the finest private collection in Europe, and in England unique; it was said to contain some 3,000 specimens admirably prepared and arranged, especially the injected specimens. The College of Surgeons alone possessed 500 of his preparations, and there were large numbers in the museums of St. Thomas's and Guy's. Sir James Paget, in a communication to the lecturer, wrote: "Sir Astley Cooper deserves honour for having been one of the few who, in the beginning and early part of this century, promoted the science of pathology by the study of morbid anatomy. At that time there was not in any school in London, nor indeed in any part of the country, any place for the objective study of, or teaching of pathology. Pathology, as then taught, was little more than a summary of the hypotheses which were supposed to be the foundation of practical medicine and surgery. The visible consequences of diseases were looked at in bodies examined after death, but few of them were carefully described, fewer still were reserved for more careful study. Hospital museums were unknown or neglected. The chief or only museums for morbid anatomy were private collections, as those of the Hunters had been, and among the collections in London the best was Sir Astley Cooper's. The museum of the College may show what it was, for the Council very wisely purchased it as soon as this became possible, as they did also the private collections of Longstaff, Howship, Liston, and some others. The contents of these once private museums, or the best specimens selected from them, form an important part of the present pathological museum of the College, and among them all none display so perfectly as Sir Astley Cooper's the art of showing to the naked eye morbid changes of structure in the most demonstrative manner; they remain not only as illustrations of his written works, but as admirable examples of skill in injections and in well-planned sections. Many of them are even now as instructive for study by the unaided sight as they were when first taken from the dead body, or removed by operation during life, at a period when the naked eye and the fingers were the only means for the study of pathological anatomy. It can scarcely be doubted that this portion of Sir Astley Cooper's work contributed largely to the growth of the conviction, though this growth was very slow, that morbid anatomy must be thoroughly taught in our medical schools, and a token of his influence may be seen in the present condition of our hospital museums and the almost complete absence of private anatomical collections."

Up to the last Cooper was engaged in physiological and anatomical inquiries, indefatigable in the search after knowledge and the accumulation of fresh facts and new experiences. He died at the age of 73, and his last words addressed to the friends who surrounded him were "God bless you, and goodbye to you all."

A PLEA FOR THE PERFORMANCE OF OVARIOTOMY BY OBSTETRIC PHYSICIANS,

CONTAINING A REPORT OF A FIRST SERIES OF FIFTY
OVARIOTOMIES.

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[AFTER advertizing to the frequent absence in ovariectomy records of information on such essential points as union by first intention, suppuration, sinuses, hernia, after-history, and to the influence of the practice at University College Hospital in obtaining for obstetric physicians the right to operate, the writer stated, with regard to his own operations, that there had been no selection of cases, that no tumour had been tapped by him, though six had been aspirated by other practitioners (not necessarily those given in the table), a procedure to be condemned, except under very rare circumstances. He deprecated the practice of omitting from lists of ovariectomies "incomplete" operations, and gave it as his opinion that every case in which an attempt was made to remove the tumour should be published as an ovariectomy. He had only had two incomplete operations, with broad liga-

ment cysts (Cases 6 and 8), both of which healed, and the latter of which he would now be able to remove. Primary union took place in 47 cases; some suppuration in the remaining 3, including a case of stitch-hole abscess (the only one which occurred). In no case did a hæmatocele develop after the operation, nor a ligature come away.]

After these introductory remarks, I now proceed to an analysis of the cases as given in the table. Of the fifty cases forty-four were operated upon in University College Hospital, and six were private patients, and were treated in a nursing home. The private cases are indicated in the table by a single initial letter.

The heading, "age of patient," calls for no special remarks, except that Case 46 was, at the time of operation, over 82½ years old. (See JOURNAL, December 9th, 1893, p. 1271.)

She is, as far as I know, the oldest patient upon whom ovariectomy has been performed, with the exception of Dr. Homans's case,¹ which was apparently a few weeks older. Although she only wore an abdominal belt for about six weeks after getting up, she has now a firm linear scar, without the slightest tendency to hernia, and I saw her on November 1st, 1893, in very good health for her age.

Thirty-six of the patients were married, 7 of these being nulliparous; 14 were single women. Six of the fifty operations lasted over an hour, the longest duration being 80 minutes.

I think it most desirable that operators should publish the length of time occupied by their operations. Any time beyond three-quarters of an hour adds appreciably to the danger of an operation. Yet I hear of operators taking as long as two hours and a-half or even three hours over an adherent case. My own practice is in favour of rapid removal of the tumour, but of spending sufficient time in cleansing the peritoneum, ligating the pedicle, and accurately suturing the wound. Of the 50 cases, in 15 the tumour was on the right, in 22 on the left, and in 13 on both sides.

In 33 cases there were adhesions, often very extensive and strong. (See Table.) The cases which had been previously tapped were very adherent, with one exception (12); in this there were twenty pints of fluid in the peritoneum, and nearly five in the left pleura. Drainage was employed in 11 cases; of these, 5 were broad ligament cysts; in Case 32 the abdominal wall only was drained. The peritoneal sac was drained in 5 instances only; amongst these the fatal case occurred. In this case (16) the Keith's drainage tube slipped into the abdomen, an accident which has led me to use a glass drainage tube with two large flanges, which render such an accident impossible. I believe that several of these 5 cases would have done equally well without the tube, and that drainage is resorted to far too frequently by some operators.

Flushing the peritoneal cavity has not been employed in any case; I regard it as unnecessary and even dangerous, and it seems to frequently require the subsequent use of the drainage tube. I would restrict it almost entirely to cases of encysted septic or purulent fluid.

The temperature has been taken for five minutes in the rectum, and for fifteen minutes in the axilla, every four hours by day and by night, and I have no trust in charts where it is taken less frequently. It would be useful if operators would agree to the four-hour record, and would state whether it is taken in the rectum, axilla, or mouth. On the whole, I think the axillary temperature is most convenient, but the rectal most trustworthy. The rectal temperature is, however, higher by about a degree, and sometimes two or three degrees higher, than the axillary. In the table I have stated the highest temperature recorded in the first seven days after the operation; this gives a less favourable and less valuable record than the average temperature; but I intend to treat the question of temperature after ovariectomy more fully elsewhere. The average highest rectal four-hour temperature during the first week after operation was 101.2, and similarly the average highest axillary temperature was 100.4. The highest temperature recorded, 103.4 (rectal) occurred in the fatal case just before death.

Of the whole series but 1 died (Case 16). This patient had a suppurating ovarian dermoid of the size of an infant's head, extremely adherent to the surrounding parts. She had also extensive ulceration of the rectum and descending colon; in

¹ Boston Med. and Surg. Journal, 1888.

one place the gut was reduced by this ulceration to its peritoneal coat. The drainage tube (Keith's) slipped or was pushed into the abdomen by the patient on the second day, but was easily withdrawn by forceps. She was greatly collapsed after the operation, which was very difficult, and she died with symptoms of exhaustion (probably due to sepsis) in fifty-three hours. There were three or four ounces of clotted blood and bloody fluid in the pelvis which had oozed from torn adhesions. Coils of intestine were adherent to each other round the drainage tube and the effused fluid. There seemed to be commencing inflammation of the general peritoneum, but this was not marked. The gut had not been injured by the drainage tube. I think infection of the effused fluid took place through the wall of the rectum and colon, which were extensively ulcerated.

The remaining 49 cases recovered and were discharged well with the wound completely healed and free from sinus or suppuration.

The patients usually got up at the end of three weeks and were discharged about the fourth week, but when any complication arose they were detained until they had completely recovered. Of the 50 cases 42 were tumours of the ovary of which 5 were dermoids, 8 were tumours of the broad ligament or parovarium; 1 of these was malignant, of enormous size, weighing about 70 lbs., and was treated by enucleation and hysterectomy.

Five of the tumours were suppurating (16, 24, 32, 37, 47), several others had puriform contents, which the microscope showed not to be pus. In all (with perhaps the exception of Case 16) the suppuration followed labour and was probably occasioned by infection at that time. One case was three months pregnant at the time of operation, she went to term and was safely delivered of twins. Eight cases were observed at or soon after labour. Six tumours had been previously tapped and 7 had a twisted pedicle. Two of the cysts had recently ruptured.

In the last column of the table I give later information of the patients as to their being alive and free from hernia. I have been able to get information concerning 48 patients, and it will be seen that hernia at the site of the scar has occurred in 4 cases. The ages of these patients were 66, 58, 64, and 41—thus all, except the last, were somewhat advanced in years. The last was a very bad case of suppurating cyst which had been tapped and the trocar left in the cyst for three weeks. None of the patients suffer any pain or discomfort from the hernia, but its presence undoubtedly is a source of danger and I should be glad to adopt any method of treatment which would prevent its occurrence. Reliable statistics upon this important subject are much needed, but the records to be of any value must be given with dates, for, until I undertook the preparation of this paper I was only aware that hernia had occurred in one of my own cases.

I may add to the information contained in the last column of the table that Case 4 died after operation for intestinal obstruction produced by a peritoneal band, about fifteen months after the ovariectomy, and Case 20 succumbed to peritoneal and pelvic cancer in about fourteen months. Concerning two of the cases I can get no information, as their address is unknown. I have no reason to believe they are otherwise than alive and well.

THE METHOD OF OPERATING.

The operations have been performed in a private room at University College Hospital or at a nursing home. The room is usually "sulphured" and occasionally limewashed between the operations. In the hospital cases the patient was moved down two flights of stairs and through four wards into the general ward; in the earlier cases on the seventh day, in the later cases on the third or fourth day. The slight excitement of this journey sometimes caused a temporary rise of temperature. The operation was done under strict Listerian precautions, including the spray. Although I have now abandoned the spray as unnecessary and inconvenient, I think the result of this series of operation shows that its employment is not followed by any serious consequences.

The patient is prepared by aperients, followed by enemata on the two nights preceding the operation. The skin is washed and a towel soaked in 1 in 20 carbolic acid is placed

on the abdomen for three hours before the operation. The operator's and assistants' hands and forearms are washed and scrubbed with soap, after soaking in solution of iodine (liquor iodi 2 drachms to the pint); they are then immersed in 1 in 20 carbolic acid for about two minutes.

The sponges (ten in number) are prepared by beating and washing and soaking for successive periods of twelve hours in the following solutions: 25 per cent. hydrochloric acid, 5 per cent. sulphurous acid, and 1 in 500 corrosive sublimate. They are then placed in 1 in 20 carbolic acid, in which they are kept for at least a week, until the operation, when they are put into 1 in 40 carbolic acid. They are always counted by myself before and after the operation.

The instruments (made entirely of metal) are carefully cleaned and brushed after the operation, and before the operation they are boiled for an hour in 1 in 20 carbolic acid, in which they are placed during the operation.

Floss silk of moderate thickness is used for the pedicle and abdominal wound. It is prepared by boiling for three hours in 1 in 20 carbolic acid, and then placed for twelve hours in 1 in 500 corrosive sublimate, then in 1 in 20 carbolic acid, where it remains for at least a week before it is used. Thus prepared it is absolutely safe as regards sepsis. No patient has gone away with a sinus, nor has a ligature ever come away. I prefer floss silk to "Chinese twist," because it is cleaner, of more open texture, less liable to be damaged by manufacture, and can be drawn tighter. In case of broad or thick pedicle the first knot is seized with forceps; "Chinese twist" is then apt to snap. The pedicle is tied in two halves, and then as a whole with a reef knot as tight as possible. To pass the pedicle ligature I use a short, straight, round needle made of "delta" metal; it is much more convenient than the handled needle, is safer, saves time, and does not rust. If the raw surface of the pedicle is extensive I sometimes stitch it over with fine silk and tie any prominent vessels. Adhesions requiring ligature are tied with fine silk, in the earlier cases with carbolised catgut.

The wound is sewed up by passing the thick silk through all the layers of the abdominal wall, and the skin is accurately apposed by fine silk. The wound is dressed with Lister's carbolic gauze (or sometimes with iodoform gauze) kept in place by a many tailed flannel bandage.

THE AFTER-TREATMENT.

Nothing is given by the mouth for twenty-four hours, or, where vomiting persists, for thirty-six hours or more; on the second day barley water with milk and Gerrard's peptones in small quantities; no solid food for the first week. In some cases milk disagrees and causes vomiting; for these rectal feeding with peptones is employed. No morphine is given except for prolonged sleeplessness; it is rarely required and better avoided. Rarely is alcohol administered. The bowels are opened by aperient and enema on the eighth day, when the sutures are removed and strapping applied. The urine is drawn off—when necessary—every six hours by rubber catheter kept in a 1 in 2,000 sublimate solution. In persistent vomiting and distension, which rarely occur, the bandage is removed, a copious enema is given, and the abdomen massaged. I have never reopened the abdomen.

The patient lies as much as possible on the back for the first week, does not sit up for three weeks, gets up two or three days later, and is discharged usually at the end of the month wearing an abdominal belt, which she is instructed to use for at least a year.

OTHER ABDOMINAL SECTIONS.

During the period over which these 50 ovariectomies extend I have also performed 18 abdominal sections other than ovariectomies, of which 2 died. One of these was a case of rupture of the uterus from neglected shoulder presentation; she was moribund from shock and hæmorrhage, and died in a few minutes, before the operation was completed. The other was a case of exploratory operation for malignant disease of the ovary and peritoneum. Finding secondary growths in the omentum and peritoneum, I closed the wound without removing anything. The patient recovered well, and the wound healed by first intention. On the twelfth day, when she was apparently quite well, she suddenly died of pulmonary embolism, the clot having come from a

TABLE I (Abridged).—First Series of Fifty Ovariectomies.

Number.	Age.	Children.	Abortions.	Date of Operation.	Duration of Operation in Minutes.	Side.	Adhesions.	Drainage.	Highest four-hour Temperature in first week.	REMARKS.	Alive and free from Hernia.
163	2	0	0	10/15/87	60	L	Yes	Yes	101.2°	Multilocular ovarian, size of three Rugby footballs. Previously tapped several times.	Oct. 30, 1893.
246	4	0	0	10/20/87	40	L	Yes	No	101.8°	Large multilocular cyst; much solid growth. Stich-hole abscess formed.	Oct. 22, 1893.
367	18	1	0	3/11/87	—	L	Yes	Yes	101.6°	Large multilocular ovarian. G=4½ in. T=10.4, F=152, and patient very ill two hours before operation.	Seven months later.
442	0	0	0	8/4/89	—	L	Yes	Yes	101.4°	Large broad ligament cyst 10½ in. above pubes. G=3½ in. Tumour enucleated, broad ligament stitched, and dropped.	Dec. 31, 1893.
526	0	0	0	12/8/88	—	R & L	Yes	No	101.0°	Two multilocular ovarian cysts, size of orange and small apple.	Six months later.
639	0	0	0	26/8/88	—	R & L	Yes	No	101.2°	Multilocular broad ligament cyst, burrowing around uterus. Main part enucleated; drained.	End of 1892.
747	5	6	0	3/8/88	20	R & L	No	No	100.6°	Large left ovarian (17 pints). G=3½ in. Right ovarian fibroid (size of almond).	Oct. 29, 1893.
826	2	0	0	14/8/88	—	R	Yes	No	100.0°	Small broad ligament cyst, size of duck's egg. Partially enucleated; drained.	Oct. 29, 1893.
950	0	0	0	27/6/80	—	R & L	No	No	100.4°	Multilocular ovarian, size of eight months uterus (11 pints). Twisted pedicle.	Oct. 24, 1893 (small hernia).
1066	0	0	0	27/6/80	—	R & L	No	No	100.8°	G=4½ in. Left ovarian to within 1 inch of ensiform. Cystic right ovary.	Oct. 11, 1893.
1188	0	0	0	2/8/80	—	L	Yes	No	101.4°	2½ galons ascitic fluid, cystic multilocular ovarian, size of uterus at term, previously tapped; pleural effusion (left). 97 ounces drawn 2 days before operation.	End of 1892.
1389	4	0	0	10/2/91	23	R	No	No	100.0°	Ruptured multilocular ovarian, holding about 1 pint.	Oct. 22, 1893.
1484	0	0	0	20/3/91	23	L	Slight	No	101.6°	Multilocular ovarian, size of large football, removed with ovary.	Oct. 24, 1893.
1527	0	0	0	1/4/91	22	L	No	No	99.2°	Multilocular parovarian, size of small football, removed with ovary.	Nov. 1, 1893.
1632	1	0	0	16/4/91	60	R	Yes	Yes	103.4°	Suppurating dermoid, size of emu's egg. Ulcerative colitis, which probably infected bloody serum in pelvis.	Died.
1788	0	1	0	6/5/91	50	L	Yes	No	99.0°	Multilocular ovarian, size of goose's egg.	Nov. 11, 1893.
1840	0	0	0	16/5/91	36	L	Yes	No	99.4°	Multilocular ovarian, size of uterus at sixth month.	Oct. 24, 1893.
1940	2	0	0	26/5/91	22	R & L	No	No	101.0°	G=2½ in. Right multilocular, size of uterus at term. 1½ in. above pubes; eft, size of pear.	Nov. 2, 1893.
2042	0	0	0	15/6/91	44	L	Yes	No	101.4°	Ruptured malignant ovarian, removed. G=5½ in.	June, 1893 (recurrence).
2127	0	0	0	26/6/21	65	R & L	Yes	No	95.2°	Right multilocular ovarian, with fallopian tube opening into it; size of man's head. Left tubo-ovarian, size of fist. Fallopian tube.	Nov. 2, 1893.
2222	0	0	0	3/7/91	40	R & L	Yes	No	100.2°	G=3½ in. Large high multilocular dermoid. Small blood cyst of left ovary.	April, 1893.
2343	4	1	0	14/8/91	40	R & L	Yes	No	101.0°	Small parovarian, size of goose's egg. Hole in ligament stitched and dropped.	Oct. 3, 1893.
2432	1	0	0	12/10/91	50	L	Yes	No	101.0°	G=8½ in. Suppurating ovarian (over 10 pints). Fever and extreme emaciation before operation. As burrowing in abdominal wall. Tumour removed. Suppuration recurred at lower angle of wound. Connected August 13th, 1893.	Oct. 26, 1893.
2545	3	0	0	28/10/91	40	R & L	Yes	No	96.6°	G=3½ in. Large multilocular ovarian within 2 inches of ensiform. Small 2-inch multilocular cyst of direct ovary. Right ovary only tapped.	Nov. 3, 1893.
2624	1	0	0	10/30/91	30	L	No	No	99.6°	G=3½ in. Parovarian (10 pints) removed with ovary. Delivered August 26th, 1891.	Oct. 26, 1893.
2732	1	0	0	9/11/91	23	R	No	No	100.8°	Parovarian (4 pints collected); enucleated. Broad ligament stitched and drained.	Oct. 28, 1893.
2837	1	1	0	11/11/91	45	R & L	Yes	Yes (3 days)	100.0°	G=2½ in. Right multilocular ovarian (4 pints+2 lbs. 6 oz.). Left multilocular ovarian, size of cocoon.	Oct. 30, 1893.
2934	4	0	0	11/12/91	45	R	Yes	Yes (2 days)	101.6°	G=3½ in. Multilocular ovarian (26 pints). Influenza, 10th to 15th day.	Oct. 26, 1893.
3034	0	0	0	12/12/91	45	R	Yes	No	100.0°	G=4½ in. Pregnant 3 months at operation. Placenta multilocular ovarian (6 pints). Delivered Oct. 4, 1893.	Nov. 4, 1893.
3127	3	0	0	16/2/92	30	R	Yes	No	100.0°	G=4½ in. Pregnant 3 months at operation. Placenta multilocular ovarian (6 pints). Delivered Oct. 4, 1893.	Nov. 4, 1893.
3241	2	0	0	10/3/92	49	R	Yes	Abdominal wall for 24 hours	99.0°	Ovarian. Twisted pedicle, fecal pus. Tapped twice three weeks before operation (10 pints pus). Delivered Oct. 24, 1893 (small hernia).	Oct. 24, 1893 (small hernia).
3336	6	0	0	27/3/92	32	R	Yes	No	101.0°	G=3½ in. Multilocular ovarian, size of uterus at term. Twisted pedicle. Patient confined, December 15th, 1891.	—
3464	7	2	0	4/4/92	27	L	No	No	99.8°	G=4½ in. Multilocular ovarian (9 pints collected, some lost).	Nov. 1, 1893 (hernia).
3531	1	0	0	19/4/92	45	R & L	No	No	102.0°	Right multilocular ovarian, reaching 5 in. above pubes. Left cystic ovary. Swelling noticed after difficult instrumental confinement, 21 months ago.	Oct. 27, 1893.
3632	0	0	0	28/4/92	29½	R & L	No	No	101.2°	Right multilocular ovarian, size of shadowbox. Left multilocular ovarian, size of small orange. Delivered December 28th, 1891. Tumour noticed 10th day. Suppurating multilocular ovarian, with twisted pedicle, size of large fist. Complicated with pleurisy.	June 15, 1893.
3738	10	5	0	4/6/92	59	R	Yes	No	102.2°	Ovarian, twisted of fetal head. Complicated with hydrops, pints (removed).	Oct. 10, 1893.
3834	1	0	0	9/6/92	80	L	Yes	Yes (24 hours)	98.4°	G=4½ in. Multilocular ovarian within 2 in. of ensiform.	Oct. 30, 1893.
3940	0	0	0	16/6/92	50	R	Yes	No	101.6°	Multilocular ovarian (8½ pints). Tapped 3 months ago, 3 gallons removed.	Oct. 30, 1893.
4034	0	0	0	22/6/92	38	R	Yes	No	100.6°	Dermoid ovarian (13 ounces of fluid, and hair, and seb.).	June 14th, 1893.
4131	3	1	0	17/8/92	38	R & L	Yes	No	100.0°	Multilocular ovarian (10 pints). Left cystic ovary.	Jan. 14, 1893.
4231	0	0	0	29/9/92	25	R	No	No	98.4°	Multilocular ovarian, size of shadowbox.	Oct. 14, 1893.
4330	0	0	0	5/12/92	25	L	Yes	Yes (gauze in broad ligament)	102.8°	G=4½ in. Malignant colloid cystic tumour of left broad ligament, previously tapped three times, weighing about 70 lbs.; invading the uterus. Enucleated. Hysterectomy.	Months later; married.
4430	0	0	0	5/12/92	30	L	Yes	No	100.4°	Right multilocular ovarian within 1 in. of ensiform. Left cystic ovary. Convalescence delayed by thrombosis of left femoral vein.	Oct. 31, 1893.
4537	0	0	0	11/12/92	30	R & L	Slight	No	99.2°	Multilocular ovarian. G=3½ in. Tumour rises 10 in. above pubes. Twisted pedicle.	Nov. 1, 1893.
4632	5	0	0	19/12/92	17	L	No	No	102.0°	G=3½ in. Confined 6 weeks. Suppurating ovarian (15 pints). T=108.6°. Papilloma in interior.	Oct. 31, 1893.
4723	1	0	0	31/1/93	29	L	Yes	No	101.4°	G=30 in. Multilocular ovarian (6 pints). Twisted pedicle.	July 28, 1893.
4819	0	0	0	20/2/93	37½	L	Yes	No	100.0°	Multilocular papillomatous ovarian (8½ pints puriform fluid).	July 28, 1893 (small ventral hernia).
4958	1	0	0	6/3/93	70	L	Slight	No	100.0°	Multilocular ovarian dermoids. Right, walnut; left, swan's egg. Large ventral hernia (excised).	July, 1893 (slight separation of recti).
5026	2	0	0	15/4/93	72	R & L	No	No	100.6°	Multilocular ovarian dermoids. Right, walnut; left, swan's egg. Large ventral hernia (excised).	—

NOTE.—All the cases recovered except No. 16.

* R=Rectal; A=Axillary.

sacculus in the iliac vein, as shown by the necropsy. The remaining 16 cases recovered.

List of Abdominal Operations other than Ovariectomy.—For hydrosalpinx, 2; pyosalpinx, 1; tubal mole, 1; pelvic abscess, 4; hernia after hysterectomy, 1; ruptured uterus, 1 (died); oöphorectomy for fibroids, 1; Cæsarean section (Porro) for fibroids obstructing labour, 1; abdominal hysterectomy for fibroids, 2; exploratory for malignant ovarian, 1 (died); exploratory for fibroid of abdominal wall, 1; exploratory for abscess in broad ligament (opened per vaginam), 1; exploratory for retroperitoneal sarcoma, 1—total, 18, with 2 deaths.

These 68 operations constitute the whole of the abdominal sections I have performed up to April 15th, 1893.

I now proceed to consider the cases of ovariectomy as bearing upon the question, Who should perform ovariectomy in the general hospitals?

The present first series of 50 ovariectomies (with 1 death) is, as far as I know, the most successful of such series which has yet been published. I am very far from desirous of claiming for this result any personal credit, which belongs rather to my predecessor, whose methods I have followed. But I think the result is a justification of the system, adopted for twenty years at University College Hospital, and of late years at most of the other general hospitals in London, of allowing the obstetric physicians to perform ovariectomy. But a few years ago it was thought to be highly dangerous to perform the operation in a general hospital; and at University College Hospital, until 1884, the operation used to be done in a neighbouring house; since that date it has always been performed within the walls of the hospital. I think the present series of cases shows that, when performed by a specialist, ovariectomy is at least as successful in a general as in a special hospital. There was at one time a danger that major gynæcological operations would disappear from our great medical schools. This danger is now past, but there are still some who assert that obstetric physicians should not perform operations or, at least, not abdominal sections, or only those abdominal sections which are of obstetric importance—such as Cæsarean section. Now it is quite impossible to carry on an obstetrical or gynæcological practice without operating; an obstetric physician may limit his operations, but he cannot exclude them; and there seems to be no reason why he should be allowed to remove a uterus by vaginal and not by abdominal section (the former being more difficult than, and often quite as dangerous as, the other) no reason why the field of his operative activity should be limited by the plane of the pelvic brim. And it does appear to be as illogical as it is to the patient unfair to allow Cæsarean section—the greatest of all operations, and, when complicated with tumours, one of the most difficult and dangerous—to be performed by an obstetric physician who is not allowed to remove a simple ovarian cyst.

It is often said that the operation ought to be done in general hospitals by general surgeons and not by obstetric physicians. Against this view it may be urged that, supposing all the surgeons of a general hospital do the operation, and that one or more have not a tendency towards gynæcological specialism (for which their clinical opportunities afford no justification), then each surgeon would get but three or four ovariectomies annually at the present rate of admittance, and it is generally acknowledged that extensive experience is more necessary in abdominal than in almost any other kind of surgery. With such a system patients would cease to come, and doctors would cease to send them to these inexperienced general surgeons, and the cases would go to the special hospitals, and be lost to the medical schools.

Neither does the system of allotting the ovariectomies to one surgeon for a short term of years meet the requirements of the case, for the services of the surgeon are lost at the time when they have become most valuable.

At some schools it is the custom for both surgeons and obstetric physicians to do these operations. Where this practice has had a fair trial, it is found that the great bulk of the cases go to the obstetric physicians.

I have heard the opinion expressed by surgeons, who admit that obstetricians should operate, that surgeons should occasionally perform a simple ovariectomy to "keep their hand in," the obscurer and difficult cases going to the obstetric physician. Such an arrangement is obviously unfair to the obstetric physician, and puts him at a dis-

advantage when compared with the gynæcologist at a special hospital.

The system which most conduces to the interests of the medical schools is undoubtedly either that which puts the operation in the hands of one surgeon for a long term of years, or that which gives it over entirely to the obstetric physicians.

I am not one of those who think that there is any mystery about ovariectomy, or that a well-equipped surgeon cannot perform the operation well. But what I maintain is that he cannot perform it so well as one who devotes his whole time to the study of this and allied subjects and keeps himself abreast of the latest advances in gynæcological pathology and treatment, who is daily examining the pelvic organs of women, and who, from the nature of his practice, has acquired skill in diagnosing pregnancy and disease such as no general surgeon has the opportunities of obtaining. In endeavouring to arrive at a right judgment in this matter there are two considerations of prime importance: the first is the welfare of the patients, the second is the teaching of students and the advancement of medical knowledge. How far the welfare of the patient is affected by the operator being an obstetric physician I offer the present paper as evidence, and regret that few general surgeons have similarly published all their cases. Were this done I believe the question would be at once settled, if not by the statistics of their ovariectomies, at least by their errors in diagnosis, such as those awful cases in which, through ignorance of obstetrics, the healthy pregnant uterus has been opened. In order to guard against similar occurrences, general surgeons might, it may be suggested, call the obstetricians in consultation, and this is usually done; but is it fair that the obstetrician who can diagnose a tumour and remove it should be prevented from operating by a surgeon who is only competent to remove it? Is it fair that the treatment of the most important diseases affecting the organs which are the obstetric physician's special study should be taken out of his hands? In any case, is it fair that the question should be settled by medical committees in which the surgeons' votes numerically far outweigh the obstetric physicians'?

Medicine has been divided by our universities, our Royal Colleges, and our medical schools into three great divisions—medicine, surgery, and obstetrics and gynæcology. The third subject—obstetrics and gynæcology—is taught by the obstetric physicians of our medical schools. An obstetric physician without experience of operations labours under great disadvantages in teaching modern gynæcology; he is unable to compare the clinical signs with the actual facts of the case; he who should teach others is deprived of one of the most certain means of teaching himself, while in handing over to the surgeon his cases for operation he is giving up pathological material of the greatest value for the study of that branch of medicine which it is his duty to teach.

There is a natural connection between obstetrics and gynæcology which is convenient in practice, and which it is impossible, even if it were advisable, to sever; and, since these subjects are the special study of the obstetric physician, I think it is right that he should have a free hand in the treatment of the diseases which come within their domain. And I would further appeal to our surgical colleagues in the medical schools to extend their generosity and give up to the obstetric physicians the operations upon the uterus and its appendages. Such a gift would entail but a small sacrifice upon the surgeon, for the days are past when a general surgeon in London will get any considerable number of gynæcological operations, while it would be appreciated as a great boon by the obstetric physicians; it would enhance the value of gynæcological teaching, promote the cause of scientific medicine, and, above all, be, I believe, the means of saving human lives.

At the last ordinary meeting of the Board of the Manchester Royal Infirmary, the executors of the late Miss Louise H. F. Bennett handed over a sum of £5,397 to the funds of the hospital. A subcommittee has been appointed to consider what alterations in and extension of the infirmary are desirable and necessary. Mr. Alex. Wilson, F.R.C.S., was reappointed senior anaesthetist, and Mr. Thomas Porter, M.B., assistant medical officer.