the result was as related. It is (now) six years since that operation took place. The patient is now well, having good sphincter power, except in diarrhoea; but the healing was tedious and troublesome. Any one who has had experience in excision of the rectum will, I am sure, appreciate Professor Esmarch's suggestion.

A NEW FORM OF VAGINAL PESSARY.¹

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A CASE of retroversion of the uterus, presenting conditions of unusual difficulty, first suggested the idea of the instrument here delineated.

It is on the plan of the familiar trestle used by builders for supporting stages or platforms, and is made of soft caoutchouc enclosing a steel spring-wire frame. The pessary consists of a transverse bar superiorly, and lateral fenestrated supports or wings. These latter are inclined outwards from the points of their attachment to the transverse bar, and also follow a curve downwards and forwards, corresponding

as nearly as may be to that of the vagina. The wings are also everted anteriorly, not only to accommodate the distension of the bladder, but to prevent the lateral rotation of the instrument. The slight concavity of the upper surface of the bar seems to give more fixed support in cases where there is great uterine mobility, or greater than usual

weight of uterus, but it may readily be bent so as to become convex if need be. The bar is intended to be placed in the vaginal cul-de-sac (*fornix*), either behind or before the cervix uteri, according to the nature of the displacement, while the wings rest on each side of the pelvic floor.

This pessary is very easily introduced, on account of its comparatively small size and the compressibility of the wings. The free curved extremities of the latter are approximated closely between the forefinger and thumb of the right hand, and the bar is passed through the vulva with its long axis antero-posteriorly; then a quarter of a turn, with gentle sustained pressure, brings the wings with their curve forwards within the vagina, and, the hold being relaxed, they separate, and their

inferior curves at once adapt themselves to and rest upon each side of the floor of the pelvis. It is only then necessary to pass the forefinger up between the wings that adjust the bar behind or in front of the cervix, as desired. I have found that a pessary of this shape will give more efficient support than a Hodge's, or Albert Smith's pessary quite two-fifths longer in the vertical axis. It is necessary to bear this in mind in the selection of the necessary size. In very many cases this question of mere size is a most important consideration.

The exact *modus operandi*, even of the familiar Hodge type of pessary, is still a moot point among gynecologists; but the action of this trestle pessary is quite simple, and readily enough understood. Like every other form of vaginal pessary, it can only influence the position of the uterus indirectly, through its ligamentous connections. The uterus has, of necessity, a considerable range of physiological displacement; and indeed, so long as its utero-sacral attachments or broad ligaments do not permit a material displacement downwards; an amount of anteversion or of retroversion, quite pathological strictly speaking, may be borne without giving rise to any distressing symptoms. The transverse bar of the trestle pessary, when placed either in the posterior or in the anterior vaginal fornix, gives a point of support to the cervix, at the point of its junction to the body of the uterus, and at the same time raises it with its broad ligaments, restoring the normal tension of the latter, the loss of which is so important a factor in determining the lesion. The restored equilibrium is maintained by the lower segments of the wings resting on the sides of the pelvic floor, above the tuberosities of the ischia, where there are no sensitive or mobile viscera. The bladder and rectum are thus enabled to distend and contract in the discharge of their functions, without impediment on their part, or disturbance of the pessary.

As I have already said, this instrument was designed to meet the exigencies of a case of retroversio uteri presenting local and reflex symptoms of extreme urgency; among others, persistent and painful menorrhagia with intense nausea and gastrodynia. The patient was an unmarried lady. The displacement was of many years' standing, and complete, the fundus resting in Douglas's pouch, and easily recognised through the upper posterior vaginal wall, while the os uteri was tilted upwards and forwards, behind the symphysis pubis. The whole uterus was curved backwards, but not completely flexed. The situation was further complicated by enormous congestive hypertrophy of the dislocated organ, the sound measuring nearly six inches of cavity, and by the presence of a fibroid in the left posterior wall of the fundus, by which, probably, during a period of laborious nursing, the malposition of the organ was originally determined. After reposition, which was a work of extreme difficulty, principally on account of adhesions, every variety of pessary of the Hodge type was tried by eminent gynecologists, both of Edinburgh and London, as well as by myself; but the relief afforded by these aids was only temporary, and never complete even when the instrument was kept *in situ*, on account of the weight and extreme mobility of the uterus, while the frequent necessity for readjustment was a source of the greatest trouble and distress. The difficulty with the Hodge's pessary was the impossibility of a sufficient fulcrum for the lower bar, so as to support the weight above. This lower bar was continually slipping forwards across the vulva, while the fundus uteri was allowed to fall again into Douglas's pouch, over or by the side of the upper bar. It became evident, after much consideration, that a fixed support on the pelvic floor was the only means of meeting the indications of the case; and to obtain this I had the pessary I have described made for me by Messrs. Maw and Co. The effect of its introduction was immediate and complete; and, as far as nearly four months' experience can enable one to judge, promises to be permanent. Indeed, the results far exceeded my most sanguine expectations. The menstrual and other functions resumed their normal character, all the distressing reflex disappeared, and the patient, who had to be carried up and down stairs for the most part, and could hardly walk or drive without extreme suffering, was at once enabled to move about freely, and is rapidly recovering her lost health.

I have since had the opportunity of employing this pessary in several cases, both of retroversion and of anteversion, and also in a case of prolapsus with great protrusion of the bladder and posterior wall of the vagina of very great difficulty, and with results so satisfactory, that I am sure it is an instrument that will be found useful in a large number of cases in which the weight of the uterus, extreme relaxation of its ligamentous connections, deficiency of perineum, or irritation of the bladder or other surfaces, necessitate a more fixed support than can be afforded by other forms of pessary acting more or less on the lever principle, with a movable fulcrum. Indeed, I venture to think that it may be used with advantage, even in a much wider range of cases than those I have indicated.

¹ This pessary is made in three sizes, of which the drawings are exactly to the scale of the largest.