continuous irrigation a great amount of detritis washed out, finally fecal fistula closed, patient had normal movements, gained in health and returned to her work, but during latter part of winter of '94, growth had increased, and in May she suffered from a fistulous opening connected with sarcomatous mass, giving off an offensive discharge. Not heard from since.

CASE XLV.—Mrs. N. A., family history tubercular maternal side, good otherwise, personal history anæmia, but fairly well nourished. Two children, youngest five; no miscarriages. After birth last child, pain developed right side over ovary. 1890, first noticed growth in right side, which gradually increased; menstrual flow normal and regular until five months previous to operation, then more profuse, and dull pain followed advent, in right side; feeling of numbness in right leg since birth last child. Operation March 18, '91. Removal both ovaries, left adherent. Tumor felt right side proved to be an ectopic pregnancy. Bowels moved third day, stitches removed eighth; on twelfth patient sat up for one hour and walked about ten feet; made splendid recovery and discharged on seventh day. Later patient had her menstrual period for over a year. I then curetted cavity uterus thoroughly. Since which time she has remained well.

CASE XLVI.—Mrs. M. S., cœliotomy April 23, '91. Multilocular ovarian cyst, left side; right ovary undisturbed; there were some adhesions; glass drainage for five days, then rubber—after removal discharge, at times pus, continued for six months when ligature came away and patient made a good recovery.

CASE XLVII.—Mrs. E. C., father died of phthisis at thirty-four; mother living at fifty-six, and has had cerebral hemorrhage. Menstruated at fourteen; ceased for year, regular since; one child, aet six; no miscarriages. Since birth

of child menstruation very painful; peritonitis after birth of child, again in '83, brought on by lifting; typhoid fever at seventeen; pneumonia at twenty; in '89 had cough and slight hemorrhage from lungs. Occipital headache; appetite poor; urine normal. Cœliotomy, May 4, '91. Oöphorectomy; both ovaries cirrhotic — left cystic — bound down by firm adhesions; tube packed every ten minutes with gauze for three hours; removed May 5, much pain until tube removed; no noticeable improvement until eighth day, when enema given was followed by very free movement of gas and feces. Recovery uninterrupted except for obstinate cystitis, present still when discharged on thirty-fifth day.

Case XLVIII.—Mrs. A. McC., family history good. Menstruated at twelve, painful; fifteen years previous to operation trouble began, accompanied by spasms. Second child born, '83, two years later diagnosis of uterine misplacement made and she received treatment. Pain in right ovary for ten years, along spine painful points, occasional points pain along angle ribs, sternum on left at juncture true and false ribs. All treatment failed and cœliotomy done May 22, '91. Both ovaries diseased; right markedly cirrhotic; salpingitis. Improved rapidly and discharged twelfth day. Re-admitted to hospital September 24, '91, very hypochondriacal — no special treatment and patient left much improved, October 12, '91. March '92 much improved mentally and physically.

Case XLIX—Mrs. E. C., aet thirty-three, family history good. Suffered from dysmenorrhœa; at twenty had peritonitis; married at twenty-one; first child one year after; labor very difficult; dysmenorrhœa ceased after that; since birth of child has had dull aching pain, both sides ovarian regions. Treated fall of 1890 for stricture of rectum and lacerated cervix; no improvement; mass size large orange left side of pelvis. Diagnosis of salpingitis, operation advised. Cœliotomy May 27, 1891. Both ovaries enlarged, cystic, double pyosalpinx; appendages removed; many firm adhesions; glass drainage tube — rubber substituted third day, serous discharge still quite free; drainage removed seventh day; some pain over abdomen, otherwise recovery uninterrupted. Discharged on twenty-first day; in perfect condition of health September, '94; gained in flesh and strength; able to get about with absolute comfort.

Case LI. — Miss L. M., invalid many years, vague trouble. Physician suppesed it chronic case hysteria, but first examination revealed enlarged, inflamed ovary right side; extremely irritable descending colon; well marked myelitis lumbar region; extremely anæmic, erotic, sleepless, plaster jacket applied for artificial support, later Paquelin's cautery, down spine, excellent line of treatment tried with only temporary relief; menstruation irregular, scanty, painful. Diagnosis cirrhotic ovary double salpingitis. Oöphorectomy July 13, '91. Diagnosis confirmed, also pyosalpinx left side. Patient did nicely with exception of nausea for few days; stitches removed fifth day; recovery uneventful and discharged August 15, '91. Letters from Dr. Church and patient later report good result.

Case LII.—Mrs. A. E. B., family history good. Well during childhood; menstruated thirteen; delicate until twenty; one miscarriage. Periods not painful, but flow profuse. Well until eight weeks previous to operation. May, '91, noticed enlargement abdomen, supposed due to gain in flesh. October, '90, to June, '91, flowed constantly, but small in quantity. No show

since June, '91. July, '91, sudden, severe pain left side abdomen; diffuse and general peritonitis developed, lasting four weeks. Cœliotomy, September 1, '91. Large ovarian cyst, left side Both ovaries removed. Patient very weak during progress operation; hypodermics of brandy and strychnine given. Drainage-tube removed second day; bowels moved fifth day. Good recovery. Discharged nineteenth day.

Case LIII.—Mrs. M. M., family history negative; patient generally well; menstruated at fifteen; always regular—dysmenorrhœa. In '79, had inflammation of bowels. One miscarriage first year of marriage. Six months previous to operation noticed enlargement left inguinal region; increased rapidly, distending whole abdomen. Slight dyspnœa. Cœliotomy, October 1, '91. Ovarian cyst, left side, two gallons fluid. Pedicle of sac from left broad ligament—ligated in sections and removed, also tube and ovary, that side—cyst and hydrosalpinx. Patient rallied well from operation; troubled with nausea and vomiting two or three days. Sat up eleventh day; home fourteenth day, feeling very well. In good health one year later.

Case LIV.—Mrs. V. S., family history of paralysis; menstruated at fourteen, when she took cold; afterwards suffered from dysmenorrhœa; married at twenty-one; no children; no miscarriages. Thirteen or fourteen years previous to operation, tumor in right hypochondrium—contents evacuated, she said, through stomach. Sick nine years. Spinal trouble prevented walking for six months. Misplacement of uterus. October, '90, tumor in inguinal region—grew rapidly afterwards; in June, '91, distending whole abdomen. Menopause at fifty-two; cœliotomy, October 6, '91; short incision, large unilocular ovarian cyst, right side; six quarts fluid removed; cyst removed. Patient did nicely; bowels moved third day; discharged seventeenth day; in good health two years after operation.

Case LV.—Mrs. A. R., family history negative. Patient always in good health. Menstruated at fifteen; regular; menopause at thirty-seven. Ten children; one labor tedious and painful. May, '91, first noticed enlargement abdomen, which grew rapidly, causing dyspnœa and pain. Cœliotomy October 6, '91, before class; multilocular ovarian cyst; trocar in sac and gallon grayish, fetid pus removed; pedicle ligated and cut away; removal both ovaries; peritoneal cavity flushed with hot water; drainage tube lower end wound, packed with iodoform gauze—removed second day; fourth day, in absence nurse, patient got up; same next day, with no inconvenience except increased heart's action—120. Gained gradually; homesick and discontented and allowed to leave on eleventh day. Recovery excellent.

Case LVI.—Mrs. N. P., family history of consumption and cancer; well when young; menstruated at fourteen—regular except at seventeen when amenorrhœa three months; no children; no miscarriages; '89 doctor noticed tumor in right side; aspirated winter '91, through vagina, discharging for long time; lost flesh; appetite good, bowels regular. Cœliotomy October 8, '91; abscess in layers broad ligament; aspirated—about six ounces pus removed; great adhesions to intestines; glass drainage; nausea and vomiting for two days—improved after that rapidly; rubber tube substituted for glass few days before she went home, when she felt very well. Discharged twentieth day. Gained rapidly in flesh and strength; was well for nearly a year; then had an attack pelvic peritonitis, followed by abscess, and died, I am informed, of sepsis.

Case LVII.—Mrs. E. J. L., mother died of consumption aet forty; indefinite history dropsy. Menstruated at fifteen — regular before marriage at twenty-three. Since flow prolonged and lasting six days; sometimes overruns two or three weeks; once sixteen months. Feet wet eight years before operation, when flow excessive. One child, nineteen months old. Two attacks peritonitis — rheumatic troubles occasionally. First noticed tumor right side abdomen after birth child—grew rapidly following summer. Slight dyspnœa. Cœliotomy October 15, '91. Unilocular ovarian cyst; six quarts fluid removed; pedicle ligated and tumor removed with both ovaries; suffered second day from nausea and vomiting — lasting two days. Patient did well after this; stitches removed sixth day; sat up twelfth day. Regained strength very rapidly, and went home on sixteenth day.

Case LVIII.— Miss I. R., aet nineteen; family history good. Confined to bed part of time during menstruation. Diagnosis of chronic ovaritis with salpingitis and operation advised. Cœliotomy October 19, '91; left ovary much atrophied; removed with tube; right undergoing cystic degeneration, also removed with tube; much nausea and vomiting; considerable pain in abdomen after operation, but soon recovered; had uneventful convalescence, returning home on twentieth day. Three months after began to vomit — though having gained much in flesh and strength — which continued more or less until patient finally died with all the symptoms of cancer of the stomach, one year after operation.

Case LIX.—Miss L. L. McC., same patient operated upon October 7, '90. November 9, '91, not having improved, second cœliotomy performed; left ovary, size of hen's egg, found undergoing cystic degeneration, and removed with tube; patient much nauseated for several days, after which made an uninterrupted recovery. Discharged on twenty-ninth day. In excellent state of health August 1, '94.

Case LX.—Miss K. E. M., father died consumption aet fifty; history otherwise good; menstruated at fourteen; regular. October, '90, noticed distension abdomen, which increased; no pain until summer '91, then some in right inguinal region. Cœliotomy November 24, '91; unilocular ovarian cyst; eight quarts yellow fluid removed; tumor from left ovary; pedicle tied; right ovary cystic and removed; dressed as usual. Patient improved rapidly without any disturbance, and discharged on fifteenth day.

Case LXII.—Miss L. McK., cystic degeneration ovaries; pelvic peritonitis—salpingitis; removal uterine appendages—many adhesions; recovery; bowels moved fifth day; stitches removed seventh day. Discharged twentieth day.

Case LXIII.—Mrs. M. B. M., aet thirty-three, family history negative. Since birth first child, November, '88, has had severe attacks of peritonitis, with constant pain, more or less severe; no permanent improvement under continuous treatment; I saw her with family physician, December, '91, agreeing with him as to diagnosis of pelvic peritonitis with probable pyosalpinx. Cœliotomy December 14, '91; tubes very much enlarged, distinct pyosalpinx right side, ovaries in a condition of cystic degeneration, many adhesions and a tedious operation; glass drainage tube; good recovery, and discharged thirty-second day. In good health up to October and November, '93, when she had a discharge from vagina very much like menstrual flow. Repeated once during winter '94, Dr. Pond, family physician, previously discovering cyst

enlargement connected with right cornu of uterus. Aside from this patient in excellent health. I saw her in May, '94; no return of discharge; uterus seemed atrophied somewhat, but in good position; otherwise pelvis presented a normal condition.

CASE LXIV.—Mrs. F. E. D., paternal grandmother died cancer uterus—otherwise history negative. Diseases childhood—otherwise healthy. Menstruated at twelve—regular—pain at first. Married sixteen years; first child ten months after; four born; youngest two and one-half years. September, '90, pain low down in pelvis, left side; flowed two weeks; in bed three; since severe pain continuously increasing in area; more severe during monthly periods. Cœliotomy January 2, '92; oöphorectomy; tubes enlarged, containing pus; ovaries enlarged and cystic. Drainage; oozing few days, Rallied quickly; good recovery. Discharged fifteenth day.

CASE LXV.—Mrs. D. B., phthisis on mother's side; otherwise history negative. Diseases childhood. Menstruated thirteen; regular until eighteen, when married. First child at nineteen; second at twenty-three. Since birth first child very weak; pain in back, and right inguinal region—some leucorrhœa. Cœliotomy January 26, '92. Miliary tubercles over peritoneum: right ovary removed—tubercular; drainage; wound dressed usual manner. Patient rallied nicely; continued to improve constantly; drainage tube removed seventh day; went home twenty-fifth day very much improved and stronger. Good health fall '94.

CASE LXVI.—Mrs. M. K., aet twenty-seven; personal history good; family history of phthisis; one sister had tumor of neck. From '82 to '88 noticed abdomen distended at menstrual periods, decreasing a few days afterwards; but in '88 increase more prominent on left side. January 30, '92, diagnosis ovarian tumor. Cœliotomy February 2, '92. Unilocular cyst right ovary; very broad pedicle; dermoid cyst connected with left ovary; removed. In closing incision hemorrhage presented from pedicle on right side; controlled by chain stitch, and using fine silk for stitching over and over the peritoneal surfaces. Patient re-acted well. Visited her at four p. m., and her condition led me to fear internal hemorrhage; she was restless; pulse one hundred and forty; immediately re-opened, but only about one ounce of bloody serum in cavity of pelvis; ligatures, etc., in good condition. Drainage introduced; patient recovered during night; following day seemed much better, but heart's action weak, although other conditions favorable, and she died unexpectedly February 8 at five P. M. Autopsy revealed cause of death pulmonary embolism of right lung, with clot in right heart. I believe it was a great mistake, on my part, to re-open the peritoneal cavity. It was an additional shock to the patient, and if avoided she might have recovered.

CASE LXIX.—Mrs. F. S., tubercular peritonitis. Removal of uterine appendages March 9, '92. Recovery. Discharged thirty-first day. This patient had some symptoms of a return of her disease a year later.

CASE LXX. Miss B. C., tubercular peritonitis. Cœliotomy April 8, '92. Removal uterine appendages—drainage tube packed often. Removal sutures twelfth day. Recovery. Discharged thirty-second day. After history satisfactory.

CASE LXXII.—Mrs. A. H., family history negative. Diseases childhood. Menstruated thirteen; regular, profuse. Typhoid fever ten.

January, '91, sharp abdominal pains—constipated two years—micturition normal; lost flesh. Cœliotomy May 26, '92. Large trocar introduced; removed four gallons fluid; cyst adherent several places—pedicle right ovary—adhesions ligated; drainage inserted. Patient recovered nicely. Discharged thirtieth day.

CASE LXXIII.—Mrs. L. G., aet forty-two; family history negative. July, 91, severe pain in region right ovary; repeated attacks followed with vomiting. Two years after first attack abdomen enlarged; May 27, '92, patient measuring forty-six inches around umbilicus; large quantity of sugar in urine; specific gravity 1038; however, I was induced to operate, and cœliotomy performed May 29, '92. Multilocular ovarian cyst from left ovary; glass drainage; removed second day. Until this time no unfavorable symptoms; secretion of urine abundant, specific gravity 1030, color unchanged, etc., but large quantity sugar present. Amount passed second day, twenty-four hours after operation, fifty-six ounces, when secretion suddenly ceased; patient sank into comatose state, dying night third day after operation. Truly, this was a case not suited to any operative interference and should have been left alone, or merely tapped.

CASE LXXIV.—Mrs. I. L., father died cancer stomach; otherwise history negative. Diseases childhood. Menstruated at fourteen; normal; '85, severe pain right ovary, aggravated when riding or walking; attack lasted one year; '91 abdomen enlarged; continued until operation. April, '92, raking in yard, when seized with severe pain right side; continued several days; enlarged more rapidly after this. Cœliotomy June 15, '92. Cyst wall laid bare, trocar introduced and two gallons fluid removed, tumor from left ovary adherent in several places; left ovary and tube removed; abdomen flushed with warm water; six inch drainage tube inserted, packed with iodoform gauze. Patient made excellent recovery. Discharged twenty-ninth day. In good health June, '94.

CASE LXXVI.—Mrs. L. C. B., paternal grandmother died cancer. Patient well and strong. Menstruated at fifteen; regular until menopause at fifty. Since flowed irregularly until age of sixty. Ten children; two miscarriages. March, '91, first noticed pain and growth right side, ovarian region; not definitely located one spot. Gradual enlargement abdomen, but pain and soreness left after few weeks, returning March, '92. September, '92, very little pain in abdomen; vomited some; persistent insomnia. Cœliotomy September 30, '92. Large multilocular ovarian cyst right side removed; one or two cysts emptied in peritoneal cavity. Fluid clear in color; sixteen pints; drainage tube removed in twenty-four hours; vomited fourteen hours. Good recovery. Discharged thirteenth day.

CASE LXXVII.—Mrs. H. G., aet forty, widow, family history of phthisis. Menstruation always accompanied with more or less nausea, with vomiting. Married at thirty-six. Husband dissipated; married life not happy. September, '90, had first attack pelvic peritonitis, three months after abdomen enlarged, left side, in broad ligament; another attack pelvic peritonitis six months after first, tumor gradually enlarging. December 11, '91, suffered from all symptoms suppuration. At one time patient able to get out, came to my office and I confirmed her physician's diagnosis that of double pyosalpinx. with pelvic abscess, origin probably specific. Cœliotomy October 10, '92.

Double pyosalpinx, removal uterine appendages very tedious. They were the largest and abscess cavity greatest of any specimen I have ever removed. Glass drainage; discharge on examination gave evidence gonococci present. Patient rallied well from operation, all seemed well up to end fourth day, when vomiting began, presenting evidences peritonitis with great exhaustion; died end sixth day.

CASE LXXX.—Miss E. W., aet twenty-four. Decided history of phthisis. Patient had well-marked lateral curvature with rotation. Menstruation more or less irregular, during which time abdomen enlarged for three days, and she suffered much pain. Increase more rapid after '91. Cœliotomy November 1, '92. Multilocular cyst, right ovary; broad pedicle. Some adhesions, but not firm; drainage; vomiting not well controlled. Intestinal obstruction on third day, not relieved by any line of treatment, and patient died end of fifth day. Death caused by adhesions between small intestine and stump of pedicle.

CASE LXXXI.— Miss E. W., paternal side tubercular. Patient had very severe nose bleed; bleeding stopped at age twelve when menstruation began; but patient suffered sharp pain in back. '91 noticed enlargement abdomen which increased rapidly. Attacks dyspnœa. Cœliotomy November 3, '92. Diagnosis of multilocular ovarian cyst confirmed; fluid clear and straw-colored; pedicle ligated; incision closed. Wound healed by first intention; no drainage. No complications. Patient sat up seventh day, when stitches removed. Discharged twentieth day.

CASE LXXXIV.—Mrs. E. G., family history good, with exception father who died of consumption. Patient well and strong; worked very hard. Menstruated at twelve; ceased; again regular at sixteen, until '84 when pregnant. '88 first noticed pain left side, region ovary, to pubis and knee. Trouble in passing urine. Bowels very constipated; worse at times. October, '92 movements once in eight or nine days. March, '92, very severe pain until June, then patient went to Troy, undergoing operation for "falling of womb." In bed four weeks. When lying down sensation of difficulty in breathing; vomited everything placed in stomach unless in standing or sitting position. Flowed after operation more or less. Upon movement patient felt something move in abdomen, giving sensation of bag filled with water. Cœliotomy January 16, '93. Cyst presented, fluid removed; not many adhesions; different cavities multilocular cyst emptied. Pedicle ligated including left ovary. Degenerated ovary right side; tube, containing pus, removed. Patient rallied well. Discharged nineteenth day.

CASE LXXXV.—Miss F. W., father died gastritis, maternal grandmother cancer stomach. Patient well and strong. Menstruated twelve, regular to one year ago, flow scanty, every three weeks. '89 abdomen became distended, gradually increasing. Contents abdomen and contour changed one side to other when changing position. Sense tension over abdomen and down thighs. Cœliotomy January 18, '93; Ovarian cyst, removed, with right ovary. No adhesions. Left ovary healthy and left. Recovery uneventful and discharged twenty-first day.

CASE LXXXVI.—Mrs. M. B., aet forty, father died of dropsy, otherwise family history good. '88 had peritonitis, more or less distension following; no further pain until '92 when soreness appeared in region umbilicus. Con-

tinued for two months, gradually left, but abdomen continued to distend. December 21, '92, was tapped, five gallons of thick jelly-like fluid being removed. Remained in bed three days. Fluid continued to ooze from opening made by trocar, for several days. Distension of abdomen not greatly relieved, but passed urine more freely and bowels moved readily. January 16, '93, saw patient with family physician. Measured nearly sixty-three inches at umbilicus, so tense and full it was impossible to distinguish between ascites and possible tumor, but from nature of tapping I believed she had a multilocular ovarian cyst. Pelvic examination of very little assistance, patient being so fleshy cervix could scarcely be reached. Cœliotomy done January 18, '93, eleven A. M. Some ascitic fluid removed, multilocular cyst of left ovary found, larger sac emptied twenty-seven pints thick, dirty fluid. Several smaller cysts opened and with sac weighed nearly four pounds. Patient found about four months pregnant, although she gave no rational symptoms of this condition. Right ovary and tube normal. She did nicely for forty-eight hours, when she suddenly developed active uterine pains and aborted, having sharp post-partum hemorrhage. Although pulse was good, and she rallied well from miscarriage, she kept up a constant state of worry and died January 23. Could this case have been reached earlier, particularly after first tapping, I believe her chances for recovery would have been very good.

CASE LXXXVII.—Mrs. F. K., family history good. Menstruated at twelve; regular. One child; no abortions. '85, while pregnant, fell, but did not hurt herself much. Soon after pain came in left ovarian region—more at times than others—when at work. After birth child somewhat worse. Pain continued; sometimes could feel bunch seemingly deeply located at umbilicus—left side—this region sore to touch. April, '92, growth higher up in iliac region; growth more rapid two months previous to operation. Cœliotomy January 23, '93. Tumor presented; nine pints darkish fluid removed with sac and left ovary; pedicle tied as usual—no adhesions. Upon examination right ovary small cyst found very adherent and held down firmly. This cyst also removed and pedicle ligated. Closed as usual. Patient made splendid recovery. Discharged twenty-third day.

CASE LXXXVIII.—Mrs. A. W. K., family history fair. Menstruated thirteen; always pain till age of twenty when child born—afterward menstruated regular. Had acid dyspepsia but general health better. '85 fibroid tumor uterus diagnosed. Menopause at thirty-five. '87 abdomen began to enlarge but did not pay much attention to increase in size till Xmas, '92, when she began to have severe pain left side and groin. For three weeks before operation was not able to lie down at night but slept in large chair. Since Xmas, '92, enlargement very marked. Was consulted December 31, '92, and advised an operation. Cœliotomy February 2, '93. Removed about twenty-five pints of dark fluid and large multilocular ovarian tumor, right side, found tube and ovary left side perfectly normal. Slight adhesions. Recovery. Discharged twenty-eighth day.

CASE LXXXIX.—Mrs. D. S., aet thirty-four, family history negative. Mother three children—five miscarriages. March, '92, very ill, giving history of probable pelvic peritonitis. Husband dissipated, and treated for specific urethritis. August, '92, patient had another similar attack. I saw her November 7, '92, advising removal uterine appendages, believing case one of

double pyosalpinx, having specific origin. She did not reach hospital until February 8, '93, gowing constantly weaker. Cœliotomy February 11. Tubes very much distended, filled with pus; large abscess on left side. Sac attached to rectum, very serious adhesions; operation long and tedious, but finally completed, cavity thoroughly flushed with hot saline solution and left in nice, dry condition, all bleeding points having been controlled. No drainage. Patient reacted well, kidneys did their work well, very little vomiting, and symptoms seemed favorable, but patient died in condition of exhaustion on third day.

Case XC.—Mrs. E. D., family history negative. Menstruated at thirteen; normal. Inflammation bowels when sixteen; for two years following having attacks of malaria in summer. At twenty attacks bronchitis and asthma, occurring at intervals. February 28, '91, had bearing down pain, increasing every month until May when patient had pneumonia (doctor called in for uterine pain). Breasts became so large she could not wear corsets; abdomen bloated, pain in back and circulation poor. Under local treatment for three months patient relieved, but end of this period pains came on again, increasing every month. In May, '92, Dr. Brownell, Oneonta, N. Y., dilated cervix, but pain continued, although treatment carried out. Saw her October, '92; thorough cervical dilatation, but patient unable to wear stem pessary on account of pain; every month since pain increased in severity at flow. Cœliotomy February 13, '93. Pyosalpinx, both sides; parovarian cyst and structural change in left ovary. Removal uterine appendages. Stitches removed twelfth day. Dicharged twentieth day. This patient finally made a good recovery, though having some of her old pains for a year afterward.

Case XCI.—Mrs. A. W., family history good. Menstruated at fourteen, accompanied with pain for first three months; later painless until birth second child. At eighteen confined to bed with what physicians termed kidney disease. Passed urine frequently but small amounts; leucorrhœa. Since birth second child has had severe pain over ovarian region, especially marked left side. August, '92, sudden stoppage menstruation. Had cold, then high fever; lost much flesh; delirious for six hours. Constantly thirsty; passed large quantity urine. Prolapsed ovary, left side. Her physician stated that during summer of '92, urine contained sugar; previous to operation repeated examinations failed to reveal any. Cœliotomy February 16, '93. Left ovary prolapsed and degenerated, showing beginning tumor. Right ovary cirrhotic, with parovarian cyst near. Right duct stenosed markedly about one and one-half inches from ovary. Removed uterine appendages. Discharged cured March 4, '93. Patient in excellent health, June, '94.

Case XCII.—Mrs. K. W., family history good. Menstruated fourteen to fifteen—no trouble—no children—no miscarriages. February, '91, had quivering pain left side, then went to other side, pains increasing every month. Consulted Dr. Magee of Lansingburgh who diagnosed ovarian trouble. Went to bed till August, '92. In February, '93, pains came on again and I saw her March 13, '93, advising operation; cœliotomy March 18, '93. Both ovaries in state of cystic degeneration and removed. Vein in abdominal wall bled quite a good deal. Dr. Macdonald put in two deep sutures stopping all bleeding. Firm adhesions. Recovery. Discharged twenty-first day. Year later doing well.

Case XCIII.—Mrs. S., aet twenty-seven. Confined normally about two weeks previously. Chills on fourth day, with high temperature; consulting physician curetted uterus thoroughly; some detritis. Patient improved, but relapsed in a few days when second curetting done. Case finally concluded to be one of pyosalpinx, I was telegraphed for, prepared to operate. No abdominal distension, temperature one hundred and four and upwards, decided chills, severe perspiration; no evidence of general peritonitis; bowels moving, but local tenderness over pelvic region. Uterus well contracted. Cœliotomy April 19, '93. Right ovary and tube enlarged, giving evidence of septic trouble, and removed. Good recovery from operation, but slight tendency to suppuration of one superficial stitch. Chills not controlled. Every medical aid given, but patient gradually grew worse, dying fourth day after operation. Examination of ovary removed did not reveal any marked septic suppuration. Case probably one of true septicæmia.

Case XCIV.—Miss J. K., family history of phthisis. Patient rather delicate. Menstruated October, '92; regular until February, '93, when no flow up to time of operation. In February pain in right side, distending abdomen; increased after walking or meals, but improved by aiding digestion. Abdomen enlarged, and more or less pain. Cœliotomy May 2, '93. Diagnosis of tubercular peritonitis confirmed. Incision made and drainage continued. Patient left hospital twenty-eighth day. Later gave evidence of returning symptoms of disease, but afterwards improved.

Case XCV.—Mrs. P. D., grandmother died cancer, otherwise history good. Patient always healthy. No children—no miscarriages. Menstruated regularly. '91 first noticed enlargement abdomen, about median line, some pain left groin. Never severe. Enlargement increased in size but did not influence her general health. Always able to do her work. Last few months distension somewhat more rapid. Cœliotomy May 4, '93. Diagnosis left ovarian cyst confirmed. Cyst removed. Bowels moved second day. Recovery uneventful. Discharged twenty-third day.

Case XCVI.—Mrs. E. P., aet fifty, family history of cancer. '79 ovarian cyst removed from left side by Dr. Thomas of New York; menstruation normal until menopause, just previous to second operation. '89 right side began to enlarge until she was very much distended. Diagnosis of multilocular ovarian cyst. Cœliotomy May 16, '93. Diagnosis confirmed. Uneventful recovery. Discharged fifteenth day. Case of interest simply in being second operation, last incision being made through old cicatrix, which was found in good condition.

Case XCVII.—Mrs. I. P., family history very good. Patient had grippe '89, health not good since. Menstruated at eleven; regular until two months previous to operation; since flow increased. September, '91, first child born; no miscarriages. August, '92, had what she thought a miscarriage, but attending physician considered it an abdominal tumor. After this period noticed some enlargement of abdomen, but at menstrual periods seemingly less. Prolapsus since birth child. Worse in May, '93, and confined to bed. Severe pain in side and lower part back. At first occasional severe pain, but three weeks previous to entering hospital very severe. July 20, '93, saw patient; general peritonitis and so critical I tapped her, removing 108.5 c. c. coffee-colored fluid. Great relief followed, having good effect, with other treatment, in con-

trolling peritonitis. Cœliotomy July 24, '93. Multilocular ovarian cyst; tapped from within, several places, to admit of removal. Adhesions very slight; easily separated by hand and sponge. Glass drainage; removed following morning; little, if any, discharge. July 28, stitches removed; patient discharged August 12, doing well. Patient gave history morning sickness, some nausea during day, but certain she was not pregnant and general report against such being the case, still uterus gave evidence of about three months pregnancy. In pelvic examination could isolate uterus, which was enlarged, and I said to her husband and friends I thought she might be pregnant. Later, this patient presented all the signs of pregnancy and was delivered at time of a fine, healthy child, since which time she has been in perfect health.

Case XCVIII.—Mrs. M. F., father died cancer aet sixty; otherwise family history good. Menstruated about fourteen; regular. No children; no miscarriages; no serious illness, with exception small-pox. Says, however, at four years of age she had abscess in side. March 25, '93, suddenly sick in night; feeling of weakness; next morning fainted several times, also vomited slightly. Eating caused cramps in abdomen. Diagnosis tubercular peritonitis confirmed when cœliotomy done September 7, '93. Peritoneum extremely adherent to underlying structures. Large sac presented, first supposed to be a cyst; to settle this point it was tapped and some fecal matter and gas escaped, so pronounced a distended colon. Opening in colon closed without drainage. Patient rallied well from operation. Stitches removed nine days after operation. Discharged September 20, '93. In excellent health six months after operation.

Case XCIX.—Miss M. S., diagnosis of ovarian cyst; father killed; mother died of some form of heart trouble; one sister died of phthisis. No family history of cancer. Menstruated at fourteen; always regular. '78 noticed enlargement abdomen, supposed due to dropsy; not attended by pain, enlarging very slowly until '92, after which time it grew more rapidly; did not know which side enlargement appeared first. Cœliotomy September 8, '93; no adhesions; both ovaries removed; incision closed without drainage; wound healed without any unpleasant symptoms. Patient returned to her home feeling exceedingly well.

Case C.—Mrs. E. G. D., father died disease of liver; mother of cancer stomach. Patient healthy until menstruation at sixteen; very painful in region right ovary; no children; thinks once pregnant, not menstruating for one and one-half months; called physician, who gave her something to make her flow; flow very profuse, and thinks since never pregnant. '89 severe attacks pain region right ovary; so severe could not bear feet on floor. '92 again very severe pain lower part abdomen; obliged to urinate every five or ten minutes; vaginal douche relieved this, however. February, '93, dilated for anteversion, after which she improved slowly. July 5, '93, flowed; from 11th to 30th August flowed slightly every day; August 16th again seized severe pain region right ovary; September 6th flowed naturally. On examination uterus found empty, and tumor, large as an orange, present. Ectopic gestation diagnosed by physician, Dr. E. M. Pond, Rutland, Vt., immediate operation being advised. Brought to Albany hospital Saturday night September 16, '93. Cœliotomy September 17th, ten A. M.; right

tube contained remains extra-uterine pregnancy; removed; pyosalpinx left ovary and tube removed; drainage introduced; patient rallied from operation well; glass drainage tube removed, rubber substituted, on third day; stitches removed ninth day, wound almost entirely healed; uninterrupted recovery, and discharged in good condition twenty-third day. Excellent health since.

CASE CI.—Mrs. E. W., family history of tuberculosis on both sides. Patient very delicate. Menstruated at fifteen; very irregular, painful and scanty, frequently confined to bed for two or three days; no flow three months previous to operation. Married twelve years; three children; no miscarriages; very difficult labors; pain in region right ovary eight or nine years; sensation of throbbing, and as though tumor size of an egg present. Family physician referred case to me for removal tubes and ovaries; diagnosed pelvic peritonitis and pyosalpinx, in which I fully agreed. Cœliotomy September 21, '93. Very many adhesions; both ovaries removed; drainage tube removed third day, stitches eighth. Patient did well, and discharged October 25, '93, in good condition. In excellent health June, '94.

CASE CII.—This illustrates the necessity of the surgeon not allowing the pleadings of the patient to move him in the least in his line of action. Mrs. J. C. D., aet twenty-eight; no children; irregular in menstruation. Saw her with family physician August 15, '93; menstrual period skipped six weeks previously; severe pain right side August 13th, with some shock and slight hemorrhage from uterus; patient grew rapidly worse on 14th, placed in bed, some shock and evidence internal hemorrhage during day; recovered during night, and on morning of 15th I confirmed her physician's diagnosis of probable extra-uterine pregnancy. Against our better judgment we yielded to her pleadings not to have an operation; she did nicely for three weeks; symptoms returned, and we operated on 21st September, removing four months' fœtus, with placenta, also many clots from pelvic and abdominal cavity, right tube being implicated. Patient did not rally, and died twelve hours after operation. We should have operated at once upon presentation of symptoms so unmistakable.

CASE CIII.—Miss G. T., family history good. Diagnosed tubercular peritonitis, possibly ovarian tumor. Patient never strong. Menstruated at thirteen; never regular, and flow scanty. '91 caught in rain while menstruating, and dates illness from that time. Five weeks previous to operation abdomen enlarged rapidly, patient losing some in flesh; bowels and kidneys normal. Cœliotomy September 22, '93. Large amount reddish fluid removed from abdominal cavity, latter thoroughly washed out and glass drainage introduced; stitches removed ninth day; drainage on fifteenth day, when iodoform gauze substituted. Patient recovered without any unfavorable symptom, and discharged November 15, '93.

CASE CIV.—Mrs. M. V., family history of phthisis. Patient always healthy. Diagnosis of ovarian tumor. Menstruated at fourteen; regular; summer '92, skipped two months without flowing. Patient aet fifty-two time of operation. Since October, '92, menstruated more or less continuously. June, '93, first noticed abdominal tumor, although she thought abdomen was getting larger before this. August, '93, had severe pain, lasting about one week. This especially severe when attempting to work. Could not lie down, but had to

be bolstered up in bed. Cœliotomy September 23, '93. Large ovarian tumor right ovary. Seven quarts fluid removed. Some adhesions. Good recovery; clean, fine wound. Discharged twenty-third day.

Case CV.—Mrs. E. E., mother died consumption, otherwise family history good. Patient healthy as a girl. Menstruated at thirteen; regular, menopause seven years previous to operation at forty-seven years of age. About a year previous to operation ailing, and during past six months grew larger, but able to walk and lie down comfortably until six weeks ago. Since noticing tumor bowels constipated; ankles never swollen. Diagnosis multilocular ovarian cyst. Cœliotomy September 25, '93. Large multilocular ovarian cyst; tapped and removed with ovary right side; twenty pints fluid removed. No drainage. Patient did well and discharged sixteenth day. Good health August, '94.

Case CVI.—Mrs. I. A., family history good. Oldest child nine years of age had it lived. When seven months' pregnant taken sick and had convulsions, followed by abortion and child born dead. Youngest child three years and seven months old. Menstruation always regular. '89 noticed abdominal enlargement which steadily increased. Tumor when first seen large as hen's egg and movable when lying down. Cœliotomy September 28, '93. Multilocular ovarian tumor; fourteen quarts fluid, dark, gelatinous coffee-colored, removed, also tumor, right and left ovary. Drainage. Patient did well and discharged twenty-first day with no unfavorable symptoms.

Case CVII.—Miss E. E., aet twenty. Two years previous to operating suffered much pain in left inguinal region; mental condition not at all good; tendency to melancholia. Spring, '93, found to be suffering from ischio-rectal abscesses, with fistulous tract, also an opening into the vagina discharging pus. Very severe case of vaginitis, requiring thorough operation. Good recovery with exception of sinus connecting with vagina. Mental condition such that later oöphorectomy resorted to. Cœliotomy October 4, '93. Left ovary diseased, double pyosalpinx; removal uterine appendages. Patient made a good recovery, some improvement in general condition. Sinus in vaginal wall left side, healed. June, '94, not fully improved in mental condition.

Case CVIII.—Mrs. M. S., family history fair. Patient well, exception attacks of neuralgia, until marriage. Three children born, one alive. Four miscarriages, last, summer '92. Very ill during parturition. Menstruated at twelve, and during pregnancy after third month up to confinement. Regular since curetted, July 26, '93. Six weeks previous to operation had peritonitis, keeping her bed, almost continuously. '91, Dr. Boyd operated, she thinks, for lacerated perineum. June, '93, some intestinal obstruction, bowels not moving for three weeks. Cœliotomy October 7, '93. Both ovaries and tubes removed, latter adherent and right one cystic. Right tube in a condition of pyosalpinx. Patient convalesced nicely, although drainage was necessarily kept in lower end incision for over four weeks, owing to abscess that formed at that point. Discharged November 30, '93. Good recovery. Patient obliged to go to work at once. September, '94, presented with threatened hernia.

CASE CX.—Mrs. J. M., aet forty, married, two children, suffered from severe attack of pelvic peritonitis, with suppuration; confined to bed several months at a time, an invalid more or less past five years. Cœliotomy October 12, '93. Case double pyosalpinx, with atrophy ovary left side; right enlarged. Quite a number of adhesions. Removal uterine appendages. Patient made a quick and good recovery. Discharged from private hospital, November 8, '93.

CASE CXI.—Mrs. I. DeL., mother died heart disease and phthisis, otherwise family history good. Patient healthy as a girl. Menstruated at fourteen; never regular, and attended with pain. At twenty fell down stairs, hurting back. Three days after large passage blood from rectum. Ill for three weeks, and never strong after. '83 chair pulled from under her and worse since. Married twenty-three years; no children; no miscarriages. After last accident noticed tumor, supposed to be connected with uterus. First observed when using syringe taking vaginal douche. Under treatment tumor disappeared for three years. September, '92, reappeared, attended with very severe pain. Cœliotomy October 15, '93. Diseased ovary left side; double pyosalpinx. Removal uterine appendages. Recovery. Discharged November 18, '93. June, '94, doing very well.

CASE CXII.—Mrs. H. M., aet thirty-six, family history cancer and tuberculosis. Confined to bed at sixteen with bowel complaint for some time '91 began to flow more than usual, told she was pregnant, but passed term of confinement, when Dr. Rossman, of Ancram, N. Y., told her she had an ovarian tumor, which did not enlarge rapidly. October, '92, came to hospital, by advice physician, remaining for a short time. Distinct fluctuation right side abdomen, from pelvic region up. Owing to her feeble condition did not operate, but drew off about two quarts fluid. Repeated two or three times during following year, patient gradually improved, and grew stronger, although flow irregular. Diagnosis double ovarian cyst, possibly associated with a fibroid. Cœliotomy October 21, '93. Double multilocular ovarian cyst, fibroid size cocoanut connected with fundus of uterus, interstitial. Uterine artery secured; broad ligament tied in sections. No clamp; few adhesions. Operation one hour and fifty minutes. Fourteenth day lower end wound opened and quite a portion of pedicle with two silk ligatures came away. Some discharge of pus for ten days. Sinus packed. Recovered and discharged on twenty-seventh day. Doing nicely, March, '94.

CASE CXIV.—Miss M. N., aet thirty-one, family history good. Menstruation very irregular. '93 noticed growth in left side abdomen. Diagnosis of multilocular ovarian cyst. Symptoms increased, and cœliotomy done October 30, '93. Double ovarian cyst, multilocular. One contained about ten pints fluid, the other not so much. Large fibroid of uterus; removed by supravaginal hysterectomy. Tait clamp. Good recovery; discharged December 23, '93. Patient came under observation December, '94, with sarcoma of the pelvis and implicating sigmoid flexure. No operation possible.

CASE CXV.—Mrs. M. C. P., family history fairly good. Patient always healthy as a girl. Menstruated at thirteen; never regular, but painless. Married three years; one child fourteen months old; no miscarriages; menstruated when child was six weeks old; then flow ceased, re-appearing April, '93. Never noticed enlargement abdomen herself, but physician told her she

had some trouble. Thought at first she was pregnant; never in pain, and in good health all summer. Cœliotomy November 2, '93. Small ovarian cyst, left side; tapped with aspirator; both ovaries removed: right cirrhotic; recovery; discharged nineteenth day. In good health June, '94.

Case CXVI.—Mrs. S. H., aet twenty-six., history of two years' illness; well-marked attacks pelvic peritonitis, pelvic abscess, cystitis, pus in urine, evidence pyelitis left kidney, accompanied with vomiting. In New York hospital for several months. Saw her September, '93, but she was so feeble and emaciated I did not feel an operation could possibly be done. Under treatment she improved, and cœliotomy done November 2, '93. Double pyosalpinx, previously diagnosed. This confirmed, and appendages removed. Patient recovered, end of second week, when obstruction of bowels presented, partially relieved at times, but she died from exhaustion November 29, '93. No autopsy. I believe that here was a case of obstruction due to adhesions between the small intestines and surface of pedicle, possibly peritonitis only.

Case CXVII.—Mrs. R. C., family history of dropsy, phthisis and paralysis. Patient always healthy. Menstruated at fourteen; regular until '88. Married twenty-five years; six children, youngest sixteen years of age; no miscarriages. First noticed abdominal enlargement September 1, '93; not attended with pain until four or five weeks previous to operation. Cœliotomy, before class, November 2, '93. Twelve quarts yellowish fluid removed from abdominal cavity, which was found studded with tubercles; glass drainage; good recovery; discharged nineteenth day.

Case CXVIII.—Mrs. E. McC., no history of cancer or tuberculosis Patient healthy, with exception of having what she says was progressive muscular atrophy when seventeen. Menstruated fourteen. Married at fourteen; never had any children, but miscarriage when fifteen: always regular. In February, '92, first noticed feeling weight and oppression in left side and in back; sewed a good deal with sewing machine, always worse afterwards; April, '92, fell off stoop, struck on left side and felt worse since; February, '92, began to flow every two or three weeks; since April, '93, has been regular; August, '92, confined to bed for a time, and occasionally since. Cœliotomy November 16, '93. Both ovaries adherent; left one especially, removed first; right cystic, also removed; firm adhesions; glass drainage introduced; drainage removed after twenty-four hours; recovery; discharged December 30, '93.

Case CXIX.—Miss K., diagnosis old general and pelvic peritonitis—dysmenorrhœa—hystero-epilepsy. Diagnosis confirmed at operation, November 29, '83, private house. Left ovary and tube could not be found; removal ovary and tube right side, like small intestine; many and very firm adhesions; recovery. Very much better for six months after operation; since then occasional convulsions, not so severe, however; has had an occasional flow.

Case CXX.—Mrs. H. W., family history good. Eight children; one miscarriage, July, '92. Patient always healthy, with exception serious illness at thirteen; menstruated at that time, always regular; since miscarriage, pain in left side abdomen; May, '93, had inflammation kidneys; œdema ankles at times. Cœliotomy November 30, '93. Left ovary cystic, removed first; right cirrhotic, also removed; no drainage; good recovery; discharged twenty-second day. Excellent health eight months later.

Case CXXI.—Miss E. L. H., family history good. Patient always delicate. Menstruated fifteen; regular. '90 noticed enlargement abdomen, thinks first apparent right side; enlarged slowly but steadily since—no pain—sore when she walked far and feeling of being tired. Cœliotomy December 7, '93. Large ovarian cyst attached left ovary, contained twenty pints fluid—cyst when removed weighed fifteen ounces; right ovary atrophied, also removed; no drainage; good recovery. Discharged January 23, '94.

Case CXXII. Miss S., invalid for past three years, unable to get about her household duties; confined to room a good share of time. Menstruation at times very painful, quite free, much leucorrhœal trouble and bladder irritation. Diagnosis double pyosalpinx. Cœliotomy December 7, '93. Tubes very much thickened, full of pus, ovarian abscess on left side (right side tube double), ovary adherent to small fibroid situated in posterior wall uterus. Latter not disturbed.. Uterine appendages removed, patient making excellent recovery; discharged from private hospital on fifteenth day after operation.

Case CXXIII,—Mrs. E. M., family history good. Patient in fairly good health, though suffering much from pelvic pains at different times. Two months previous to operation suffered severe pelvic peritonitis, with undoubted salpingitis. Diagnosis double pyosalpinx, with adhesions. Patient emaciated and weakened. Cœliotomy December 15, '93, eleven A. M. Left ovary very adherent to surrounding structures, liberated with great difficulty. Trendelenberg position — considerable hemorrhage. Right ovary very adherent. Appendages thoroughly removed. Bleeding points controlled with one exception down on right side, where it seemed impossible to place ligature. Long artery forceps placed and left in position. Cavity abdomen thoroughly flushed with saline solution. Glass drainage; tampons iodoform gauze inserted around tube and forceps. Operation eighty minutes. Took anæsthetic nicely, but none for last half hour. Did not rally, dying from shock 10:50 P. M. day of operation. Impossible to have lessened this operation in any way. It was either to have abandoned it in beginning or to go on and complete, and result proved it too much for her strength.

Case CXXIV.—Mrs. M. S., aet seventy-one. Family history tuberculosis, paralysis and cancer. Menstruation not painful but irregular; passed menopause safely at fifty-one. January, '93, had severe attack of grippe, November, '93, first noticed abdominal enlargement and pain, particularly left side. Increased somewhat rapidly. Oedema of lower extremities during summer, '93. Tapped four times by family physician, Dr. A. W. Van Slyke, and once, in consultation, with myself about December 1, '93. Diagnosis multilocular ovarian cyst, and operation advised, although patient emaciated and weak. Cœliotomy December 18, '93. Large multilocular cyst, right ovary. Thirty-two pints fluid removed. Obliged to break down one cyst within another before removal of sac. Adhesions not numerous. Weight of cyst trifle over three pounds. Glass drainage. Patient did not rally from operation and died suddenly 4:15 A. M., December 19, '93, from symptoms of pulmonary infarction. This case would have stood a very much better chance for recovery had the operation been done immediately after first tapping.

Case CXXV.—Mrs. P. S., family history phthisis. Patient well as a girl. Menstruated thirteen—never regular—often twice month. 1891 suffered from pain right side abdomen. Attacks lasted half hour. Physician diagnosed

biliary colic. March, '93, after attack, noticed enlargement abdomen. Never painful. No history of being jaundiced. Operation December 21, '93. Small ovarian cyst right ovary; tapped and removed. Few adhesions. Left ovary cystic and removed. Small cyst left ovary ruptured, when attempting removal ovary. No drainage. Rallied nicely—some nausea. Bowels moved second day. Recovery uneventful. Discharged January 14, '94.

CASE CXXVI.—Miss H. V., aet nineteen, family history good. First noticed enlargement left side abdomen, August, '93, accompanied with much pain. Tumor increased rapidly. Cœliotomy January 2, '94. Large multilocular cyst left ovary, containing eleven quarts fluid, thick, viscid, dark-colored. Firm adhesions, from left side abdomen, with some coils small intestines. Right ovary in condition cystic enlargement, removed with tube. Glass drainage; removed second day. Recovery very rapid. Patient very homesick and allowed to return on tenth day. Returned to hospital May 15, '94, with marked growth left side of pelvis, probably nature sarcoma. Patient very much emaciated. No further operation advised.

CASE CXXVII.—Mrs. E. F. S., family history good. Mother two children. After birth second child, '86, patient had severe pain lower part abdomen—greatly increased when nursing child. Ulceration uterus treated daily, but never cured. Irregular flow; bearing-down pains; could not walk; lacerated cervix repaired February 10, '93—improved. This operation followed six weeks later by pelvic abscess which discharged through rectum. Pain in right ovary continued. Cœliotomy February 22, '94. Removal uterine appendages; many firm adhesions. Glass drainage. Uneventful recovery; discharged twenty-sixth day.

CASE CXXVIII.—Miss J. D., had given many symptoms of pelvic disturbance, but no special organic change to be observed. Had been vomiting more or less for six months, quite continuously for past three months. No line of treatment apparently any good. Finally, at the earnest solicitation of herself and friends, it was decided to do a cœliotomy, believing there was some diseased condition of the tubes and ovaries impossible to make out. Operation February 23, '94. Uterus not fully developed, yet tubes and ovaries presented a normal healthy condition. There were some few adhesions giving evidence of past pelvic peritonitis. These adhesions loosened up, tubes straightened, but appendages not removed. The case went on to complete recovery. Stomach behaved very much better after the operation, patient able to retain more nourishment. Morphine given for short time after operation. Slow but excellent recovery.

CASE CXXIX.—Miss A. E., pelvic peritonitis—dysmenorrhœa. Cœliotomy February 24, '94. Removal uterine appendages. Many firm adhesions. Excellent recovery.

CASE CXXX.—Miss M. D., family history very good. Never sick with exception two attacks diphtheria, last occurring '89, and dates all trouble from this. Menstruated sixteen, never regular, painful. Latter part '92, noticed pain right hypogastric region associated with enlargement in that locality. Pain increased, but tumor decreased. Cœliotomy February 27, '94. Double ovariotomy. Right ovary cystic, removed, cyst wall breaking down and fluid not measured. Left ovary in like condition. No drainage. Recovery uneventful. Discharged 30th day.

Case CXXXI.—Mrs. W. J. O., diagnosis doubtful as to nature tumor. No children; three miscarriages. Cœliotomy March 1, '94. Removal ovarian cyst left side. Enlarged ovary right side with pyosalpinx. Many adhesions. Recovery.

Case CXXXII.—Miss S. N., family history negative. Patient well until six months prior to operation, when languid, not inclined to work, and excitable. Menstruated fourteen; regular, scanty and painful. Sharp pain lower part abdomen. Cœliotomy March 19, '94. Left ovary cystic, tube much enlarged and corrugated—removed first. Right ovary showed similar condition and removed. Many adhesions. Wound closed without drainage. Recovery uneventful—discharged 19th day.

Case CXXXIII.—Mrs. L. D., married, one child. For past two years has suffered greatly from repeated attacks of pelvic peritonitis. An operation finally advised by her family physician, and in which I fully concurred. Cœliotomy March 23, '94. Many adhesions, tubes thickened; excellent specimens pus tubes. Uterine appendages thoroughly removed. One hypodermic morphine given after operation. Patient developed on third day an attack of bronchitis, temperature 101, pulse 100, respiration 22, but from this she made a good recovery. Wound did nicely, and she made excellent recovery.

Case CXXXIV.—Miss J. McC., family history good. Menstruated fourteen; irregular first few years, then regular but scanty and painful. Patient complained pains in back in lumbar region, persistent headache, more severe during menstrual periods. Never noticed enlargement abdomen. Scarlet fever in childhood, followed by inflammatory rheumatism. Diagnosis pyosalpinx. Cœliotomy March 30, '94. Ovaries and tubes low down in pelvis and hard to reach. Diagnosis confirmed; uterine appendages removed. Iodoform dressing used. Many adhesions. Patient made uneventful recovery—discharged 25th day.

Case CXXXV.—Mrs. H. A. L., aet forty-three, widow, no children. During married life constantly under treatment for uterine troubles, wearing all manners pessaries, confined to bed frequently for year at a time, had severe leucorrhœal trouble, at times dysmenorrhœal trouble. I saw her five years previous to operation with family physician, found her suffering severely from retroversion, enlarged tubes and every evidence of pyosalpinx. Advised an operation but patient would not consent. During five years following under variety of treatment, most of time making use of tampons herself; would recover for a month or so, but most of time confined to bed; great irritation of bladder frequently; constipated, very careless in every respect in care of person, had little love for medical profession, and no kind word for any one. February, 1894, consented to an operation, it requiring nearly a week's work on part of nurse to get surface of patient's body and vagina in any kind of aseptic condition. She was absolutely rebellious to taking of a bath, and proper evacuation of bowels. Made an effort to quarrel with nurse morning of operation because an additional scrubbing was insisted upon. Cœliotomy in my private sanitarium March 30, '94. Diagnosis confirmed. Operation difficult, though adhesions gave rise to little hemorrhage. Patient recovered from ether quickly, but rebellious in every respect as to carrying out line of treatment. Insisted upon sitting up in bed; objected to use of

bed-pan. Little vomiting, little tenderness over abdomen, but difficult to keep dressings on she was so restless. Bowels moved second day thoroughly well. At this time noticed abscess developing in left labia, opened and discharged pus very freely. Stitch-hole abscess lower end incision. Began to vomit at this time, which continued more or less. She wore out strength and patience of two nurses, and at last hypodermic injection of morphia necessary, learning then she had been using it for long time. Wound in every respect, aside from stitch-hole abscess, presented a healthy appearance, healing quickly, but patient died, evidently of septic peritonitis, April 5, '94. No autopsy. I think I voice the sentiment of every operator when expressing the desire to be delivered from such a patient.

CASE CXXXVI.—Miss J. K., family history consumption and diabetes. Menstruated fourteen; regular exception first few periods, then having seizures resembling epilepsy. Flow normal in amount. Diagnosis hystero-epilepsy. Cœliotomy April 6, '94. Removal uterine appendages—not difficult. Recovery; discharged 24th day. Had one convulsion six months after operation.

CXXXVII.—Mrs. M. S., family history consumption paternal side; good otherwise; menstruated fourteen, regular; dysmenorrhœa. No children; no miscarriages. Typhoid fever '86, two years later pain in ovaries and back. Bloating extremities and abdomen disappearing after time. Fell from hammock beginning menstruation, injuring back; later strained herself leaning over manger, followed by tumor in abdomen, not perceptible exteriorly, but noticed moving around. Cœliotomy April 17, '94. Ovaries found undergoing cystic degeneration; tubes corrugated and distended. Removal uterine appendages. Many adhesions. Good recovery. Bowels moved third day. Discharged May 23, '94.

CASE CXXXVIII.—Miss L. S., never strong; family history, several members died phthisis. During fall '93 patient suffered a prolonged, serious attack of pelvic peritonitis, giving evidence at times of trouble with appendix —probably tubercular peritonitis. From this attack she made a fairly good recovery and improved somewhat during the winter, although at times there presented occasional symptoms of appendicitis. Cœliotomy April 28, '94. Ovaries much enlarged, much thickened, pelvic peritonitis, perineum studded and giving evidence of old tubercular trouble. Appendix had many adhesions, as well as being thickened. This, together with the uterine appendages, was removed. Patient made good recovery, and discharged May 20, '94 from private hospital.

CASE CXXXIX.—Mrs. F. F., well as girl. No menstrual trouble. Married at eighteen; two children; '86 began to have pains in back; menstruation irregular since. Diagnosis cystic ovaries. Cœliotomy April 30, '94. Diagnosis confirmed. Removal appendages. Few adhesions. Wound closed silk worm gut sutures. Good recovery. Discharged 22d day.

CASE CXL.—Mrs. E. V., family history: father died Bright's disease, mother cerebral hemorrhage, otherwise good. Patient menstruated seventeen; married nineteen; first pregnancy normal; at second run over with wagon twice. Three children; two miscarriages, last October 10, '93, dating illness from this. Severe pain all time, both sides uterus, aggravated during micturition. No movements without use cathartics. Never noticed tumor in abdomen. Diagnosis fibroid uterus; dysmenorrhœa. Cœliotomy May 12, '94. Removal appendages. Recovery. Discharged 22d day.

Case CXLI.—Miss E. M. K., diagnosis ovarian cyst confirmed at operation May 20, '94. Removal double ovarian dermoid cysts. Few adhesions. Drainage. Recovery. Well June 16, '94.

Case CXLII.—Mrs. L. D., family history consumption, tumor and kidney trouble. Patient menstruated fourteen—regular, painful and profuse; two children; no miscarriages; '89 troubled with faintness, pains in abdomen, inguinal region and back. Severe headaches, dizziness, catarrh bladder. Diagnosis cystic degeneration both ovaries. Chronic peritonitis. Operation May 29, '94. Diagnosis confirmed. Removal uterine appendages. No drainage; good recovery; discharged 26th day.

Case CXLIII.—Mrs. A. G. W., married, one child. Five years previous to '88 she had given history some pelvic lesion, being confined to bed almost continuously. At this time much emaciated, waxy, pale looking. On examination then by Dr. Church there was found complete retroflexion with pelvic cellulitis, position of uterus and all giving very distressing condition of constipation and pain in securing movement of bowels. She had taken a great quantity of medicine, powerful laxatives having very little effect. There was much distress on pressure over the vertebræ in dorsal and lumbar region, sensitive throughout whole extent of spine with some lateral curvature. In the doctor's attempt to restore the uterus to its normal condition she suffered a sharp, acute attack of pelvic peritonitis. This was followed by a bloody discharge from the rectum giving indications of chronic dysentery. Spinal trouble treated successfully by application of plaster of Paris jacket. After uterus had been restored to its more normal position, the doctor dilated the cervical canal for relief of the stenosis which was followed by her only pregnancy. After fully recovering she was attacked with grippe which was followed by another long siege of dysentery, with evidence of some trouble about the left hip, thought at one time to be a case of hip disease. Finally all symptoms external to the pelvis improved and she could walk about quite well, when taken with severe cystitis which continued in a very tedious manner for some time, accompanied with paroxysms of pain of a most excruciating and lancinating character, in right iliac region, resulting in a discharge from vagina of an exceedingly copious disagreeable-smelling pus. Her general health was now very feeble, complete loss of appetite, free perspiration. At same time a swelling could be observed in right lumbar region, also below Poupart's ligament and at one time there was quite definite prominence in Scarpa's triangle making one feel quite positive that it was a case of psoas abscess. All of these conditions subsided immediately after free discharge from pelvis. When the case came under my observation in the beginning of winter of '94, I felt it was one of true double pyosalpinx and advised an operation. This was done May 30, '94. Many adhesions present; diagnosis fully confirmed; removal of uterine appendages followed by recovery; patient doing exceedingly well in every respect; discharged from private hospital on 26th day.

CXLIV.—Miss M. C. F., family history fairly good. One case phthisis on mother's side. Noticed enlargement left side abdomen about nine months previous—all symptoms of unilocular ovarian cyst; cœliotomy June 6, '94; removal left ovary and single cyst; diagnosis confirmed; simple operation in every respect; uninterrupted recovery. Patient left private hospital June 20, '94.

Case CXLV.—Mrs. A. McN., possible history phthisis on father's side. Patient healthy and robust as a girl; menstruated at fourteen; caught cold; flot ceased, not re-establishing itself for over a year. Regular up to present trouble, which commenced in '87. Last noticed slight flow May '94. Married twenty-two years; one child still-born, sixteen years ago. Supposed miscarriage about six years ago, at which time she suffered a great deal of bearing-down sensation and pain in lower portion abdomen and back. Oedema of ankles at times. Thinks enlargement abdomen increased slowly. More rapid for three or four months previous to operation, occurring right side first. Cœliotomy at own home June 16, '94. Multilocular ovarian cyst right side; short, broad pedicle; hemorrhage; recovery. Ligature came away latter part July. Patient developed symptoms phlebitis, but August, '94 around house and doing well.

No.	Name.	Physician and Residence.	Age. Civil Con.	Diagnosis of Disease.	Date of Operation.	Nature of Operation. Removal.	Result.	Remarks.
1	Mrs. C. C.	Dr. Weidman, Medusa, N. Y.	52 M	Multilocular ovarian cyst.	Feb. 20, 1888.	Multilocular cyst right ovary. Papilomatous. Many adhesions, Short, broad pedicle.	D	Patient died 4th day from intestinal obstruction. Autopsy, obstruction due to loop small intestine, attaching itself to stump pedicle.
2	Mrs. S. B.	Dr. Glidden, Little Falls, N. Y.	37 M	Unilocular ovarian cyst.	Feb. 24, 1888.	Diagnosis confirmed. Weight 20 lbs.	R	Uninterrupted recovery.
3	Mrs. F. C.	Dr. Houston, Cohoes, N. Y.	68 M	Multilocular ovarian cyst. Sarcoma of mesentery.	April 9, 1888.	Multilocular cyst and uterine appendages. Drainage.	R	Patient in good health six months after operation.
4	Miss C. D.	Dr. Bush, Springfield, N. Y.	24 S	Double pyosalpinx, cystic degeneration ovaries.	May 1, 1888.	Uterine appendages.	R	Stitch-hole abscess sixth day. Finally good union and excellent recovery.
5	Mrs. L. W.	Dr. Wright, Canaan, N. Y.	43 M	Unilocular ovarian cyst.	May 15, 1888.	Unilocular cyst, right ovary.	R	Uninterrupted recovery.
6	Mrs. A. M.	Dr. Hotaling, W. Township, N. Y.	46 M	Unilocular cyst, left side.	May 31, 1888.	Unilocular cyst, left ovary; also right ovary. Many adhesions. Weight 35 lbs.	R	Hypodermic injection morphia every six hours for 24 hours, then discontinued.
7	Mrs. A. O'C.	Dr. Grover, Port Henry, N. Y.	46 M	Multilocular ovarian cyst. left side.	May 31, 1888.	Multilocular cyst left ovary also right ovary. Many adhesions to intestines and bladder. Weight 20 lbs.	R	Temperature rose on the 8th day to 102-104 4-5 deg., returning to normal on 12th day after tarry, fetid discharge from vagina. No suppuration.
8	Mrs. P. A. R.	Dr. Wheeler, Pittsfield, Mass.	55 W	Double multilocular ovarian cyst.	July 5, 1888.	Diagnosis confirmed. Some intestinal adhesions giving rise to considerable hæm., requiring several ligatures. Weight, 40 lbs.	R	Uninterrupted recovery.
9	Miss E. B.	Dr. Montgomery, Lu Zerne, N. Y.	26 S	Many attacks pelvic peritonitis. Salpingitis.	Oct. 1, 1888.	Uterine appendages. Operation difficult.	R	Good recovery. Two years later patient died from what at time supposed to be sarcoma of cavity of pelvis.
10	Miss M. W.	Dr. Melick, Fort Edward, N. Y.	20 S	Unilocular ovarian cyst, left side.	Oct. 4, 1888.	Diagnosis confirmed.	R	Death on 14th day from general peritonitis. Autopsy revealed evidence pelvic hæm. probably caused by ligature becoming loosened in some way.

11	Mrs. C. W.	Dr. Noble, Cairo, N. Y.	34 M	Multilocular ovarian cyst.	Nov. 19, 1 888.	Multilocular cyst, left ovary. Right healthy, not removed; drainage for 48 hours.	R	Uninterrupted recovery.
12	Mrs. H. T. T.	Dr. Johnson, Belleayre, N. Y.	37 M	Multilocular ovarian cyst.	Dec. 21, 1888.	Diagnosis confirmed, 12 qts. fluid.	R	Uninterrupted recovery. Patient in good health, June, 1894.
13	Mrs. H. M. R.	Dr. Reiley, Fair Haven, Vt.	29 M	Salpingitis.	Dec. 22, 1888.	Uterine appendages.	R	Good recovery. Patient had metrorrhagia for six months after operation; finally, complete recovery.
14	Mrs. E. B.	Dr. Vander Veer, Albany, N. Y.	39 M	Pelvic or psoas abscess.	Jan. 4, 1889.	Pyosalpinx. One ovary and tube. Drainage.	R	Drainage continued for over two weeks.
15	Mrs. N. M.	Dr. Lape, Fair Haven, Vt.	26 M	Tubercular peritonitis.	Jan. 5, 1889.	Right ovary and tube. Drainage.	R	Mass removed proved on examination to be tubercular. Glass drainage gave much discomfort and 4th day replaced by rubber tube, this removed on 12th day.
16	Miss I. R.	Dr. Du Bois, Albany, N. Y.	26 S	Salpingitis. Pelvic peritonitis.	April 5, 1889.	Uterine appendages.	D	Death from peritonitis on 11th day, Possibly obstruction.
17	Mrs. M. E. H.	Dr. Wheeler, Chatham, N. Y.	45 M	Multilocular ovarian cyst.	April 12, 1889.	Cyst and ovaries.	R	Uninterrupted recovery.
18	Mrs. E. C.		26 M	Multilocular cyst, left ovary.	May 21, 1889.	Diagnosis confirmed. Right ovary in state cystic degeneration and removed. Drainage.	R	Uninterrupted recovery.
19	Mrs. F. W.	Dr. Van Vranken, West Troy, N. Y.	40 M	Unilocular cyst, left ovary.	June 15, 1889.	Multilocular cyst, left ovary. Drainage.	R	Good recovery but patient suffered from hernia six months after operation.
20	Mrs. B. A.	Dr. Maxon, Chatham, N. Y.	22 M	Unilocular ovarian cyst.	Aug. 20, 1889.	Unilocular cyst left ovary also right ovary. Very adherent.	D	Death from shock.
21	Mrs. E. B.	Dr. Fuller, Huntsville, N. Y.	47 M	Multilocular cyst, left ovary.	Sept. 23, 1889.	Cyst and uterine appendages. Colloid degeneration. Drainage.	R	Uninterrupted recovery.
22	Mrs. C. L.	Dr. A Boyce, E. Schodack, N. Y.	63 M	Multilocular ovarian cyst.	Oct. 14, 1889.	Diagnosis confirmed. Many adhesions. Drainage.	R	Severe vomiting for 48 hours after operation. Drainage quite free. Excellent recovery.
23	Mrs. C. C.	Dr. Johnson, Champion, N. Y.	59 M	Unilocular cyst, right ovary.	Oct. 15, 1889.	Diagnosis confirmed.	R	Uninterrupted recovery.

No.	Name.	Physician and Residence.	Age. Civil Con.	Diagnosis of Disease.	Date of Operation.	Nature of Operation. Removal.	Result.	Remarks.
24	Mrs. M. B.	Dr. Layman, Middleburg, N. Y.	47 M	Unilocular cyst, left ovary.	Oct. 29, 1889.	Diagnosis confirmed.	R	Uninterrupted recovery.
25	Mrs. R. H.	Dr. Babbitt, Cooperstown, N. Y.	36 M	Pelvic peritonitis. Salpingitis.	Nov. 4, 1889.	Adhesions loosened but too severe for removal of appendages.	R	Good recovery. Patient very much improved in health, one year after operation.
26	Mrs. R. A.	Dr. Best, Middleburg, N. Y.	35 M	Unilocular cyst, left ovary	Nov. 11, 1889.	Unilocular cyst, left ovary; also right ovary.	R	Uneventful recovery.
27	Mrs. D. S.	Dr. Allen, Greenbush, N. Y.	37 M	Supposed, large ovarian cyst.	Nov. 13, 1889.	Incision. Right ovary removed. Tubercular peritonitis.	R	Error in diagnosis. Patient died later on of return of peritoneal dropsy.
28	Mrs. S. N. from Montana.	Dr. St. J. Middle, Brunswick, N. Y.	32 M	Large unilocular cyst right ovary.	Dec. 5, 1889.	Unilocular cyst, right ovary; also left ovary. Cyst 22 lbs.	R	Chill on 4th day controlled by quinine. Uninterrupted recovery followed.
29	Mrs. H. N.	Dr. Hall, W. Hartford, N. Y.	34 M	Chronic ovaritis. Pelvic peritonitis.	Jan. 27, 1890.	Uterine appendages.	R	Uneventful recovery.
30	Mrs. A. McK.	Dr. Turner. Mineville, N. Y.	20 M	Chronic ovaritis.	Feb. 23, 1890.	Uterine appendages, cystic degeneration of ovaries. Many adhesions.	R	Good recovery.
31	Mrs. E. H.	Dr. Dunlop, Waterford, N. Y.	55 M	Multilocular cyst, left ovary.	April 20, 1890.	Diagnosis confirmed. Hard mass on right side not disturbed.	R	Good recovery. Hernia observed one year after operation, not troublesome. Hard mass still observed 2 years, 6 months after operation, not enlarging. Ligature came away, July, 1890.
32	Mrs. J. V.	Dr. Traver, Troy, N. Y.	30 M	Multilocular cyst, left ovary.	April 30, 1890.	Diagnosis confirmed. Drainage removed on seventh day.	R	Excellent recovery, although long search had to be made, for sponge lost in cavity.
33	Miss A. O.	Dr. Pearson, Schenectady, N. Y.	30 S	Chronic ovaritis. Dysmenorrhœa.	June 16, 1890.	Uterine appendages.	R	Uninterrupted recovery.
34	Mrs. E. C.	Gray, N. Y.	34 M	Unilocular ovarian cyst.	Sept. 20, 1890.	Multilocular cyst, right ovary. Parovarian cyst, left side.	R	Uneventful recovery.

35	Miss L. McC.	Dr. Young, Glenville, N. Y.	23	S	Chronic salpingitis. Left ovary cystic. Retroversion.	Oct. 7, 1890.	Right ovary and tube. March, '89, had been to Seney hospital, N. Y., and Alexander's operation done by Dr. Pitcher.	R	Recovery uninterrupted.
36	Miss M. G.	No. Easton, N. Y.	18	S	Multilocular cyst, right ovary.	Oct. 10, 1890.	Diagnosis confirmed. Left ovary healthy, not removed.	R	Good recovery. Apposition lower angle wound not perfect, silk-worm gut. Exuberant granulations.
37	Mrs. E. W.		24	M	Chronic salpingitis. Pelvic peritonitis.	Oct. 21, 1890.	Right ovary and tube. Left healthy.	R	
38	Mrs. S. K.	Dr. Bissell, Troy, N. Y.	33	M	Pyosalpinx double.	Oct. 30, 1890.	Uterine appendages and a small fibroid fundus of uterus Drainage.	R	Free hæm. from fundus uterus when fibroid removed, controlled by thermo-cautery. Ligature came away 8 weeks after operation. Recovery uneventful.
39	Mrs. F. M.	Dr. Matte, No. Adams, Mass.	35	M	Ovaritis; salpingitis.	Nov. 29, 1890.	Uterine appendages.	R	Patient made a slow but good recovery.
40	Mrs. J. E.	Dr. Kathan, Schenectady, N. Y.	26	M	Ovaritis, right side.	Dec. 18, 1890.	Right ovary size turkey egg and tube.	R	Quick recovery. Two years after patient became pregnant, passed through successfully, delivered of living child. Excellent health since.
41	Miss E. K.	Dr. Vander Veer, Albany, N. Y.	33	S	Unilocular ovarian cyst, probably left.	Jan. 3, 1891.	Unilocular cyst, left ovary and uterine appendages. Drainage.	R	10th day lower end incision opened and from 4 to 5 ounces fetid pus discharged. Irrigation tract of drainage tube. Good recovery.
42	Miss M. G.	Valley Falls, N. Y.	20	S	Tubercular peritonitis Left ovary enlargsd.	Jan. 14, 1891.	Left ovary and tube. Drainage.	R	Good recovery. Patient in excellent health, June, 1894.
43	Miss J. S.	Dr. Vander Veer, Seward, N. Y.	19	S	Unilocular cyst, left ovary.	Feb. 28, 1891.	Diagnosis confirmed. Right ovary, cyst and incised.	R	Immediate hæm. due to slipping of ligature, abdomen re-opened, pedicle re-ligated. Two pints saline solution poured into peritoneal cavity.
44	Mrs. A. E.	Albany, N. Y.	20	M	Multilocular ovarian tumor.	March 3, 1891.	Mass from left side sarcoma; cyst from right ovary. Drainage.	R	Patient did well. Able to do her work for more than a year. 2d operation; removal part of new growth. Living June, 1894, with fistulous tract from which protruded sarcomatous mass.

No.	Name.	Physician and Residence.	Age. Civil Con.	Diagnosis of Disease.	Date of Operation.	Nature of Operation. Removal.	Result.	Remarks.
45	Mrs. N. A.	Dr. Stickles, Philmont, N. Y.	30 M	Hæmatosalpinx.	March 18, 1891.	Uterine appendages. Right side extra-uterine pregnancy.	R	Patient had regular menstrual flow for more than a year, then cavity uterus thoroughly curetted, packed with iodoform gauze when flow ceased and she has remained well since.
46	Mrs. M. S.	Dr. Rulison, Amsterdam, N. Y.	44 M	Multilocular ovarian cyst.	April 23, 1891.	Multilocular cyst, left ovary. Right ovary undisturbed	R	Ligature came away nearly 6 months after operation; sinus readily healed. In good health August, 1894.
47	Mrs. E. C.	Dr. Babcock, Albany, N. Y.	33 M	Chronic ovaritis.	May 4, 1891.	Uterine appendages. Extensive adhesions. Drainage.	R	Good recovery. Hernia one year after operation.
48	Mrs. A. McC.	Dr. Webster, Schuylerville, N. Y.	32 M	Chronic ovaritis and pyosalpinx. Specific.	May 22, 1891.	Uterine appendages.	R	Good recovery from operation, but complained for over two years of old feeling; weakness about pelvis and pain in back.
49	Mrs. E. C.	Dr. Neher, Nassau, N. Y.	33 M	Chronic ovaritis and pyosalpinx.	May 27, 1891.	Uterine appendages. Drainage.	R	Good recovery. Patient had undergone operation for lacerated cervix 3 months previously. Excellent health Aug., 1894.
50	Mrs. E. B.	Dr. McHarg, Albany, N. Y.	28 M	Multilocular ovarian cyst.	May 30, 1891.	Multilocular cyst and both ovaries. Drainage.	R	Excellent recovery.
51	Miss L. M.	Dr. Church, Oneonta, N. Y.	26 S	Cystic degeneration ovaries and salpingitis.	July 13, 1891.	Uterine appendages.	R	Good recovery—somewhat slow. In excellent health, Aug., 1894.
52	Mrs. A. E. B.	Dr. Bigelow, Albany, N. Y.	42 M	Multilocular ovarian cyst. Peritonitis.	Sept. 1, 1891.	Multilocular cyst, left ovary and right ovary. Cyst suppurating. Drainage.	R	Excellent recovery and in good health, June 1894.
53	Mrs. M. M.	Dr. Felter, Troy, N. Y.	32 M	Unilocular cyst, left ovary.	Oct. 1, 1891.	Left ovary, also hydrosalpinx, right side.	R	Good recovery. Patient in good health one year afterwards.
54	Mrs. V. S.	Dr. Nichols, Worcester, N. Y.	53 M	Ovarian cyst, right side.	Oct. 6, 1891.	Unilocular cyst, right ovary. 6 qts. fluid.	R	Excellent recovery and in good health two years after operation.
55	Mrs. A. R.	Dr. Mambert, Rondout, N. Y.	55 M	Multilocular ovarian cyst.	Oct. 6, 1891.	Suppurating cyst and both ovaries. Drainage.	R	Excellent recovery.

56	Mrs. N. P.	Dr. Lamont, Catskill, N. Y.	31 M	Supposed suppurating ovary, right side.	Oct. 8, 1891.	Incision; great adhesions of intestines. Large abscess. Drainage.	R	One year after operation developed second abscess, producing septicæmia, from which she died.
57	Mrs. E. J. L.	Dr. Magee. Lansingb'gh, N. Y.	30 M	Unilocular ovarian cyst with peritonitis.	Oct. 15, 1891.	Cyst and both ovaries.	R	Good recovery. In excellent health two years after operation.
58	Miss I. R.	Dr. Salmon, Lansingb'gh, N. Y.	19 S	Chronic ovaritis Dysmenorrhœa.	Oct. 19, 1891.	Uterine appendages. Atrophy of both ovaries.	R	Very good recovery but died one year after from cancer in stomach, vomiting almost continually for 3 months previous to death.
59	Miss L. L. McC	E. Glenville, N. Y.	24 S	Cyst of left ovary.	Nov. 9, 1891.	Cyst left ovary like small orange.	R	Second operation. (See case 35). Patient in excellent health, Aug., 1894.
60	Miss K. E. M.	Dr. Bigelow, Albany, N. Y.	23 S	Unilocular ovarian cyst.	Nov. 24, 1891.	Unilocular cyst, left ovary. Right ovary cystic and removed.	R	Excellent recovery.
61	Mrs. M. J. V.	Dr. Gray, Cambridge, N. Y.	40 M	Unilocular ovarian cyst.	Dec. 7, 1891.	Unilocular cyst, left ovary.	R	Excellent recovery.
62	Mrs. L. McK.	Dr. Vander Veer, Albany, N. Y.		Cystic degeneration ovaries. Pelvic peritonitis salpingitis.	Dec. 7, 1891.	Uterine appendages.	R	Excellent recovery.
63	Mrs. M. B. M.	Dr. Pond, Proctor, Vt.	33 M	Pelvic peritonitis. Pyosalpinx.	Dec. 14, 1891.	Uterine appendages. Many adhesions. Atrophy both ovaries. Drainage.	R	Excellent recovery. Patient relieved promptly from all sufferings. November and December, 1893, quite a flow each month. Excellent health since, last seen, May, 1894.
64	Mrs. F. E. D.	Dr. Sheffield, Masonville, N. Y.	27 M	Pyosalpinx.	Jan. 2, 1892.	Uterine appendages. Tubes large and filled with pus. Drainage.	R	Excellent recovery.
65	Mrs. D. B.	Dr. Edwards, Gloversville, N. Y.	30 M	Unilocular ovarian cyst, possibly tubercular peritonitis.	Jan. 26, 1892.	Right tube and ovary. Tubercular peritonitis. Drainage.	R	Good recovery.
66	Mrs. M. K.	Dr. Simons, Canajoharie, N. Y.	27 M	Unilocular ovarian cyst.	Feb. 2, 1892.	Right tube and ovary. Also right ovary. Dermoid. Drainage.	R	Broad pedicle. Immediate hæmorrhage from retraction vessels before abdominal incision closed. Vessels tied separately. At end 48 hours, from condition, pulse and symptoms, possible internal haemorrhage. Wound re-opened. Only 1 oz. blood in pelvic cavity. Drainage. Death 6th day from exhaustion.

No.	Name.	Physician and Residence.	Age. Civil Con.	Diagnosis of Disease.	Date of Operation.	Nature of Operation. Removal.	Result.	Remarks.
67	Mrs. I. H.	Dr. Infield, Sandy Hill, N. Y.	59 M	Multilocular ovarian cyst.	Feb. 12, 1892.	Cyst, right ovary. Slight adhesions.	R	Good recovery. In excellent health, May, 1894.
68	Mrs. M. A. D.	Dr. Still, Johnstown, N. Y.	25 M	Salpingitis. Hystero-epilepsy.	March 5, 1892.	Uterine appendages.	R	Menstruated nearly every month since operation. Better for some time of epileptic seizures, but September, 1894, quite as bad as ever.
69	Mrs. F. S.	Dr. Gray, Greenwich. N. Y.	35 M	Tubercular peritonitis.	March 9, 1892.	Uterine appendages. Drainage.	R	Patient in excellent health, May, 1894.
70	Miss B. C.	Dr. Holdridge, Niskayuna, N. Y.	16 S	Tubercular peritonitis.	April 8, 1892.	Uterine appendages. Drainage.	R	Patient died 3 months after operation, from all symptoms general tuberculosis.
71	Mrs. A. B.	Dr. Millbank, Greenbush, N. Y.	32 M	Tubercular peritonitis.	May 2, 1892.	Incision, cocaine. Ovaries studded with tubercles; also peritoneum. Drainage.	R	Patient in excellent health, May, 1894.
72	Mrs. A. H.	Dr. Nichols, Sand Lake, N. Y.	28 M	Ovarian cyst, peritonitis.	May 26, 1892.	Cyst, right ovary; numerous adhesions. Ligated; drainage.	R	Good recovery. Patient in good health one year after operation.
73	Mrs. L. G.	Dr. Papen, Albany, N. Y.	42 M	Multilocular ovarian cyst.	May 29, 1892.	Cyst of right ovary and tube; many adhesions. Left tube and ovary removed. Drainage 2d day.	R	Suffered from diabetes for 2 years. At time of operation passed urine containing 9 grains sugar to oz. Died comatose 3d day.
74	Mrs. I. L.	Dr. Haynes, Cohoes, N. Y.	35 M	Unilocular ovarian cyst.	June 15, 1892.	Cyst, left side; right ovary healthy. 2 gals. fluid. Drainage	R	Excellent recovery and in good health, June, 1894.
75	Mrs. M. D.	Dr. Hannan,	48 M	Ovarian cyst,	Aug. 30, 1892.	Diagnosis confirmed.	R	Uninterrupted recovery.
76	Mrs. L. C. B.	Dr. Wilson, Schodack, N. Y.	71 M	Multilocular ovarian cyst.	Sep. 30, 1892.	Cyst, right ovary. Left ovary not disturbed. Some adhesions. 8 quarts fluid. Drainage.	R	Good recovery. Patient alive, June, 1894.
77	Mrs. H. G.	Dr. Geel, Berlin, N. Y.	40 W	Double pyosalpinx, specific.	Oct. 10, 1892.	Uterine appendages. Very tedious operation; many adhesions. Drainage.	D	Death on 6th day from exhaustion.
78	Mrs. M. A. A.	Dr. Knapp, Forest City, Pa.	27 M	Double pyosalpinx and tubercular peritonitis.	Oct. 14, 1892.	Uterine appendages. Drainage.	R	Good recovery. Patient writes May, 1893, seldom had such good health as then enjoying.

79	Miss A. A.	Dr. Kellogg, Plattsburgh, N. Y.	39 S.	Double pyosalpinx, cirrhotic ovaries.	Oct. 30, 1892.	Diagnosis confirmed. Uterine appendages.	R	Good recovery. Much improved in health, December, 1893.
80	Miss E. W.	Dr. Scully, Rome, N. Y.	24 S	Multilocular ovarian cyst. Peritonitis.	Nov. 1, 1892.	Cyst, right ovary. Some adhesions.	D	Death on 5th day, due to intestinal obstruction.
81	Miss E. W.	Dr. Taylor, Bainbridge, N. Y.	16 S	Multilocular ovarian cyst.	Nov. 3, 1892.	Diagnosis confirmed.	R	Recovery on about 16th day.
82	Miss C. L. L.	Drs. Kniskern and Stover, Amsterdam, N. Y.	40 S	Double pyosalpinx.	Nov. 29, 1892.	Diagnosis confirmed. Uterine appendages.	R	Excellent recovery.
83	Mrs. K. O.	Dr. Johnson.	37 M	Unilocular ovarian cyst.	Dec. 1, 1892.	Diagnosis confirmed.	R	Good recovery.
84	Mrs. E. G.	Dr. Carty, North Granville, N. Y.	37 M	Ovarian cyst and pyosalpinx.	Jan. 16, 1893.	Cyst and uterine appendages.	R	Excellent recovery.
85	Miss F. W.	Dr. Lough, Edmeston, N. Y.	19 S	Unilocular cyst, right ovary.	Jan. 18, 1893.	Diagnosis confirmed. Left ovary healthy. Not disturbed.	R	Excellent recovery. In good health, Sept., 1894.
86	Mrs. M. B.	Dr. Papen, Albany, N. Y.	40 M	Multilocular ovarian cyst and suspected pregnancy.	Jan. 18, 1893.	Multilocular cyst, right ovary. Pregnancy 4 months. 27 pints fluid.	D	Patient's history very interesting. Tapped twice. Aborted 48 hours after operation. Death from exhaustion on 5th day.
87	Mrs. F. K.	Dr. Phillips, Gloversville, N. Y.	30 M	Cyst, left ovary.	Jan. 23, 1892.	Unilocular cyst, each ovary, 9 pints fluid.	R	Excellent recovery. Good health, June, 1894.
88	Mrs. A. W. K.	Dr. Gorham, Albany, N. Y.	57 M	Multilocular ovarian cyst. Recent peritonitis.	Feb. 2, 1893.	Cyst right ovary. Left ovary and tube normal. Slight adhesions. 25 pints fluid. Drainage.	R	Excellent recovery. In good health, Sept., 1894. Looks ten years younger than before operation.
89	Mrs. D. S.	Dr. Brownell, Oneonta, N. Y.	34 M	Double pyosalpinx. Specific probably. Several attacks pelvic peritonitis.	Feb. 11, 1893.	Uterine appendages. Very serious adhesions.	D	Operation long and tedious. Death from exhaustion on 3d day.
90	Mrs. E. D.	Dr. Brownell, Oneonta, N. Y.	23 M	Double pyosalpinx.	Feb. 13, 1893.	Uterine appendages.	R	Good recovery, though at times suffering from pelvic pain and had some flow for few months following operation.
91	Mrs. A. W.	Dr. Hall, Adamsville, N. Y.	24 M	Left ovary diseased. Dysmenorrhœa, etc.	Feb. 16, 1893.	Uterine appendages. Left ovary, prolapsed and developing cyst. Right cirrhotic stenosis of tube.	R	Good recovery. In excellent health, June, 1894.
92	Mrs. K. W.	Dr. Magee, Lansingburgh, N. Y.	25 M	Pelvic peritonitis. Pyosalpinx double.	March 18, 1893.	Uterine appendages. Cystic degeneration of ovaries. Firm adhesions.	R	Not a rapid recovery, but ultimately improved aud presents the best appearance of health. June, 1894.

No.	Name.	Physician and Residence.	Age. Civil Con.	Diagnosis of Disease.	Date of Operation.	Nature of Operation. Removal.	Result.	Remarks.
93	Mrs. S.	Dr. Lincoln and Dr. Hodgman, Wilton, N. Y.	27 M	Pyosalpinx puerperal.	April 19, 1893.	Right ovary.	D	Operation following confinement 12 days previously. Septic condition. Uterus curetted twice. Chills, etc., not controlled. Death 4th day.
94	Miss J. K.	Dr. Ross, Whiting, Vt.	15 S	Tubercular peritonitis.	May 2, 1893.	Incision. Drainage.	R	Excellent recovery.
95	Mrs. P. D.	Dr. Johnson, Ashland, N. Y.	40 M	Ovarian cyst.	May 4, 1893.	Unilocular cyst, left ovary.	R	Uninterrupted recovery.
96	Mrs. E. P.	Dr. Fritts, Hudson, N. Y.	50 M	Cyst, right ovary.	May 16, 1894.	Unilocular cyst, right ovary.	R	Quick recovery. Second operation. Dr. T. G. Thomas removed cyst, left ovary, 1879
97	Mrs. I. P.	Dr. Rider, Buskirk's Bridge, N. Y.		Multilocular ovarian cyst. Peritonitis. Possible suppuration and pregnancy.	July 24, 1893.	Multilocular cyst, right ovary, Slight adhesions. 3 months pregnant.	R	Good recovery followed by normal confinement at full time. In excellent health, June, 1894.
98	Mrs. M. F.	Drs. Archambeault and Morrow, Cohoes, N. Y.	32 M	Tubercular peritonitis.	Sept. 7, 1893.	Diagnosis confirmed. Drainage.	R	Good recovery. In excellent health 6 months later.
99	Miss M. S.		38 S	Unilocular cyst, right ovary.	Sept. 8, 1893.	Diagnosis confirmed. Pyosalpinx; left tube removed with ovary.	R	Excellent recovery.
100	Mrs. E. G. D.	Dr. Pond, Rutland, Vt.	27 M	Extra uterine pregnancy, right side.	Sept. 17,	Extra uterine pregnancy, right side, with tube and ovary. Pyosalpinx, left ovary and tube removed. Drainage.	R	Rapid recovery.
101	Mrs E. W.	Dr. Stover, Albany, N. Y.	29 M	Double pyosalpinx, probably specific.	Sept. 21, 1893.	Uterine appendages.	R	Good recovery. Patient doing well, June, 1894.
102	Mrs. J. C. D.	Drs. Keegan and Hennesy, Albany, N. Y.	28 M	Extra-uterine pregnancy.	Sept. 21, 1893.	Four months fœtus and placenta. Many clots, right side.	D	Death from shock in 12 hours.
103	Miss G. T.	Dr. Smith, Poultney, Vt.	18 S	Tubercular peritonitis.	Sept. 22, 1893.	Uterine appendages. Ovaries and tubes studded with tubercular masses. Tubes thickened. Drainage.	R	Excellent recovery.

104	Mrs. M. V.	Dr. Easton, Van Hornesville, N. Y.	52 W	Multilocular cyst, right ovary.	Sept. 23, 1893.	Diagnosis confirmed. Some adhesions. Left ovary healthy. Not removed. 7 qts. fluid.	R	Splendid recovery.
105	Mrs. E. E.	Dr. Ullman, Albany, N. Y.	27 M	Multilocular cyst, right ovary. Peritonitis.	Sept. 25, 1893.	Diagnosis confirmed. Firm adhesions, one spot. Left ovary normal, not disturbed. 10 qts. fluid.	R	Excellent recovery. In good health August, 1894.
106	Mrs. I. A.	Dr. Riley, Adams, N. Y.	54 M	Multilocular ovarian cyst.	Sept. 28, 1893.	Multilocular cyst, left ovary, also right ovary and tube. 14 qts. fluid.	R	Rapid and excellent recovery.
107	Miss E.	Dr. Gray, Greenwich, N. Y.	20 S	Ovarian abscess. Pyosalpinx double.	Oct. 4, 1893.	Uterine appendages.	R	Good recovery. Fairly encouraging result. Private hospital.
108	Mrs. M. S.	Dr. Kniskern, Amsterdam, N. Y.	27 M	Double pyosalpinx.	Oct. 7, 1893.	Uterine appendages. Tubes very much thickened and filled with pus. Drainage.	R	Good recovery. Patient obliged to go to work at once. September, 1894, presented with threatened hernia.
109	Miss M. R.	Dr. Bigelow, Albany, N. Y.	60 S	Multilocular cyst, right ovary.	Oct. 12, 1893.	Diagnosis confirmed. No adhesions. Left ovary senile, not disturbed.	R	Excellent recovery.
110	Mrs. J. M.	Dr. Mead, Jerusalem, N. Y.	40 M	Double pyosalpinx. Abscess.	Oct. 12, 1893.	Uterine appendages.	R	Slow but gradual recovery. Patient very neurasthenic.
111	Mrs. L. de L.	Dr. Willard, Watertown, N. Y.	45 M	Diseased left ovary. Very painful. Double pyosalpinx.	Oct. 15, 1893.	Diagnosis confirmed. Uterine appendages.	R	Recovery retarded. September, 1894, relieved of all pelvic pain but still confined to bed more or less.
112	Mrs. H. M.	Dr. Rossman, Ancram, N. Y.	36 M	Double ovarian cyst and uterine fibroid.	Oct. 21, 1893.	Diagnosis confirmed. Supravaginal hysterectomy. Ligatures. Drainage.	R	Excel ent recovery.
113	Mrs. J. S.		36 M	Cyst, left ovary.	Oct. 21, 1893.	Large cyst, right ovary, also left ovary for cystic degeneration.	R	Good recovery.
114	Miss M. N.	Dr. Vander Veer, Troy, N. Y.	31 S	Multilocular ovarian cyst.	Oct. 30, 1893.	Double multilocular ovarian cyst. Uterine fibroid supravaginal hysterectomy. Tait clamp. 5 qts. fluid.	R	Good recovery.
115	Mrs. M. C. P.	Dr. Wheeler, Chatham, N. Y.	23 M	Probably sarcoma, left broad ligament.	Nov. 2, 1893.	Multilocular cyst, left ovary. Right ovary cirrhotic and removed with tube.	R	Good recovery. In good health, June, 1894.

No.	Name.	Physician and Residence.	Age. Civil Con.	Diagnosis of Disease.	Date of Operation.	Nature of Operation. Removal.	Result.	Remarks.
116	Mrs. S. H.	Dr. Niver, Hillsdale, N. Y.	26 M	Double pyosalpinx.	Nov. 2, 1893.	Diagnosis confirmed. Uterine appendages.	D	Patient did nicely. Wound healed; began to sit up on 21st day; 22d day symptoms obstruction presented. Unable to relieve and died on 27th day.
117	Mrs. R. C.	Dr. H. H. Smith, Hudson, N. Y.	46 M	Tubercular peritonitis.	Nov. 2, 1893.	Incision, drainage. Diagnosis confirmed. 12 qts. liquid.	R	Good recovery.
118	Mrs. E. McC.	Dr. Reynolds, Saratoga, N. Y.	34 M	Pelvic peritonitis. Dysmenorrhœa.	Nov. 16, 1893.	Uterine appendages, Firm adhesions.	R	Excellent recovery.
119	Miss K.	Dr. Chambers, Kingston, N. Y.	30 S	Old general and pelvic peritonitis. Dysmenorrhœa. Hystero-epilepsy.	Nov. 29, 1893.	Right ovary and tube like intestine. Many and very firm adhesions. Left ovary and tube could not be found.	R	Good recovery. Patient very much better until May, 1894, when severe convulsive seizures, flowing coming on two months in succession at this time.
120	Mrs. H. W.	Dr. Knapp, Forest City, Pa.	28 M	Pelvic peritonitis.	Nov. 30, 1893.	Uterine appendages. Cystic degeneration ovaries. Firm adhesions.	R	Good recovery. In excellent health 8 months later.
121	Miss E. L. H.	Dr Vander Veer, Troy, N. Y.	32 S	Unilocular ovarian cyst.	Dec. 7, 1893.	Multilocular cyst, left ovary. Right ovary for atrophy. Fluid 10 qts. Cyst 15 oz.	R	Excellent recovery.
122	Miss S.	Dr. Cook, Albany, N. Y.	28 S	Double pyosalpinx. Uterine fibroid.	Dec. 7, 1893.	Diagnosis confirmed, Uterine appendages.	R	Excellent recovery. Patient in good health. June, 1894.
123	Mrs. E. M.	Dr. Ross, Poultney, Vt.	27 M	Pelvic peritonitis. Double pyosalpinx.	Dec. 15, 1893.	Uterine appendages. Very firm adhesions.	D	Death from shock.
124	Mrs. M. S.	Dr. Van Slyke, Coxsackie, N. Y.	71 M	Multilocular ovarian cyst.	Dec. 18, 1893.	Multilocular cyst, right ovary. 16 qts. fluid. Cyst 3 lbs.	D	Patient recently suffered from grippe. Death from pulmonary infarction.
125	Mrs. P. S.	Dr. Crosby, E. Nassau, N. Y.	27 M	Unilocular ovarian cyst.	Dec. 21, 1893.	Unilocular cyst, right ovary; also left ovary. Cystic enlargement.	R	Good recovery.
126	Miss H. V.	Dr. Papen, Oneonta, N. Y.	19 S	Multilocular ovarian cyst. Acute peritonitis.	Jan. 2, 1894.	Cystic papillomatous mult. cyst, left ovary. Right ovary cystic. Firm adhesions. Drainage Removal second day 11 qts. fluid.	R	Patient made good recovery. Returned in August with marked growth, left side pelvis, probably nature, true sarcoma. No fnrther operation done.

127	Mrs. E. F. S.	Dr. Sabin, W. Troy, N. Y.	42 M	Pelvic peritonitis. Double pyosalpinx.	Feb. 22, 1894.	Uterine appendages. Many and firm adhesions. Drainage.	R	Good recovery.
128	Miss J. D.	Dr. Johnson, Amsterdam, N. Y.	26 S	Supposed disease of ovaries, causing sympathetic vomiting.	Feb. 23, 1894.	Section, ovaries and tubes. Healthy; not removed, Some adhesons loosened and tubes straightened.	R	Slow but excellent recovery.
129	Miss A. E.	Dr. Millington, Argyle, N. Y.	28 S	Pelvic peritonitis. Dysmenorrhœa.	Feb. 24, 1894.	Uterine appendages. Many adhesions.	R	Excellent recovery.
130	Miss M. D.	Drs. Stover and Kniskern, Amsterdam, N. Y.	22 S	Pelvic peritonitis and enlarged ovaries.	Feb. 27, 1894.	Uterine appendages. Cystic enlargement both ovaries.	R	Good recovery.
131	Mrs. W. J. O.	Drs. Babcock and Pomeroy, Springfield, N. Y.	23 M	Diagnosis, doubtful as to nature cyst.	March 1, 1894.	Multilocular cyst, left ovary. Right ovary enlarged with pyosalpinx. Many adhesions.	R	Good recovery. Patient on returning home had much pain, relapsing into former morphine habit.
132	Miss S. N.	Dr. McCulloch, Gloversville, N. Y.	29 S	Pelvic peritonitis. Chronic disease left ovary. Severe dysmenorrhœa.	March 19, 1894.	Uterine appendages. Many adhesions.	R	Excellent recovery.
133	Mrs. L. D.	Dr. Johnson, Amsterdam, N. Y.	29 M	Double pyosalpinx.	March 23 1894.	Uterine appendages.	R	Excellent recovery.
134	Miss J. McC.	Dr. Mosher, Granville, N. Y.	27 S	Double pyosalpinx.	March 30, 1894.	Uterine appendages. Many adhesions.	R	Excellent recovery.
135	Mrs. H. A. L.	Dr. Nichols, Sand Lake, N. Y.	43 W	Pelvic peritonitis retroversion. Diseased ovaries.	March 30, 1894.	Uterine appendages. Many, very firm adhesions.	D	Death from peritonitis. Patient very stubborn and hard to manage.
136	Miss J. K.	Dr. Lee, Canaan, Conn.	33 S	Hystero-epilepsy. Chronic ovaritis.	April 16, 1894.	Uterine appendages. Not difficult.	R	Speedy recovery. At end of third month no return of epileptic seizures.
137	Mrs. M. S.	Dr. Shaw, Hoosick Falls, N. Y.	25 M	Double pyosalpinx. Enlarged ovaries.	April 17, 1894.	Uterine appendages. Many adhesions. 7 qts. fluid.	R	Excellent recovery.
138	Miss L. S.	Dr. Garnsey, Kinderhook, N.Y.	31 S	Double pyosalpinx. Enlarged ovaries. Possibly tubercular appendicitis.	April 28, 1894.	Uterine appendages and appendix. Few adhesions.	R	Excellent recovery.
139	Mrs. F. F.	Dr. Melick, Sandy Hill, N. Y.	36 M	Double pyosalpinx. Pelvic peritonitis.	April 30, 1894.	Uterine appendages. Few adhesions.	R	Good result. Patient improved very markedly 3 months after operation.

No.	Name.	Physician and Residence.	Age. Civil Con.	Diagnosis of Disease.	Date of Operation.	Nature of Operation. Removal.	Result.	Remarks.
140	Mrs. E. V.	Dr. Starks, Chatham, N. Y.	30 M	Small interstitial fibroid uterus. Dysmenorrhœa.	May 12, 1894.	Uterine appendages.	R	Good recovery. No return of flow. Aug. 24, 1894, patient improved very decidedly.
141	Miss E. M. K.	Dr. Seymour, Troy, N. Y.	34 S	Ovarian cyst.	May 24, 1894.	Double ovarian dermoid cysts. Few adhesions.	R	Splendid recovery.
142	Mrs. L. D.	Dr. Faust, Schenectady, N. Y.	30 M	Double pyosalpinx. Chronic peritonitis.	May 29, 1894.	Uterine appendages.	R	Excellent recovery.
143	Mrs. A. G. W.	Drs. Reed and Church, Oneonta, N. Y.	29 M	Double pyosalpinx.	May 30, 1894.	Uterine appendages.	R	Good recovery. Patient doing nicely when leaving private hospital.
144	Miss M. C. F.	Dr. Heenan, Albany, N. Y.	27 S	Unilocular ovarian cyst.	June 6, 1894.	Unilocular cyst, left ovary.	R	Excellent result. Patient had improved in health. Sept. 10, 1894, looking very much better.
145	Mrs. A. McN.	Dr. Bissell, Troy, N. Y.	40 M	Unilocular ovarian cyst.	June 16, 1894.	Unilocular cyst, left ovary. Short, broad pedicle. Hæmorrhage.	R	First ligature slipped requiring three additional ones. Pedicle then brought up and attached to lower end incision. Second week, portion sloughed, pedicle came away. Some phlebitis of left leg. Otherwise excellent recovery.

In presenting somewhat brief, yet quite as full histories of these cases as space would permit,—and perhaps taking much more time to read than many will care to do,— it will be observed that occasionally one is omitted, and this is in consequence of notes having been mislaid, or the history not being sufficiently completed in my record book. It will be observed, however, that in the table a sufficient history is given to enable one to classify the cases without difficulty.

I am not unmindful that it would have been much more comforting to myself to have commenced this paper by reporting to you my successful cases; cases that have brought to me much encouragement in my work, meeting patients in improved health, and in receiving letters filled with gratitude and acknowledgement of recovery.

Regarding the preparation of patients, it seems to me quite difficult to establish a fixed line of action. I believe that, so far as possible, it is wise to carry out the preparations at home, before the patient enters upon hospital life. It is true that there are some cases very calm and not affected by the thought of entering the hospital, and yet there are many who are made somewhat nervous by being kept under observation too long away from home. I would like to emphasize somewhat the importance of regulating the bowels and proper attention to such diet as does not constipate previous to the time of operation. I also wish to say that I place much stress upon the importance of a careful examination of the urine.

Now that we understand so well the evil effects of the bacillus coli communis we should see that the intestinal tract is put in a good, sanitary condition. The previous habit of the patient as to the use of morphine or opium should be carefully observed, and is not a contra-indication to operation, but the same will necessarily be needed after, and without fear in giving as full doses as may be required to relieve pain.

As to the preparation of the room, I have long since done away with the use of the carbolic spray, having had a tiresome experience in that direction, and rely upon thorough cleanliness, washing all wood-work, walls and floors with the bichloride solution.

A large proportion of these cases reported were operated upon in the amphitheatre of the Albany Hospital, and some in the presence of one hundred and fifty or more students. As to the length of the incision I can only say that my exper.ence endorses all that Dr. Joseph Price has said in his admirable paper upon this subject. I have endeavored to make it as short as possible with safety.

As to the drainage tube, usually glass, it may be said that I have used it with greater freedom than most of the operators at the present time. I must be excused somewhat by reason of the anxiety I have experienced in immediate hemorrhage, in the two cases reported, and therefore, have felt that the tube wherever there was any possible fear of this occurring, or where the oozing was likely to be greater than the peritonæum could care for, was the safest procedure. I have employed it in thirty-nine cases, exclusive of the cases of tubercular peritonitis proper, and have not hesitated to leave it in as long as the gauze tent introduced through the calibre of the tube gave no disagreeable staining, removing it sometimes within six hours after the operation, and sometimes leaving it in from eight to ten days. Where left in this length of time have followed it with the rubber tube. I have invariably made use of the rubber dam and then employed the gauze packing instead of the syringe for removal of the accumulating fluid, and have found this procedure quite as comfortable to the patient, and to myself it has seemed better than the employment of the syringe. I may be mistaken, but I believe that this table of cases exhibits quite as many and as severe adhesions as present in the average run of cœliotomies. Of the whole number, twelve cases gave a record of previous tappings, and only two or three had escaped adhesive inflammations.

Regarding the closure of the wound in the use of silk, however well prepared, I have had occasionally a stitch-hole abscess. For the past four years I have use silkworm-gut exclusively, and have very seldom met with this condition, as the table will show. I desire to emphasize here that I know of no kind of operative surgery that requires such care-

ful apposition of wound surfaces, bringing like tissue in connection with like, as in the abdominal incision. I have not made use of the different rows of sutures, still I am not unmindful of the valuable arguments presented in favor of this procedure.

As to the time of removing the stitches it is well if the superficial ones are removed at the end of the second day, or during the first dressing of the wound, and then the deep ones I believe it is wise to leave until about the eighth or tenth day. They do no harm and certainly help to keep the abdominal incision in more perfect apposition.

In conditions of continued oozing from adhesions, and where the abdominal walls have been greatly stretched by size of the tumor, I must say that I have seen, in two of my cases, a most happy result from folding the abdominal wall over on itself, having previously put in through and through sutures of silkworm-gut, taking them out at the end of forty-eight hours.

As to hernias resulting, as far as I have been able to learn, I know of but three cases, and in one instance this was plainly due to the carelessness of the patient in attempting too much heavy lifting within so short a time after the operation.

As to the dressing of the wound, I have uniformly employed the powdered iodoform, one part to three of starch, then the iodoform gauze, with the Gamgee pads and flannel bandage, doing the first dressing at the end of forty-eight hours, removing what is usually but soiled iodoform gauze, reapplying the second dressing and letting it remain until the wound is healed, except in cases where the drainage tube may have produced some soiling.

Out of this number of cases I can report only one where the Fallopian tubes were freed from adhesions, straightened — not removing the ovaries — and a good result followed.

It will be observed that my mortality list contains three cases in which a fatal intestinal obstruction was due to a coil of intestines becoming fastened to the stump of the pedicle. For the past two years, in such cases, where the stump seemed to flatten out over the ligature, I have brought the peritoneal

surfaces together with one, two or three interrupted sutures of very fine silk, and comfort myself with the belief that it has, perhaps, had some effect in obviating this unfortunate post-operative complication.

The annoying cases I have found, and somewhat disastrous, are those brought to me by the family physician desiring an immediate operation that day or the next morning, in order that he might return home, but anxious to see the operation. These cases are fortunately growing less and less, as members of the profession realize more and more the importance of preparatory treatment, and of the operator seeing the case long enough in advance to feel sure of his diagnosis and operative procedure. I wish to make an observation, and that is in reference to the serious cases that are likely to come from one particular practitioner, one who procrastinates and keeps the patient, either by medication or tapping, under his treatment as long as possible, and then suggests operative interference when all the chances are against the surgeon. My mortality list contains three of these cases from one practitioner. I do not wish to criticise, but would enter a plea that wherever an abdominal tumor presents, in the practice of any physician, that it becomes almost his duty to call in the aid of a surgical assistant, that the line of treatment may be agreed upon as early as possible. In the study of these cases I have been impressed in two or three by the very marked history given by the patient of the tumor having appeared on one side, and yet when the operation was reached, the pedicle and attachment was found on the other side.

As to the pulse and temperature, I am satisfied that the former is of far more importance than the taking of the latter. The heart's action plainly tells of serious trouble going on in the way of intestinal obstruction, or of either form of peritonitis. There are many conditions really non-essential as to the recovery of our patient, that will cause an increase in temperature apparently alarming. Any nerve strain, a visit from a friend, the discharge of blood that occurs from the vagina after an operation, and which appears in quite a number of cases, will sometimes prostrate the patient mentally, in itself

producing an increase of temperature, but is of no serious import as regards recovery.

In getting the histories of patients I have been much impressed with the number of cases having a family history of phthisis, or malignancy. Thirty-nine cases of this table gave a distinct history of phthisis, fifteen of cancer in some form, while fifty-seven gave a history of marked irregularity of menstruation, with dysmenorrhœa, many of them from the beginning of the menstrual act.

Making a closer analysis of the table there were thirty-nine cases of ovarian cyst, multilocular, with five deaths; twenty-five cases of ovarian cyst, unilocular, with two deaths; three cases of double ovarian cyst, multilocular, with one death, two cases of multilocular cyst complicated with pregnancy, with one death; two cases of double mutilocular ovarian cyst, complicated with fibroid tumors; there were twenty-seven cases of double pyosalpinx, with one death; tubercular peritonitis, six cases; tubercular peritonitis, with removal of one or both ovaries, five cases; extra-uterine pregnancy, three cases, with one death; exploratory incision-relieving adhesions and straightening tube, one case; one double pyosalpinx and removal of appendix; removal of uterine appendages for uterine fibroid, one case, making a total percentage of mortality in 145 cases of eleven per cent. In making a closer analysis we find there were three deaths from peritonitis; two deaths from hemorrhage; three deaths from shock; three deaths from intestinal obstruction; one death from diabetes; three deaths from exhaustion; one death from puerperal septicæmia; one death from pulmonary infarcation.

Among the cases of recovery there are a few thoroughly instructive. Cases XXXV and LIX constitute the same patient. The others are cases XXXVIII, XLI, XLIV, XLIX, LVIII, LXIII, XCVI, CVII, CXII, CXIV and CXL.

A word as to the time of patient's returning home after an operation. I do not believe that it is always the greatest wisdom to hurry a patient home with encouragement to go on with their household and other duties, and particularly is this true in cases of removal of uterine appendages, for pyo-

salpinx and such like conditions. They must be made to understand that all their unpleasant symptoms will not disappear at once. It takes months for them to recover, and they are sometimes greatly disappointed in their hopes not being promptly realized.

I have but one case to report of keen anxiety in the loss of a foreign substance in the peritoneal cavity, and that is case thirty-two, Mrs. J. V., where a small sponge became entangled in mesentry of the small intestines and gave great trouble in search for it. I am now exceedingly careful about having any very small sponges handed me.

I regret that more careful attention was not paid to the weight of tumors in the table, but part of this work was confided too much to advanced students and house surgeons, and not done thoroughly well.

Three cases give an interesting history of ligatures escaping through the sinus left by the drainage tube, the ligature in one case being of coarser silk than ought to have been used. No ill effect followed, the sinus being closed as soon as the ligature was recovered. Possibly in one patient, case thirty-one, Mrs. E. H., it may have assisted in causing the hernia.

As to the after treatment I am most rigid in not allowing the patient the use of the hypodermic injection of morphia any more than is absolutely necessary, but prefer to give it where there is restlessness due to a weak heart's action, and where the pain is so great as to be intolerable.

For treatment of persistent vomiting I have seen excellent results from the combined administration of cocaine, calomel and oxalate of cerium, and then I can only endorse the use of calomel and salines for moving the bowels. A movement should be secured if necessary by the aid of injection, as early as the second and third day, not later than the fourth day after the operation. As to diet, my patients have been greatly benefited by the carrying out of the hot water treatment, and the use of matzoon, particularly if the stomach is at all nauseated; also, for relief of thirst, rectal injections of hot water, slightly saline.