toneum is then opened to the full extent of the four-inch incision, and the cut edges of the peritoneum are seized on each side by a pair of forceps and are pulled severally to the respective sides. No better retractors can be employed.

The piece of india-rubber drainage tube about eighteen inches or two feet long is now held as a loop between the fore and middle finger of the left hand, and is by that means slipped up over the uterus and pulled down over the cervix, passing the fingers behind the cervix to see that coils of intestine are not included in it. One hitch is then made on the tubing when it has been got as far down as possible, and it is pulled as tight as is consistent with safety. The second hitch may be made in it, but what is far better, an assistant keeps the tube on the strain, so that the one hitch will be quite enough to effect the most efficient clamping.

A small hole is then made in the uterus, just large enough to admit the finger; if it is possible, the position of the placenta may then be ascertained; if not, the right forefinger follows its colleague, and between the two, by gentle rending, an aperature is made in the uterus, and the leg of the child is seized. The fœtus is then carefully delivered feet first, and this, despite all the authorities on the contrary, is by far the best proceeding; less blood is lost, and it requires but very gentle manipulation to relieve the head.

As soon as the fœtus is removed the placenta is sought for, and removed similarly; the uterus itself, being then completely contracted by this time, is pulled out of the wound, and the elastic ligature is tightened once more, and finally arranged round the cervix, and the second hitch is applied. The main details of the operation is now completed; all that is required is to pass the needles through the flattened tube and through the uterus, and out at the other side, forming a St. Anthony cross or two parallel parts to support the weight of the uterus and the stump, and to keep it outside the wound. A complete toilet of the peritoneum is then made, not forgetting the anterior vesical cul-de-sac; stitches are passed in the ordinary way to close the wound accurately round the uterine stump.

The uterus is now removed close down to the needles and strangulating rubber tube, so as to leave a little tissue above. It does not do to run any risk of the ligature slipping off, though this is hardly possible after the needles have been placed carefully through the structure of the tube. A little perchloride of iron is then rubbed gently over the surface of the stump; it is dressed with dry lint and some dry cotton gauze, an ordinary obstetric wrapper is put on, and the operation is at an end. The operation really takes very much less time to perform than it takes to describe, and, as I have said before, because the details must always be the same as an operation in which there never can arise any unforeseen or unexpected difficulty.

THE BLUNT CURETTE IN UTERINE HÆMORRHAGE.

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The use of the curette is best limited to those troubles arising from diseases of the endometrium, while that of electricity should be limited to those affections arising from disease of the parenchyma or the appendages of the uterus. Each of these fields overlaps the other to some extent, and here either agent can be used indifferently.

The bleeding caused by fibroids of the uterus can be arrested by the curette, but we do not get the diminution in the size of the fibroid that is obtained by the use of electricity. Metrorrhagia, due to degeneration of the endometrium, may be cured by electricity, but it takes more time and the results are not more satisfactory than those given by the curette. But the curette is as inapplicable in salpingo-ovaritis as is electricity in uterine polypi. The field of each is pretty sharply defined, and the closer each agent is confined to its own sphere, the better will be the results obtained.

The present tendency in America seems to be to ignore the blunt curette in all cases where the sharp curette can be used.