Boro-glyceride in the preparation of the pledgets. In rare cases it may be necessary to spend six or even eight weeks in preparing the uterus for dilatation.

The mode of operation: While in Philadelphia last fall I was fortunate enough to see Dr. Goodell do the operation several times, and I shall briefly describe the operation as done by him.

The patient is thoroughly anæsthetized, and a suppository containing one grain of aqueous extract of opium is slipped into the rectum. She is placed in the dorsal position, the buttocks close to the edge of the table, the knees supported by assistants.

Goodell's bivalve speculum is introduced and the vagina swabbed out with a five per cent. solution of carbolic acid.

The uterus is steadied by a strong tenaculum, and the smaller dilator introduced as far as it will go. As soon as the cavity is reached the handles are gradually approximated and the instrument allowed to remain in position for two or three minutes. The small dilator being withdrawn, the larger one is introduced and the handles are then slowly screwed toward one another until the register on the cross bar marks at least one-and-a-quarter inches; as the operation owes its success to the thorough stretching, or even tearing, of the circular fibres; unless this is effected the improvement will be but temporary.

If the flexion is very *marked*, before full dilatation is reached the instrument is withdrawn and re-introduced, with its curve reversed to that of the flexion, and the dilatation completed. The speculum is filled with a five per cent. solution of carbolic acid; the instrument is allowed to remain in position for about ten minutes, when it is removed and a ten grain suppository of iodoform placed in position.

The operation should be done midway between two monthly periods.

Wylie employs hard rubber drainage plugs after complete dilatation. These are introduced at the time of the operation, and their retention secured by the employment of vaginal tampions of absorbent cotton saturated in bichloride solution (1-5000) and sprinkled with iodoform. On the third day the pledgets are renewed, and on the seventh the plug is removed for cleansing and reintroduced for say one or two weeks longer, the patient remaining in bed. The same operator frequently repeats the operation two or three months later.

I have no hesitation in stating that done in carefully selected cases, few gynæcological operations yield to the operator so much gratitude, and to the patient and her friends so much of comfort and relief, as rapid dilatation of the cervix. Any of the long list of hystero-neuroses, and their name is legion, may develop as the result, direct or indirect, of stenosis (either by contraction or angulation) of the uterine canal.

After one application of the dilators I have seen the headache (often intense and prolonged) the nausea, palpitation, insomnia, and diarrhœa disappear as completely as though they had never had an existence, while the improvement in temperament was as decided as it was happy.

True, the symptoms do sometimes return, but fortunately in a comparatively small proportion of the cases operated on, and in some of these a more permanent relief may be secured by a repetition of the operation. Many who have employed moderate but not complete dilatation (or divulsion) will be able to recall cases of well marked hysteria, caused by the retention in the fundus of one or two drams of mucous, through the presence of a marked flexion, where a complete and prompt cessation of the symptoms occurred on the escape of this fluid, through the introduction of the dilator; many of these cases may be permanently relieved by means of the glycerine tampon, divulsion, use of the drainage plug, and temporary subsequent support, from a well fitting pessary or wool tampon. Of course many cases of flexion will recur despite the most careful and intelligent treatment, as they do after pregnancy; but what is claimed is that in many mild, yet pathological flexions, we have in dilatation a very safe, prompt, and successful form of treatment, if uncomplicated by serious disease of the uterine appendages.

Very frequently cases are met with where the desire for children, rather than the presence of the dysmenorrhœa, has prompted the patient to seek medical advice. Here even where sterility and dysmenorrhœa have been wholly due to the existing stenosis, whether by contraction or angulation, the prognosis as to probable relief of the sterility will depend entirely upon the amount o