force of sexual excitement. Knowing as we now do the wonderful changes that occur at such times, it is a matter of surprise that uterine disorders are not more common than they are. We have physiological as well as moral grounds for discountenancing late hours, fashionable dressing, sentimental reading, indolent and luxurious habits which are making sad inroads upon the vigor and beauty of our young ladies. Our present knowledge is invaluable in preventing uterine disease, and absolutely imperative for its successful treatment. With regard to menstrual derangements there are two forms commonly met with, viz., menorrhagia or excessive flow, and also a diminution of the flow. The former is more frequent than the latter. The period suited for the application of internal remedies in one class would be eminently unsuitable for the other class. When the flow is simply excessive and not due to any other disease, it indicates a too rapid or pathological maturation of the decidua, and hence our treatment should be applied during the first half of the menstrual interval. Our object is to promote a more robast and natural condition of the mucous membrane.

Whereas in these cases of deficient menstruation the local treatment is most appropriate during the latter part of the interval, whereby the membrane is excited to a more rapid growth and speedy maturation. The danger of strong applications immediately before or after menstruation is readily perceived. There remains much that might be advanced upon the details of this subject, but time forbids and I pass on to make a few remarks upon the treatment of uterine fibroids. Excision of the uterus is now ranked among recognized surgical operations. The accumulated experience gathered from reports of the operation give us not unreasonable grounds to expect that a much greater success awaits us than it has been the surgeon's good fortune heretofore to enjoy. That we may be able to save one half of such cases, is, I think a tenable hope. There is another mode of dealing with these growth, otherwise than excising them, by removing the ovaries. In those cases where the tumor is sub-mucous or, if interstitial, more sub-mucous than sub-peritoneal we have much reason to expect a favorable issue by means of the hypodermic injection of ergotine. Enucleation may also frequently be resorted to with uccess. The latter method is more rapid and suitab e in cases of excessive and uncontrollable hemorrhage, but is not so safe as the former whereby the tumour is rendered sub-mucous and eventually polypoid, when its removal is comparatively easy.

When, however, the growth is sub-peritoneal or, if interstitial, more sub-peritoneal than sub-mucous we have to deal with a case where enucleation is impossible and the use of ergot hopeless for relief. It is proposed in such a case to excise both ovaries rather than extirpate the uterus. The risk of life is much less, and the success that has followed the proposed method has been such as to commend it to the favor of the profession. In a case reported both ovaries were removed for sub-peritoneal and interstital refibroids after the failure of all treatment to afford lief. For some three months after the operation apparent menstruation continued, but, as the flow was hemorrhagic, astringents were used and the flow effectually arrested without any untoward results. Had the discharge been menstrual it could not have been arrested permanently with impunity. From observing this case we have good reasons to hold to the old view that menstruation depends upon the presence of the ovaries. When their physiological life is ended, or they are removed, menstruation must cease, *i.e.*, nidation and denidation are the results of ovarian activity. Such are the views advanced in the report of this case, and I doubt not they will be certified to as correct by future observers. The subject is an interesting one, and is commended to the consideration of the members of this association.

There is another subject lately brought before the profession by Dr. Lenneker, with regard to the treatment of antiflexions of the uterus by means of removing a part of the mucous membrane from the posterior wall of the canal and allowing the cut surfaces to heal with uterine stem in situ to correct the flexion. The operation is said to be successful and ably advocated by its author. It is, however, not free from serious risks or easy of proper performance, and will hesitatingly be accepted if it wins a place among recognized operations at all.

Before closing these imperfect remarks I wish to refer to Bozeman's new method of treating *vesico vaginal* fistulæ. The most frequent cause of failure is due to the dense and unyielding cicatricial tissue of the fistula. You all know how the wound will gape and the stitches cut into the tissue in these cases. The remedy proposed, by the author referred to, is to remove the cicatricial tissue by pressure and small incisions. By these means he secures the absorption of the dense tissue. The pressure is secured by means of gum-elastic balls of 1. 2 to 2.35 in diameter, also of cylinders of the same material 2.35. to 3.6. The balls and cylinders are perforated and provided with a string which serves for their