certain that the temporarily replaced organ will return to its abnormal position), or the impaled organ is held firmly forwards while the pessary is forced into place, the handle of the sound being used as a guide. All this can be avoided by adopting the position I recommend and using my uterine repositr, which acts externally to the uterus, and so dispenses with the use of the sound in these cases altogether, except perhaps for the purpose of diagnosis. There are several cases on record where the womb has been perforated by injudicious attempts to use this instrument, and this danger should be remembered when efforts are being made to remedy a misplacement by its means, as still recommended by some of the latest text-books on the subject. In my opinion, neither the uterine sound, nor any other instrument, however ingenious, introduced into the uterine cavity, should ever be used to remedy a malposition, but should only be used for diagnostic purposes, for which, I believe, the "sound" was originally designed.

I have often remarked that in women with broad pelvis there is much more tendency to misplacement of the womb, so that the value of this pessary, if only by affording a certain amount of fixity and rest to the organ, is certainly not the least of its many advantages.

I have found it very useful to examine patients in the erect position where symptoms point to flexion or prolapse, as the laxity of the ligaments can be much more easily determined by the mobility of the uterus upwards.

It will also be found useful to direct the patient to bear down during the examination, when, by the patient's voluntary efforts, the uterus can be felt to come down much lower in the vagina, shortening the fornices, and so giving greater facility for diagnosing a flexion or prolapsed ovary. Should the uterus be tender to the touch, it will be advisable not to introduce a pessary, or, indeed, attempt to remedy the displacement till local depletion has been practised or a glycerine tampon introduced and allowed to remain *in situ* for twenty-four hours, after which the uterus will probably tolerate manipulation.

There are some who maintain that it is quite impossible to cure a chronic misplacement by means of pessaries; for my own part I am convinced that if the rules which I invariably follow myself, were generally adopted, the permanent curability of misplacement by the proper use of this pessary would be universally admitted. The points to which I attach most importance in this connection are: First, the replacing of the uterus in as nearly as possible its normal position by means of the repositr. Secondly, the judicious selection and application of a suitable instrument; and thirdly, the graduated change of pessary at regular intervals.

By substituting a slightly longer instrument at each change of the pessary (till the normal position is retained without the necessity for wearing one any longer), I find, if the last instrument applied has been worn for a sufficient time, there is no return of the misplacement whatever. I am a firm believer in the Hodge's lever action, when properly placed *in situ*, and this can be put to ocular demonstration by raising the posterior wall of the vagina with the duckbill speculum; when, if the patient be in proper position, and the pessary mainly held in place by the lateral pressure of vaginal walls, it will be observed to move backwards and forwards by each inspiration and expiration of the patient. It is this valuable property of the pessary which slowly but surely raises the body of the uterus, and by taking the weight and strain off the ligaments, allows them gradually to regain their natural tone and elasticity, a point almost as important as the reposition of the organ itself.

The periodical change of pessary till the normal position is permanently obtained is to my mind one of the most important points in the treatment, the neglect of which rule has (in some cases at least) caused this valuable instrument to be unjustly condemned.

I have on several occasions heard patients complaining of the presence of a pessary (which, if properly adjusted, should never be the case) and stating they had been assured by the physician who had introduced it, that the pain and discomfort complained of could not possibly be due to that cause; when on examination the instrument has been found to be at fault, either by being too long or improperly curved, and so by pressing on the neck of the bladder, or obstructing the circulation in the soft parts, exemplified in a marked degree "the vicious action of the Hodge." Well may Emmet say, in his well known work, "The practitioner to become an expert in fitting a pessary that may do no harm must have a decided mechanical talent."

Another of the valuable points of advantage in the use of this instrument is, that even should the misplacement take a considerable time to rectify permanently (which time can be roughly calculated from history of case and date of primary cause), the strain being taken off the uterine ligaments, and in many cases the pelvic nerves as well, it is a pleasure to see the patient, who a short time before limped into

the study bowed down with pain, enabled to leave it before long with marked relief to all her symptoms, again erect in posture, and showing, beyond contravention, the invaluable aid to be rendered by a properly adjusted, well-fitted Hodge's pessary.

ON A CASE OF REMOVAL OF THE ENTIRE UTERUS FOR CANCER AFFECTING THE CERVIX.

By EDWARD COTTERELL, M.R.C.S. Eng., L.R.C.P. Lond.

EXTIRPATION of the uterus may be performed either by Freund's or by Schröder's method, the latter offering many advantages, amongst which may be mentioned greatly decreased mortality, greater simplicity in its performance, and another notable feature—the whole, or nearly the whole, of the Fallopian tubes may be removed at the same time, and this especially in cases of hysterectomy for cancer, where the body has not become greatly involved.

I am aware that it is usually stated that this is not correct, and that one drawback to the vaginal operation is stated to be that the tubes are left behind, because if they are removed there is not room to apply a secure ligature to the broad ligaments, and secondary hæmorrhage may ensue.

The leaving of the tubes, these being structures in direct continuity with the uterus and its lining membrane, is a fundamental breach of the law which governs all operations for the removal of malignant disease.

In the case I am about to describe, I was able to remove nearly the whole of the right Fallopian tube and the greater part of the left one, and I have no doubt that in operating upon another case I shall be able to remove the whole of both tubes, and thus do away with this most serious objection.

With these preliminary remarks, I will now proceed to describe the case operated upon.

On September 24th, 1886, I was called to see the patient, E. E., aged 48 years. She stated that she was flooding, and had been doing so for some hours. She was perfectly blanched, and had a very feeble pulse. The hæmorrhage was arrested by appropriate means, and the cause was found to be a malignant growth from the cervix uteri.

She had been married twenty-nine years, and had had her first child twenty-six years ago; altogether she had had thirteen children; the youngest was 9 years old. Her labours had always been difficult, but had not required instrumental interference; at the first labour there was said to have been an adherent placenta; after the birth of the second child, she was told that she had ulceration of the cervix, which was cauterised. There was no family history of malignant disease.

She had had leucorrhœa more or less since her marriage. She noticed that the vaginal discharge became offensive about June, 1886. Menstruation ceased six years ago.

On October 17th an anæsthetic was administered. The urine was drawn off with a catheter, and the patient placed in the lithotomy position. A ligature was then put round the large vaginal growth as high up as possible; upon tightening this it cut through the mass, which was removed. The vagina was then syringed out with perchloride solution. A Sim's speculum was introduced into the vagina and a sound into the bladder. A pair of vulsellum forceps were applied to the stump of the uterus, and forcible traction was made. An incision was made in front of the uterus, and the bladder and peritoneum stripped off as high up as possible. A similar incision was made posteriorly, and the peritoneum stripped off behind, and the lateral parts of the cervix were denuded of tissue. The peritoneum was then perforated before and behind, and forcible traction made by drawing down the vulsellum forceps. A pair of Wells's clamp-forceps were fixed on each side of the broad ligament, and the uterus removed by cutting through this structure. The peritoneal cavity was carefully sponged with perchloride solution. There was no hæmorrhage. Iodoform was dusted in, and a large india-rubber drainage-tube inserted into the peritoneal cavity. The vagina was then packed with dry iodoform wool, and the patient put to bed.

Upon recovering from the anæsthetic there was little or no shock. The operation was done about 11 A.M. At 6 P.M. the temperature was 100° F. At 8 A.M. the next morning it was normal. At 7.30 P.M. next day the vaginal packing was removed, and Wells's forceps taken away. The bowels were opened by an injection on the fifth day. On the thirteenth day the patient sat out of bed for two hours, and from this time convalescence became rapidly established.

Subsequent History.—About three months after the extirpation of the uterus it was noticed that the vaginal walls, which at the time of the operation were apparently free from disease, had become infiltrated with a recurrence of the growth. The patient died seven months after the operation.