as a result of obstruction, the blood being forced back into the tubes from the uterine cavity.

The fourth symptom I usually look for is that of pain in the back. In women suffering from dysmenorrhœa who complain of pain in the back, associated frequently with pain on the top of the head, you will find one or another of the following conditions, or perhaps both confined, viz.: retroversion of the uterus and disease within that organ—a so-called fungoid endometritis. If I have the history of such a condition in a single woman, I am content to stop there till I examine her; but if in a married woman, then I go into a history of her married life and learn how many deliveries and miscarriages she has had, and when they took place; if a child has been born since the last miscarriage, etc. It is my experience that women who miscarry before they bear children are fewer in number than those who miscarry after they have borne children.

Now, you may have a dysmenorrhœa due to a soft thickened mucous membrane as the result of child-bearing and getting out of bed too early, or as the result of miscarriage; or you may have scar tissue at the internal os, through which you cannot pass a probe. You can readily see that you will get pre-menstrual pain in such a condition. The uterus is filled with blood, and as it contracts it gives rise to the same pain as in the expulsion of a fœtus. You may find the uterus normal in size and a cyst on its side, which will account for the dysmenorrhœa.

So from this you can readily see that you have to obtain all the points before you can make up your mind as to the form of dysmenorrhœa present in any given case. Then having determined upon the cause of the dysmenorrhœa, you can prescribe for your patient and give a fairly good prognosis. I am, however, always guarded in my statement with regard to the cure of any case. I in that way I do not disappoint the patient and hold her confidence, she obeys my instructions, and I am allowed time to treat whatever condition is present. I will now dwell a little while on the treatment of dysmenorrhœa, and in this connection I wish to say that I will allude only to three specific conditions, which are anteflexion in a girl, subinvolution in a married woman, and retroversion in either. If you have an anteflexion with a dysmenorrhœa in a virgin you have a difficult case to treat. It is a very difficult matter to treat such dysmennorrhœa, without rupturing the hymen. Now the subject of electricity comes up in this connection, and I speak of that first because I sometimes employ it first in these cases. I place the patient on her back, make a digital examination and find out the position of the uterus. Then one electrode fastened to the pad is placed on the abdomen, and the patient is turned over into Sims' position. Then with this Sims' speculum, which you can pass into any girl's vagina without inflicting injury, I simply draw the hymen back so as to allow the air to enter, and that inflates the vaginal canal, and with my headmirror I inspect the cervix. I next introduce my other electrode into the os. I can now apply the electricity with the patient lying on her side, and I know that the electrode in the cervix is doing its work satisfactorily by the appearance of froth at the os. I begin with a current of 20 to 30 milliamperes and gradually increase that up to 50, but seldom go beyond that number. The application of a current of 50 milliamperes for a space of ten minutes at a time, twice a week, is my method of using electricity. Then after removing the electrode from the cervix I cleanse the vagina, and if there is tenderness about the uterus, I apply iodine to the parts. I then take a small glycerine tampon and place it in front of the cervix in such a manner that the glycerine shall act upon the anterior surface of the os. If after a few such treatments as this the patient has pain, I stop the use of the electricity for a time and give applications of iodine or ichthyol in glycerine.

If after two months' treatment the patient returns with the same symptoms, or with symptoms modified to a certain extent, I tell her that she has a stricture at the internal os, which is of so dense a character that it must be divided. Then at my office, or at her home if possible, I put her in Sims' position, cocainize the parts, and with a ureterotome I cut the internal os in four different directions, and with Dr. Hanks' dilator I dilate the strictured part quite freely. Four days later I dilate a little more, until in a short time I am able to use a currette and scrape the mucous membrane of the uterus. Having scraped this membrane I pass in a strip of iodoform gauze and let the patient wear this as long as she may, repeating this procedure once a week until menstruation appears. Then I withdraw the gauze during the menstrual period. If the dysmenorrhœa be due to obstructive causes, the next menstruation will be an easy one.

But if, on the other hand, the case has been going on for years, and pain across the abdomen accompanies the pain in the side, then I do not promise a cure of the trouble, but, perhaps relief of the symptoms. Many patients come to me complaining of these conjoined symptoms, and invariably after giving them electricity, I apply iodine to the tubes and ovaries and curette the uterus. If a married woman who has borne children, but has not miscarried, comes to me suffering from the same condition, I simply advise her to go to bed and have an an operation performed for the relief of these symptoms. If she has not a lacerated cervix, but a large subinvoluted uterus, I treat the cervix as if it were lacerated, cut out the scar