ments would hold it if their normal tonicity and integrity could be restored; and so that (b) the lower extremity of the vagina shall be brought forward against the pubes. The fulfilment of these two indications will restore the normal obliquity of the vagina, and will hold the cervix uteri so far back towards the sacrum that the corpus uteri must be directed forward in its normal anterior position of mobile equilibrium. With these conditions, the uterus, being at an acute angle with the vagina and having little space posteriorly, cannot retrovert and turn the necessary corner which would permit it to prolapse in the direction of the vaginal outlet. In order to accomplish this, two things usually are necessary:—

1. *Excision of the Cystocele or Anterior Colporrhaphy.* The plastic operations performed on the anterior and lateral walls of the vagina by Sims, Emmet, myself and others, which have consisted of superficial denudation and reefing of the anterior or lateral walls of the vagina, have been only partially successful, first, because they did not adequately force the cervix uteri into the hollow of the sacrum; second because efficiency requires deeper work than superficial denudation can accomplish, and third, because these operations did not utilize the broad ligaments sufficiently for support.

The above principles, emphasized by Reynolds in a recent paper, have lead me to modify my own operation materially. Complete prolapse, being hernia, should be treated according to the established principles of herniotomy by reducing it and then excising the sac in such a way as to expose strong fascial edges which should be firmly united by sutures. The absurdity of treating any other hernia by superficial denudation and reefing or tucking in the surfaces by sewing them together must be apparent to any one. In order to indicate the part which the broad ligaments must have in a correct operation, it is only necessary to observe the fact that vaginal hysterectomy commonly results in holding up the pelvic floor and with it the rectum, vagina and bladder, because in this operation the broad ligaments are usually fixed to the vaginal wound. But why should not the same result be aimed at by similar means even though the uterus is not removed? The operation of Anterior Colporrhaphy which I would urge is performed as follows: –

First Step. Split the antero-vaginal wall, that is the vaginal plate of the vesico-vaginal septum, by means of scissors, from the cervix uteri to the neck of the bladder, then to strip off the vaginal from the vesical layer of the vesico-vaginal wall, cutting away the redundant part of the vaginal plate.

Second Step. The redundant part of the vaginal wall having been removed, extend the incisions and remove the mucous and submucous structures to either side of the uterus, being sure to reach the fascial