not appear then the aperture must be dragged over the surface of the tendon till the ring is found. The finger now pressed in the wound readily detects the spine at one end by its hardness, and the ring at the other by its lessened resistance. The spine and the ring are the two landmarks for further procedure. Poupart's ligament below should warn against any searching for the ring below that structure. There should be no groping in the dark, all must be closely ascertained before the next step is taken. Cut through the intercolumnar fascia and deeper structures over all the extent of the external ring in its longest diameter. A nerve, vessels, fat, tendinous bands, and the round ligament spring out of the canal immediately. In fat people the quantity of fat conceals all the other structures. There is to be no haste to seize the round ligament, which is brought into view by everting the structures upward. The genital branch of the genito-crural nerve runs close to and along the anterior surface. At this point the ligament is round, often delicate, but easily recognized by its flesh-colored structure. Care must be taken lest it be destroyed by the forceps. Bands will be seen binding it to the adjacent structures, these are best divided with the scissors, taking the greatest care lest the ligament should be cut into. With patience and care it is freed, and comes out so easily that one is apt to think it has been broken.

At this stage it is well to cover the wound with a warm sponge and operate on the other side. The best position for the operator is on the side opposite to the one operated upon, as it affords the best view, and also enables him to make traction in the direction of the ligament.

Bands of fascia and fasciculi of the internal oblique have been mistaken for the ligament. They are, however, more friable, and, though they seem to go along the canal in the direction of the ligament, they do not pull out and should not ever be seen if the operation is properly made.

Third Stage.—This stage consists in placing the uterus in position with a sound, and pulling out the ligaments till they control the uterus. This is determined by the operator drawing out both ligaments at once till the sound (held by an assistant) is felt to move. The ligaments are now held by an assistant while the operator stitches them to both pillars of the ring, two stitches of moderately fine catgut on each side.

The bruised ends of the ligaments are cut off and the remainder stitched into the wound with the same suture that closes the incision. A fine drainage tube is inserted, and the wound well washed with anteseptic lotion before the sutures are secured. In private practice Dr. Alexander does not use the spray, but always employs a drainage tube. In cases of retroversion and prolapsus he uses a Hodge pessary to keep the organ in position during convalescence. Rest in bed is insisted upon for at least three weeks. The most important point in the 3rd stage is to secure the proper tension upon the ligaments. The drainage tube is removed on 2nd day.

The danger to life is *nil*, in an experience of over 3 years, whilst it has been successful in the case of retroversion and retroflexion as well as in cases of prolapsus of the uterus.

Society Proceedings.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Annual Meeting, October 9th, 1885.

T. G. RODDICK, M. D., PRESIDENT, IN THE CHAIR.

The annual meeting of this Society was held on Friday evening, October 9th, a large attendance of members being present.

The following were proposed for membership: Drs. R. F. Ruttan, W. McClure, F. G. Findley, S. Gustin and D. W. Eberts.

PATHOLOGICAL SPECIMENS.

Dr. TRENHOLME exhibited an *Ovarian Cyst* and *Two Extirpated Uteri*, and gave the following particulars:—

The ovarian cyst was removed from Mrs. I., of Shawville, aged 42, of spare habit and nervous temperament. Nine years married; no children. Her illness began 16 years ago, when her bladder troubled her. Feeling of pressure, pain in the back, inability to sit; bowels constipated; insomnia; menses always irregular, but for the last six months has no flow. At present time, pains are not so severe as formerly, and chiefly felt in the back and over the womb. Upon examination, the uterus is found high up and pressed above the pubis, but in the median line. A large dense tumor is felt to the back of the womb filling up the brim of the pelvis. This tumor is firm to the touch, smooth and uniform. On the left antero-lateral aspect of the tumor, a small