tient has good control of the anal sphincter, the urine being passed, as a rule, only about once in two or three hours in the daytime and only twice at night. No irritation of the rectum seems to result.

CLOSURE OF THE INTROITUS VAGINAE.

It must be borne in mind that the operation under discussion is for exceptional cases of such a nature as to preclude the hope of relief by plastic surgery. Hence these women are in a pitiable condition and should not be expected to perform their marital duties, much less expose themselves to the risk of pregnancy. At least in two cases closure of the introitus was made during menstrual life, and the women menstruated through the anus without any resulting ill effects. There is no particular difficulty in doing this operation at the first operation, provided the stitches are so passed as to preclude urinary contamination. The tendency of gas to pass from the rectum to the vagina can be combated to a great degree by a proper regulation of the diet.

DISCUSSION

ON PAPERS OF DR. GARCEAU AND PETERSON.

Dr. C. P. Noble, Philadelphia, said that he thought that Dr. Garceau was very moderate in his statements as to the curability of this condition. In his experience it is far more curable than Dr. Garceau stated. He operated on 16 women, and all of them recovered and are now in sound health. Without any suppuration they made perfect recoveries. With reference to tuberculosis of the bladder, the question of treatment resolves itself as to whether it is primary or secondary to the kidney, and by doing a nephrectomy or nephroureterectomy it will be followed by a spontaneous cure, if secondary. He has been surprised at the facility with which the women got well. The only man operated on by him, who had tuberculosis of the tract with lung involvement, died at a subsequent date. So far as early diagnosis is concerned, he long ago gave up all methods, with the exception of securing the urine and injecting it into guinea-pigs. This, he said, is the only certain way not to confuse the smegma bacillus with the tubercle bacillus. He is convinced of the curability of this trouble. In one case he was misled. He had a patient with tuberculosis of the kidney and bladder whom he sent home to die, but without any treatment she made a good recovery.

Dr. J. Wesley Bowie, Washington, D. C., agreed that the results depend largely on whether or not the disease is localized in those organs. The affections of the bladder disappear if the kidney and ureter are removed, but many cases are found in which not sufficient is done; that is, the kidney is removed and the ureter is left, and the disease tends to get worse. It is necessary to do more than one operation in these cases. Surgeons are not justly in saying that the bacillus is not found, because they are found in urine otherwise normal, so that the presence of the tuberculosis alone is not a positive indication as to the presence of tuberculosis in the kidney.

As to the cases reported by Dr. Peterson, one point is the danger of infection following the operation due to the contamination of the vagina and bladder with rectal contents. If the introitus is closed, the opening into the rectum should be near the sphincter. Make the closure higher in the vagina and get away from the sphincter, as irritation of it means more frequent evacuation. It is interesting to know, he said, whether the vaginal secretion has a bacterial action on micro-organisms in the presence of urine, as it has in the absence of urine. If he were to do an operation diverting urine from the bladder to the rectum, making use of the rectal sphincter as a sphincter, he would form an artificial bladder from the rectum, bringing down the sigmoid and attaching it also, having the sphincter ani muscle act. In these cases it can be done as a preliminary procedure, and then the opening can be made through into the newly made bladder, and there would then be no risk of future contamination.

Dr. Emil Ries, Chicago, said that in the case reported, undoubtedly various other methods could have been considered, and one was mentioned by Dr. Bowie. He thinks in a similar way the Freund operation could be considered; that of turning down the uterus and utilizing it for plastic purposes. Freund’s first case was operated in 1894 and the patient had exceedingly good sphincteric action. In Dr. Peterson’s case the woman had passed the menopause. Perhaps, he said, the uterus in his case could have been used for sphincteric purposes. In the same way the Maydl operation can be considered. But the only one who can determine what is the best operation for the case is the one who had to do the work and had the case before him.

Dr. R. Peterson, Ann Arbor, Mich., said that the implantation of the trigone to the urethral orifices into the sigmoid or rectum (Maydl’s operation) is the ideal method of diverting the urinary stream into the bowel. But it certainly is a more dangerous operation than the one he employed, and his patient was not inclined to take any unnecessary risks. He emphasized the point that when the vesical urethral orifices are preserved intact, there is very little danger of ascending renal infection, no matter what method of anastomosis is employed. The presence of the calculus in his case should not be counted against the operation. Having nothing to go by, he made the openings between bladder, vagina and rectum too small.

CONSERVATIVE SURGERY OF THE OVARIES.∗

EDWARD REYNOLDS, M.D.

BOSTON.

In recent literature it has been usual to speak of the conservative surgery of the uterine adnexa as though it were one subject. In point of fact, the resection of diseased tubes and the conservation of the ovaries belonging to them is usually brought to our attention in inflammatory cases and the question then hinges mainly on the condition of the tube, i.e., on the possibility of its restoration to functional value, as balanced against the possibility of reinfection of the pelvis from the patent stump. In this class of cases the condition of the ovary is usually a subordinate matter. These cases are etiologically in a different field from those which present normal tubes and neoplastic ovaries. They are also distinct clinically since in the latter class the decision rests wholly on the state of the ovary. I believe that confusion has been wrought, that clearness of thought has been lost, by treating the two classes as one. Though both are equally important, in this communication I limit myself to the subject of the surgical treatment of neoplastic ovaries with normal tubes.†

The advisability of the conservative surgical treatment of the ovaries must plainly be determined by observation of the ultimate results of such surgery in practice, and this is usually computed by statistical reports of a series of cases, to which is commonly added the judgment of the individual operator.

I think most of us are satisfied that the application of the strictly statistical method to questions of such comparatively vague nature as the ultimate influence of a conservative operation on the nervous system and general health of a patient is not only capable of producing any result to which the general judgment of the reporter

∗ Read in the Section on Obstetrics and Diseases of Women of the American Medical Association, at the Fifty-seventh Annual Session, June, 1906.
† From a clinical standpoint there are of course cases in which cystic ovaries are attached to infamed tubes or in which the tube attached to neoplastic ovaries is slightly inflamed, but even from a clinical standpoint the cases usually themselves clearly come into one or the other class and the existence of transitional cases may clearly be disregarded from the academic point of view.
tends, but is practically certain to result in support of the side of the case for which he is arguing. I find myself so little influenced in such matters by the percentages deduced from the tabulation of long lists of hospital or otherwise more or less forgotten cases, that in preparing myself for this paper I determined to limit my review of my own experience to the cases of those patients in my private practice whom I have been able to keep track of for at least a year and a half and who were at the same time recent enough for me to be able to retain some personal recollection of them in addition to my records. This gives me 29 cases operated on between December, 1902, and February, 1905. Most of these patients I have seen from to time; the remainder I have looked up recently, and I have used the study of these 29 cases as a basis for the modification or confirmation of the general opinions which I have formed in the course of my work. I believe the deductions to be more valuable than they would be if they had been drawn from the much larger number of less closely observed cases of which I have records from my hospital and consultation practice. The cases quoted are briefly reported at the end of the paper.

My subject proper may perhaps be summarized as dividing itself into two questions: What ovaries should be subjected to conservative surgery? By what method or methods of technique should the ovaries so selected be treated? In the attempt to answer these questions I give, then, my own conclusions as deduced from experience, believing that this is the best contribution I can make to this discussion.

WHEN CONSERVATIVE SURGERY IS ADVISABLE.

In any consideration of the conservation of the ovaries it is necessary to remember, first, that there are two ovaries, and, second, that so far as our knowledge goes one ovary is functionally as satisfactory as two. There is a general impression among surgeons, with which I am personally inclined to agree, that the existence of distension from cystic disease in one ovary tends to excite the appearance of similar trouble in the other. It is my rule that if one ovary is extensively cystic, while the other is not, it is better to remove the cystic ovary completely, even though it contains some ovarian tissue which might be conserved, but at the risk of further cystic disease. If both ovaries are considerably affected the better of the two should be operated on first by conservative methods. If it proves that but a small fragment of ovarian tissue is left, the same conservative efforts should be made on the other side; if, on the contrary, the conservative care of the first ovary leaves a substantially normal organ, and the second is extensively diseased, I think it is better to remove it. If both ovaries are slightly affected, as for instance by only one or two small superficial cysts, I think it is best that both should be subjected to conservative operation. For the rest, in applying the principles of conservative surgery to the ovaries, we must be guided partly by the physical and pathological characteristics of the individual neoplasms, and partly by the age of the patient; and as a matter of convenience in arrangement, I discuss the latter first.

The object for which conservatism is adopted is the preservation of the functions of the ovaries. These organs possess certainly two functions and possibly a third: First, their products are essential to conception; second, they govern or in some way are essential to the menstrual phenomena which are intimately connected with the woman's whole physiology during the central or active period of life; thirdly, they may or may not influence the woman's general constitutional condition through the reabsorption of a so-called internal secretion.

In the majority of cases child-bearing becomes unlikely at or about forty, and in most cases at that age the bare possibility of this which remains has usually become less important; menstruation ceases on an average about forty-five; in women after this age the only value of the ovaries lies in the somewhat hypothetical importance of their so-called internal secretion, and even the strongest advocates of this theory admit its decreasing importance as time goes on after the menopause. The value of conservatism should then be estimated differently for each of these three periods of life, i. e., for young women, for those approaching, and for those who have passed the climacteric.

In weighing the importance of preserving the ovaries in a given case the possibility and desirability of child-bearing stands first. It may be admitted that in young women with the prospect of maternity ahead of them it is always desirable to do the most conservative operation which offers a fair prospect of freedom from further ovarian disease, and if, in these days of the safe and easy performance of the lesser abdominal operations, the case is fully explained to the patient from a fair standpoint there are very few young women who will not cheerfully accept the possibility of a second operation of this nature after the lapse of some years, rather than lose both ovaries at the first operation. In women approaching forty, with whom the probability of child-bearing is decreasing or problematical, its importance will be decided by the social state, the existence of other children, and such considerations, and for women well over forty this consideration fails.

In my experience, however, the age of the patient is of perhaps equal importance as regards the government of menstruation, i. e., the amount of nervous trouble which may be expected after a castration, or avoided by a conservative operation. From puberty to maturity the tide of sexual life is rising and is one of the dominant forces in the woman's whole physiology, health and happiness. To dam it suddenly at this age spells a neurasthenic catastrophe in a very large percentage of cases. In some cases it may be necessary but it is always to be avoided if possible. From twenty-five to thirty-five the tide is full and is of almost equal importance, though I think a larger percentage of women will now avoid an actual nervous breakdown after a castration. From thirty-five on the tide is on an average ebbing. I think it is not generally appreciated that for many years before the actual cessation of the catamenia there is a gradual natural preparation for it. As a rule the intervals between conception lengthen, the sexual impulses slacken, and, with occasional exceptions, as the woman passes into middle age the sexual life becomes progressively of less and less dominant importance.

This point of the effects of castration I have been obliged to study from another set of cases. I have seldom been among the first to adopt new operations. I think I have been too slow in becoming convinced of the importance of the conservation of the ovaries in every young woman where it is possible. It is only within the last five years that I have been pursuing the conservative operations steadily, and with the many cases of destructive inflammatory disease, of malignant disease, and of the other conditions which render the retention of the
uterus inadvisable the list of total ablations in the middle-aged must always remain a large one. My own experience has been far too small. Again confining myself to my private practice and to those patients whose personalities I remember well and who fall within the same period of time I have been able to refer to a quite large list of such cases, and on reading over their records I have been confirmed in my previous impression that in women from 35 years of age and over the percentage of nervous disturbance from the forced menopause is an increasingly small one, until after forty it becomes insignificant.

Of late years in a comparatively small number of cases I have avoided the removal of normal ovaries in hysterectomy for uterine disease, but have seen no difference in the results and have become convinced that in women of middle age at least the importance of the so-called internal secretion is at most but trifling and, I think, non-existent, but on this point my experience is as yet too small to justify a firm conclusion.

My general position as derived from my experience is, that allowing for modifying circumstances the importance of conservatism varies inversely with the age of the patient; that on the average it is not to be advised after the latest thirty, but is to be insisted on in almost every instance in young women; and, again in my opinion, its importance is but little affected by the variations in the pathologic character of ovarian neoplasms, with the single exception of malignancy.

Malignant neoplasms are from their very nature excluded from consideration in conservative surgery, but in the surgery of the ovaries there may be one possible and rather theoretic exception, i.e., the existence of one normal and one malignant ovary in the case of a woman for whom pregnancy is especially desirable. In such a case it might be justifiable to leave the normal ovary undisturbed but under close observation.

**Classification of Ovarian Growths.**

The pathologic classifications of benign enlargements of the ovary are still clinically blind. From the clinical standpoint we are very little, if at all, guided in our treatment by the pathologic question as to the origin of the cystomata from Pfliiger's tubules, the Graafian follicles, the Mullerian ducts or the Wolffian body, and are mainly influenced by their physical condition, i.e., the size and number of the cysts and their situation in the ovary. A convenient classification of the benign growths is:

A. Cysts originating from the corpora lutea.
B. Dermoid cysts.
C. So-called simple Graafian cysts:
   1. Single or multiple of size sufficient to form tumors external to the ovary.
   2. Enlargement of the ovary by numerous small cysts within the stroma (Koffitsky's tumor).
D. Enlarged sclerotic ovaries.

**Technic.**

The conservation of the ovaries seems to me of almost equal importance in all these varieties and even the technic of their treatment is affected more by the size and number of cysts, and by the physical characteristics of uniformly enlarged ovaries, than by their exact pathologic character. These lesions may be treated by:

A. Evacuation, puncture and removal of the lining membrane with or without suture.
B. Resection.
C. Bi-section of the ovary and multiple puncture or resection.
D. Scarcification or multiple incision of the surface.

**Corpora Luteal Cysts.**—The smaller cysts from the corpora lutea and those ovaries which contain not more than half a dozen small surface cysts from the Graafian follicles are peculiarly adapted to puncture of the cysts and the removal of the lining membrane.

If an ovary which contains a persistent and abnormally enlarged, and enlarging corpus luteum be seized between the thumb and finger in such a way that moderate pressure is put on the base of the cyst and the distal surface of the enlargement incised by the knife the whole mass may usually be expressed on a sponge, leaving a clean surface of normal ovarian tissue behind it. The thin edges of the cyst may require trimming by the scissors but it is often surprising how small a surface is left after the removal of a cyst of considerable size, and in cysts of this character up to the size of an English walnut after the trimming of the thin cyst walls the surface left can usually be closed with a few fine sutures, without the loss of any ovarian tissue and leaving a normal organ behind it.

**Cysts of the Graafian Follicles.**—In similarly small cysts of the Graafian follicles if the ovary be seized in the same way and a pair of snap forces or is forced through the cyst wall while a sponge is held to catch the fluid, the forces may be made to seize the lining membrane and it is surprising how often by a movement of torsion of the forces or the whole lining or active portion of the cyst can be twisted out intact, and again without the loss of ovarian tissue. In many of these cases no suture is needed, the cyst wall of cysts as large as a hazel nut often shrinking together in such a way as to leave little or no cavity, and but a small puncture which has ceased to bleed before the operation is completed. The situation of that ovary is but little different from that which follows the normal rupture of the follicle. In instances which do bleed I have never seen trouble follow the insertion of deep sutures of fine silk, whipped over and over in such a way as to compress the whole base of the evacuated cyst. I have been surprised to find that the cases in which I have used fine silk for deep ovarian sutures have shown no more subsequent pain or trouble than when I have used an absorbable suture. After the removal of even four or five cysts by this method no ovarian tissue has been lost, and the organ is in a practically normal condition. The excision of each of numerous cysts would have left a much mutilated organ, but this process must be limited to fairly superficial cysts.

Careful perusal of my records shows that while a few cases treated in this way have temporarily had heavy and distinctly enlarged ovaries for a few months after the operation, the ultimate results have been exceedingly satisfactory. These were probably cases in which I underestimated the importance of oozing within the cyst cavity and neglected to place sutures where they should have been used, and the temporary enlargement in these instances was probably due to the formation and subsequeent absorption of a harmless clot within the cavity. Unfortunately my records have seldom been detailed enough to enable me to postulate this, but the results make it tolerably evident. The cases to which I am limiting myself are not sufficiently numerous to warrant any statistical conclusion, but all have been subjected to careful depletion in after treatment whenever there was any reason for it, and so far I have not been obliged to operate a second time for any of these cases.

**Large Cysts.**—Dermoid cysts, large tumors from the corpora lutea and large single or multiple, so-called Graafian cysts must be treated by excision, and here I have learned of late a fact which I chanced on by accident and which I have reason to believe is known to but
few operators. I have seen several instances of large cysts varying from the size of an orange to that of the adult head which appeared to have destroyed the entire ovary, i.e., in which no trace of ovarian tissue could be seen about the pedicle of the tumor, but in which it was, nevertheless, possible to conserve a normal and practically normal sized ovary. The first of these cases was that of a young girl about to be married in whom both ovaries were much enlarged and for whom I had promised to save any scrap of normal ovary. One ovary was distended to, perhaps, twice the size of a large English walnut by a great number of small cysts. This I felt obliged to remove. The other consisted of a single cyst, evidently of so-called Graafian origin and of about the size of a small orange. Its walls were uniformly thin and translucent, except at the hilum, where they were thick and white over perhaps the basic fourth of the tumor surface. With little hope of finding any ovarian tissue, but in strict pursuit of my promise, I made a careful superficial incision through the edge of the thin pedicle. I had earlier cut the thin translucent cyst wall under it. Passing the handle of the scalpel into this and separating the thin internal wall from the thicker external portion by blunt dissection, I found a plane of cleavage and was able to shell out the thin-walled cyst entire, hoping against hope that I might find some small portion of ovarian tissue about the hilum. To my surprise, the circle of thicker wall about the hilum so left retracted after the removal of the cyst into the shape and size and to all appearance the substance of a normal ovary. Several subsequent but less marked cases have led me to hope that there are but few cases of large single cysts of a benign nature in which this process may not enable us to preserve some portion of a normal ovary. I have gone into this phenomenon in detail, because, although it may be known to many of you, it is new to me, and, from conversations with a number of experienced surgeons, I am confident that there are some of you to whom it will be as interesting and unexpected as it was to me.

Rokitansky's Tumor.—The condition known as Rokitansky's tumor in which the ovary is distended by very numerous small cysts living not only on the surface, but throughout the stroma, each being thin walled, simple, and with no noticeable lining membrane, demands a different treatment. Until recently I believed them unfit cases for conservative treatment. I still look on them as the least hopeful and would remove a well-marked ovary of this character if the other were comparatively normal and fitted for conservative treatment. My experience of the conservative treatment of these ovaries is still too limited to enable me to draw safe conclusions, especially as the cases which I have treated by the technic I am about to describe are all among the more recent from which I have dared to draw conclusions, but the few cases which I am able to quote are all improving enough to make me feel that I shall, with some caution, pursue this line in the future. The little knowledge that I have is empirical, but the stroma of these ovaries is always edematous, the ovaries feel uniformly tense and swollen, and, acting on the theory that this abnormal tension probably favored the continued production of the cysts, I have first punctured with a blunt instrument (a fine pointed artery forceps) all the superficial cysts, then seizing each end of the hilum with compression forceps in order to lessen bleeding, and with the ovary drawn outside the abdomen and surrounded with gauze, I have bisected it from end to end and from the edge almost to the hilum, with the knife, and guided both by sight and by palpation of each half between the finger and thumb, have pushed the closed fine pointed artery forceps into every cyst that could be seen or felt, however numerous or small they might be. These numerous punctures sufficiently drain the ovary which becomes soft and flabby in the process. I have then removed the forceps from one end of the hilum, passed a needle, armed usually with fine silk, through the tissues below the ovary at about one-third distance in from the edge of the hilum and tied the suture tightly, thus cutting off about one-third of the circulation. Passing the needle again through the tissues below the ovary, I have drawn the thread around the whole ovary while the divided halves are held in apposition by the finger and thumb, and again passed the needle through the tissues below the ovary so that the stitch encircles the whole organ, holding one end of the divided halves together. Repeating this stitch again and again, the whole ovary is whipped together by successive encircling loops of silk, the needle being passed entirely beneath the ovary in the tissues of the broad ligament or through the ovarian substance, as from time to time may seem most appropriate and best calculated to hold the bisected halves in apposition. The stitch is then finished by a final knot which compresses the circulation at the other end of the hilum, again for about a third of its length, some two-thirds of the circulation being thus effectually cut off. I have reached this apparently somewhat reckless use of fine silk, or at times catgut, in the ovarian tissues by gradual stages, but have grown to be confident that deep stitches even of silk through the ovarian tissue produce no after pain or ill results. As a whole, the after history of these cases has been that such ovaries have been heavy and again enlarged somewhat after operation, and with some persistence of symptoms, but that both physical and symptomatology have been gradually improved, and for as I can see have been followed by eventual recovery.

Enlarged Sclerotic Ovaries.—The enlarged sclerotic ovaries I have considered until very recently entirely unfit for conservative operation in cases in which they have caused sufficient symptoms to demand any operation whatsoever, and I believe that substantially enlarged sclerotic ovaries have usually been removed by operators when met with as probably promising future trouble. In some cases in which I have met with them incidentally in the course of operations undertaken for other reasons, as, for instance, in myomectomies, and in which I was unwilling to remove them, I have freely scarified their surface with the knife, making parallel cuts from a sixteenth to an eighth of an inch deep and perhaps a quarter of an inch apart over the whole external surface of each ovary and have been inclined to believe that subsequent examination has shown that they have decreased in size, but the cases are too few and too recent to warrant any conclusions. I can only say that the treatment seems innocuous and promising enough to be worth trying when occasion offers incidentally.

CASE SUMMARIES.

Case I.—Mrs. C. W. (No. 2277).—Referred by Dr. Hodgdon. Operation Nov. 1, 1904. Both ovaries about twice the normal size, and showing numerous small cysts. Right ovary, a corpus luteum, removed by excision, ovary split, and several small oblique cysts punctured with forceps, closed with silk. Left ovary several superficial cysts punctured and lining pulled out.
Sutured with silk. Suspension and appendectomy. Repeatedly and recently examined. Ovaries have remained small. No pregnancy.

CASE 2.—Mrs. W. W. S. (No. 2104). Operation Nov. 4, 1905. Right ovary about three times normal size owing to single cyst of Graafian follicle, punctured and lining pulled out, sutured with silk. Suspension and appendectomy. Recently and repeatedly examined. Right ovary somewhat large and heavy, not tender thirteen months later. Not seen again for six months, when right ovary was normal, and has so continued. Unmarried.

CASE 4.—Mrs. W. S. F. (No. 2104). Referred by Dr. Lovett. Operation Nov. 4, 1905. Right ovary about three times normal size owing to single cyst of Graafian follicle. Cyst excised and wound closed with silk. Left ovary, three superficial Graafian cysts, punctured and lining membrane pulled out. Not sutured. Appendectomy. Not seen for three years, but repeatedly reported as well in interval. April 26, 1906, both ovaries slightly large, especially the right, not tender, no symptoms. Complained of sterility. Cervical secretion normal, vaginal profuse, turbid, and acid. Under treatment for sterility.

CASE 5.—Mrs. H. P. (No. 2249). Referred by Dr. Benson. Operation June 27, 1904. Left ovary size of a hen's egg, multiple cysts. Removed by excision, leaving small portion of ovary near hilum, sutured with silk. Right ovary the same condition and treatment. Cysts of Morgagni removed from each tube. Suspension, appendectomy, trachelorrhaphy, perineorrhaphy. Not seen since convalescence, but repeatedly examined and reported on by her physician, a good diagnostician. Ovaries have not enlarged. No pregnancy. Operated on for peculiar sexual psychopathia, which has not improved.

CASE 6.—Mrs. W. A. (No. 2201). Referred by Dr. Mason. Operation Feb. 8, 1905. Left ovary, hemorrhagic cyst size of a normal ovary, resected, leaving ovary almost normal size. Right ovary, numerous small superficial Graafian cysts, punctured and lining removed. Neither tube thickened, both constricted and occluded in outer third, both resected. Recently and repeatedly examined. Ovaries have remained normal size. No pregnancy.


CASE 9.—Mrs. W. G. S. (No. 2311). Operation Jan. 9, 1905. Right ovary one, left ovary two small superficial follicular cysts, punctured, lining membranes removed, sutured with silk. Two cysts of Morgagni removed, appendectomy, trachelorrhaphy and perineorrhaphy. Recently and repeatedly examined. Ovaries normal. No pregnancy, but preventive measures employed.


CASE 12.—Miss E. L. B. (No. 2306). Operation Oct. 22, 1904. Right ovary, several small superficial cysts punctured and lining removed, silk sutured. Left ovary, cysts size of English walnut excised, wound sutured, about one-third of ovary left. Appendectomy. Repeatedly and recently examined. Left ovary temporarily enlarged two months after operation, since normal. Unmarried.


CASE 18.—Mrs. G. M. N. (No. 2143). Both ovaries enlarged, edematous, and containing small cystic follicles, punctured, lining pulled out and sutured. Right ovary large and apparently persistent corpora luteum, same treatment. Suspension and appendectomy. Repeatedly and recently examined, ovaries normal. No pregnancy, preventive measures.

CASE 19.—Mrs. F. W. H. (No. 2100). Referred by Dr. Houghton. Operation Sept. 26, 1903. Both ovaries, persistent corpora lutea about doubling size of ovaries, both excised, in both luteal cells have degenerated but cysts have persisted and are probably increasing. Suspension and trachelorrhaphy. Four months later left ovary somewhat enlarged, but gradually decreased again to the normal under depletion. No pregnancy.


CASE 22.—Mrs. F. G. M. (No. 1980). Referred by Dr. Torrey. Operation March 30, 1903. Right ovary normal. Left, one large and several small cysts punctured, membranes excised and sutured. Suspension and appendectomy. Ovaries recently reported normal. Symptoms relieved. Twins.

Suspension, appendectomy, perineorrhaphy. Thrombosis of left leg in convalescence. Both ovaries somewhat swollen about two months after operation, gradually returned to normal. Seen recently, well. One pregnancy since operation.


CASE 22.—Miss S. M. P. (No. 1932). Referred by Dr. Flanders. Operation March 31, 1903. Both ovaries contained numerous hemorrhagic Graafian follicles, all superficial, all punctured and membranes removed, stitched with deep silk sutures. Appendectomy. Seen recently and repeatedly. At the end of six months both ovaries somewhat enlarged, right sensitive. Under depletion gradual decrease in succeeding six months, now normal. Symptoms much improved. Still slight dysmenorrhea. Unmarried.


CASE 24.—Mrs. F. F. H. (No. 1697). Referred by Dr. Sabine. Operation April 15, 1903. Right ovary, cyst size of orange, removed. Left ovary, hemorrhagic cyst size of American walnut, punctured, membrane extracted, not sutured. Radical cure of hernia, Dudley's operation. Repeatedly examined. In succeeding six months ovary enlarged somewhat but again decreased. No pregnancy; 35 years old.


The elder Emmet expressed the hope that future generations might be allowed to go uncastrated. More than twenty years ago Schröder first advocated the preservation of the remnant of normal ovarian tissue that could be left in the removal of cysts. About that time August Martin reported a number of cases in which he had removed degenerated portions of the tube and ovary and saved the normal tissues. A few years later William M. Polk presented to the surgical profession his brilliant results, and then considerable attention was paid to the subject in this country. Von Winkel, Hofmeier, Schatz, Zweifel, P. Muller and A. Palmer Dudley were all pioneers in this work. Considerable harm has at times been done by overenthusiastic followers of these men, the student often lacking the judgment of the teacher.

Lawson Tait was a most distinguished exponent of scientific hara-kiri. At present, were he living, he would no doubt be unpopular with most French statesmen and with our own President Roosevelt. Battey in America, Tait in England and Hegar in Germany set the pace for the wholesale removal of ovaries in three of the world's greatest countries.

In an address before the American Medical Association, the late A. Palmer Dudley said: "A quarter of a century ago he who would have advocated conservative surgery on the uterine appendages of women would have been considered by the surgical profession at large as a fit subject for the asylum." A review of gynecologic events occurring during these last twenty-five years presents a wonderful panorama of wide sweep. We have had many stars in this often tragic drama of the surgical arena. Many of the makers of gynecology could see no avenue of success but that made by the radical removal of all that lay in their path.

It is unusual for the genital organs of the male to be sacrificed for any condition save malignant disease. In inflammatory disease of the testicle or vas deferens removal, as a rule, is about the last thing thought of. The repressed sex are entitled to some privileges as well. It is distinctly of no advantage to the woman to exchange one undesirable condition for another. The belief in the mind of the woman that she has lost the generative function; that she has lost some of the finer sensibilities of the sex; that she is unlike other women, is in itself to most women productive of much mental anguish.

**Views of a number of American gynecologists.**

Believing that a general consensus of opinion is of value in the discussion of mooted questions, I addressed circular letters of inquiry to thirty-five of the leading operators of this country and received extended replies from thirty-three of them. I inquired of each operator as to his favorite and usual method of treating diseased tubes, cystic and prolapsed ovaries, whether or not he had done ovarian transplantation and about what, if any, percentage of pregnancies had followed conservative work in his hands. Replies were received from Drs. H. C. Coe, New York City; Floyd McRae, Atlanta, Ga.; J. Taber Johnson, Washington, D. C.; Edward J. Ill, Newark, N. J.; Charles R. Robbins, Richmond, Va.; J. G. Earnest, Atlanta, Ga.; William M. Polk, New York City; Joseph Brentano, New York City; Edward McGuire, Richmond, Va.; William H. Humiston, Cleveland, Ohio; S. C. Gordon, Portland, Me.; Charles G. Cumston, Boston; A. Brothers, New York City; A. Vanderwee, Albany, N. Y.; Robert T. Morris, New York City; W. H. Baker, Boston; Charles Jewett, Brooklyn, N. Y.; H. J. Boldt, New York City; I. S.