be produced by many different causes. Each case required separate and careful consideration. The usual cause of dysmenorrhœa was undoubtedly spasm at the os internum (case related showing the spasm intermittent, sometimes absent). The best way of treating this variety was over-dilatation, for, unless it was well and thoroughly done, it returned. Dysmenorrhœa from flexions required treatment of the flexion; that from tubal or ovarian disease might require oophorectomy, or what was known as Tait's operation; that from constitutional, and especially from nerve causes, required general treatment.—Dr. WALTER (Manchester) considered that the most common cause of obstructive dysmenorrhœa and sterility was stenosis of the cervix, either of the entire canal or of the internal or external os. Before giving a prognosis in such cases, especially with regard to overcoming the sterility, he recommended care to be taken in ascertaining whether the stenosis existed alone, or whether any ill results such as endometritis, metritis, or general enlargement of the body or fundus uteri were superadded. When any marked disease was discovered above the inner os, he did not feel justified in giving so favourable a prognosis. As regarded the treatment of stenosis, he advocated greater care in the antiseptic precautions adopted, and especially to the advisability of inserting into the uterus a bougie or suppository of iodoform, unless a solution of corrosive sublimate was thoroughly applied to the parts after the dilatation.—Dr. W. L. REID believed very strongly in obstructive dysmenorrhœa, but not at all so strongly in obstructive sterility. Treatment of obstructive dysmenorrhœa often so altered the condition of the uterus in important respects, that sterility was thereby cured.—Dr. HEYWOOD SMITH, while agreeing with Dr. Halliday Croom as to inflammation of the endometrium being a factor in some cases of dysmenorrhœa, yet joined issue with him as regarded the actual existence of dysmenorrhœa due to definite obstruction. He thought that the pain of dysmenorrhœa was the great guide to the diagnosis, as there was a distinct pain arising from ovarian trouble, and the pain which we called uterine dysmenorrhœa was due to the effort "pains" made by the uterus to expel the accumulating fluid of the menstrual flow. With regard to what Dr. H. Croom said about an undeveloped uterus, there was no doubt but that such a uterus would have an undeveloped vascular system, and so there would not necessarily arise any pain from disproportion between a uterus and its vessels. There was no doubt that in his (Dr. Smith's) experience there was such a thing as obstructive dysmenorrhœa, and also that he had seen much good by proper incision when combined with dilatation. He was greatly against the use of scissors for the purpose of incision, as by their means the injury was often produced that Emmet's operation was devised to obviate. The method he pursued and recommended was to draw down the uterus, pass graduated sounds up to Nos. 9 or 11, then pass a blunt-pointed bistoury or Sims's knife, and divide slightly the whole cervical canal from the inner os downwards; then the canal was to be dilated with some dilator, and the best he knew of was Sims's; and here he would give a warning against using any screw appliance, the dilator should be used with the hand alone, as then they were able to feel the amount of tearing of the fibres that went on, and there was less risk of injuring the uterus. After this operation it was only necessary to pass a warm sound of about size 13 or 15 once or twice after a day or two's interval. Of course, in this discussion they were considering not only the dysmenorrhœa, but the sterility. Now in the ordinary position of the uterus the os tince acted by imbibing the semen, which in the supine position gravitated towards the posterior *cul-de-sac*. If the shape of the os uteri was much interfered with this process of imbibition was interfered with. In cases of retroflexion the position of the os uteri with regard to this posterior *cul-de-sac* (or pond) was but little altered, but in cases of ante flexion the os uteri was lifted out of this pond. Mere dilatation of the uterine canal by sounds or bougies only was comparatively ineffective, as the uterus invariably returned to its abnormal construction, but the proper combination of slight incision and dilatation was in his (Dr. Smith's) opinion the best for their patients.—Dr. AMAND ROUTH thought obstructive dysmenorrhœa rare, and that it was advisable when true obstruction did exist to try to divide cases into (1) congenital contraction, (2) secondary (congestive or inflammatory). The congenital forms were especially important, as, according to Emmet, 73 per cent. of these cases were sterile when married. Of the inflammatory causes of obstructive sterility, Dr. Routh believed that gonorrhœa, arising from a neglected gleet in the male, remaining perhaps for years without symptoms in the female (so-called latent), was the most

serious, producing both occlusion of the Fallopian tubes and an intractable endometritis. As regarded contractions of the uterine canal, which were rarely productive of dysmenorrhœa, he did not believe that dilatation alone would permanently cure. Dilatation, with subsequent introduction of a stem over a few periods, would permanently cure true stenosis. Many of the cases of so-called obstructive dysmenorrhœa were really caused by congestion of the endometrium, and these would, of course, require quite a different treatment.—The PRESIDENT (Dr. MORRIS MADDEN) congratulated the Section on the discussion on Dr. Halliday Croom's valuable paper. That discussion, however, forcibly exemplified the first aphorism of Hippocrates—namely, "Experience is fallacious and judgment is difficult," inasmuch as this discussion had turned mainly on the obstructive or non-obstructive general origin of dysmenorrhœa and sterility. On this point more than a dozen gentlemen of great eminence and experience in this special branch of practice had just spoken, and no two of these gentlemen had been of the same opinion with regard to the relative frequency of the different factors in the causation of the morbid conditions under discussion. These causes had been sufficiently discussed, and therefore he would not again refer to them further than to say that the result of his experience, and it was not a limited one, was that obstruction was by far the most frequent of all the causes both of dysmenorrhœa and of the sterility so commonly associated therewith. And, secondly, whether that obstruction was due to a displacement or flexion, or merely to stenosis of the cervical canal, in either case the removal of the resulting sterility or dysmenorrhœa could only be obtained by recognition and effectual curative treatment of the obstruction; in the former case by the rectification of the displacement, and in the latter case by dilatation or incision of the stenosed cervical canal.—Dr. Croom briefly replied.

INSTRUMENT FOR THE RAPID DILATATION OF THE CERVIX UTERI.

Read in the Section of Obstetric Medicine at the Annual Meeting of the British Medical Association held in Glasgow, August, 1888.

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It is generally conceded that where dilatation of the canal of the cervix uteri is necessary, rapid dilatation is the most satisfactory proceeding. Bladed dilators are either too large for introduction in cases of stenosis, or, when opened, too weak to be effective. Ordinary conical dilators are extremely painful in the application.

To dilate an organic structure thoroughly, it is necessary to rupture the tissues, and the question is, how this may be most safely accomplished. The conical screws shown are graduated from a point which is small enough to pass in any ordinary case of stenosis up to one which, on its withdrawal, permits of the finger being freely inserted into the uterine cavity. The threads are sufficiently blunt to prevent their cutting the tissues, yet prominent enough to make the tissues act as a female screw, and so draw the uterus down over the instrument, instead of requiring the instrument to be forced into the uterus. As the screw-head dilates equally in every direction, the damage to the parts concerned is reduced to a minimum. There is no fear of injury to the body of the organ, as the screw-heads are only an inch and three-quarters in length. Considerable experience in its use shows that it is comparatively safe and perfectly efficient.