in turn has been removed, the vagina is thoroughly dried and is then filled with gauze. This method has proved to be most satisfactory.

ABDOMINAL HYSTERECTOMY

The operation is patterned after that described by Wertheim. Good exposure of the field of operation is absolutely necessary to secure a thorough removal of the diseased structures. When the patient is very stout, a transverse wedge of skin and fat down to the fascia may be removed, and the abdomen then entered through a longitudinal incision. This procedure greatly reduces the depth from the surface to the floor of the pelvis, and materially cuts down the time consumed in the operation.

In quite a number of the cases, we have employed an electrically heated table throughout the operation, and it has seemed to me that these patients left the table in a much better condition than the average patient after hysterectomy for cancer.

Proper illumination is of great importance in this operation, and we have found the Krönig light of much value in flooding the field of operation with a steady and most satisfactory flow of artificial sunshine. This light is a great adjunct to any operating room.

As many of the patients are weakened by the long standing hæmorrhage and discharge, I try to save the strength as much as possible by not placing the woman in the Trendelenburg posture until the pelvis has been carefully walled off and the operator is ready to expose the ureters.

As a rule, I have found no difficulty in locating and isolating the ureters except in very stout persons. Here the peritoneum appears to be excessively thin, while the underlying fat is correspondingly thick, and the small blood-vessels in the fat tear on the slightest traction. When the patient is thin, I rarely encounter much trouble until the vaginal veins to the outer side of and below the ureter are reached. These are usually readily controlled with the long Wertheim forceps, but now and then give rise to alarming bleeding. Occasionally, prior to cutting across the vagina, I apply the right-angle Wertheim clamps, but usually, after doubly walling off the uterus from the pelvic wall, and having had an assistant wipe out the vagina until the pledgets come away free from stain, I cut across the vagina, picking up the vaginal margins with Ochsner clamps.

After all oozing from the vaginal margins has been controlled the bladder peritoneum is tacked to the edge of the mucosa of the anterior vaginal wall. Thus, as the bladder distends, it is the peritoneally covered area that ascends, and no raw surface is left to ride over any drain that may be left.

In some of the cases I have removed the pelvic glands, in others I have not disturbed them. Many of my patients were much exhausted by the operation, and I felt that any further time expended in manipulation in the abdomen would seriously jeopardize the patient's life. In 1900, in my book on cancer of the uterus, I drew attention to the fact that an enlarged gland did not necessarily indicate cancer, inasmuch as the enlargement might be due to septic absorption from the cervix. Peterson, in his series, removed the glands in 29 cases, and in 5 of these found metastases. Of the 5 patients, one died after operation, 3 had a recurrence, and one was well after 3 years. Whether the glands are to be removed or not must depend on the condition of the patient, and must be left to the judgment of the individual operator.

Closure of the pelvis. After the bladder has been attached to the anterior vaginal wall and the posterior vaginal wall to the rectum, the broad ligaments are closed. If all oozing has been completely checked, a small cigarette drain is laid in the pelvis and brought out through the vaginal opening, which is now not over 1.5 cm. in diameter. Where there is a little oozing in one or both broad ligaments, I have occasionally placed a cigarette drain in the lower angle of each broad ligament, bringing the ends out into the vagina.

Duration of the operation. When the carcinoma of the cervix is in an early stage, the patient is not likely to have lost much blood, and, as little sloughing has occurred, there has been a minimal amount of septic absorption. In such cases the operation is a relatively easy one. In the far advanced cases the