or, at most, there is a slight wound of the septum. In this case we proceed at once to insert the quilled suture. When the laceration has implicated to a certain length the recto-vaginal septum, we must begin by uniting this with two or three stitches as far as the place where the triangles commence. This may be done with common needles, and the extremities of the threads may be allowed to hang out of the vagina, care being taken to distinguish them apart, by making a knot in the first, two knots in the second, &c. *Serre nœuds* may be used, to maintain the tension of the thread, and the removal of the ligatures is thus rendered more easy.

Cicatrization is often facilitated by dividing the sphincter ani near the coccyx, in order to prevent the rupture of the newly-united tissues by the movement of the bowels. This plan, first recommended by Dr. Horner, was unwisely rejected by Dieffenbach. The section of the sphincter is not indispensable, but it is free from all objection, and is especially useful with patients affected with chronic diarrhœa, or who are liable to diarrhœa from slight causes. One of the operations of M. Schuh partly failed, on this account, and it became necessary to repeat it. This case suggested to M. Schuh, who was not aware that it had been already recommended by Dr. Horner, the idea of this modification of the operation. The sphincter must not be divided, when (which is rarely the case) a prolapse of the rectum also exists. The muscle is to be cut with a blunt-pointed bistoury, before the quilled suture is introduced, just as in the case of fissure of the anus. (Why not make a subcutaneous section?) If a fold of the rectal mucous membrane projects through the incision, the latter must be again united by ligature.

The quilled suture, the only one employed by Roux and Duparcue, cannot be replaced by the simple suture, as Dieffenbach maintained. A very large needle is thrust in at a distance of half an inch to an inch outside the middle of the lower line of the triangle, and brought out at the upper angle, or near the last stitch, if any have been made. Having drawn it through (which is much facilitated by Dieffenbach's *porte-aguille*, if the triangle is very large), it is to be re-inserted into the superior angle of the other triangle, and made to pierce the skin of the opposite buttock, at the same distance from the edge of the wound as on the other side. A second thread is introduced in the same manner below, and a third above the first; the two last, of course, do not reach to the upper angle, but enter about the middle of the rectal and vaginal sides of the triangle. The quilled suture is completed in the usual way, and drawn rather tightly, in order that the denuded surfaces may be exactly applied throughout their depth. Care should be taken that no fold of the mucous membrane of the rectum, which may, perhaps, be somewhat relaxed, slips between the edges of the wound; this should be ascertained by cautiously inserting the finger into the vagina after tightening the ligatures. In case of such an accident, we must try to push back the presenting part into the rectum, by means of a probe, and if it will not stay there, an additional stitch must be inserted at this place. If this manœuvre is too difficult, the threads of the quilled suture may be slackened.