After a forcible dilatation under ether, the cervical canal rarely returns to its former bent or former narrow condition. Since lateral extension of elastic bodies antagonizes their length, the cervix shortens and widens, and the exudation provisionally thrown out by the submucous lesions sustained by the dilated part serves still further to thicken and stiffen its tissues. In other words, the stem-like neck of the pear-shaped womb is shortened, widened, strengthened, and straightened. Hence for straightening out anteflexed or congenitally retroflexed wombs, and for dilating and shortening the canal in cases of sterility, or of dysmenorrhœa arising from stenosis, or from a conical cervix, the dilator will be found a most efficient instrument. Sometimes, in sharply-bent wombs, I put in a stem-pessary immediately after the dilation. In retroflexions I always put in a pessary long enough to span the angle of the flexion, so as to straighten the womb by making pressure on the fundus. To this occasionally a stem pessary is added.

In its results this operation is not an infallible one. I have thrice been obliged to repeat the dilatation, and would like to do so in several cases did the women permit. In a very few cases I have been forced, as a final resort, to nick a pinhole os externum. But I had not then learned how far I could safely stretch open the uterine canal, and the operation of dilatation was, therefore, not so efficiently performed by me as it is now through a larger and riper experience.

It is not to cases of sterility or of dysmenorrhœa only that rapid dilatation should be limited. As before stated, I use it to stretch open the canal for the admission of the curette and of tents, or for the purpose of making applications to the uterine cavity. In cases needing irrigation of the uterine cavity, I first dilate the canal with the slender instrument, and introduce the nozzle of the syringe between the separated blades. This gives a free avenue for the escape of the liquid, and robs of its dangers this form of intrauterine medication. I also resort to the dilator in order to explore the womb with the finger. For instance, in a given case of menorrhagia, in which a polypus or some other uterine growth is suspected, in order to avoid the delay and the dangers inseparable from the use of tents, I put the woman under an anæsthetic, and after the rapid dilatation of the cervical canal to the utmost capacity of the instrument—viz., one and a half inches—am enabled to pass my finger up to the fundus. This is accomplished either by drawing down and steadying the womb by a volsella forceps fixed on to the anterior lip, or, in thin subjects, by forcing the womb down upon the finger through suprapubic pressure on its fundus. In this way I have, over and over again, at one sitting, discovered a uterine growth, twisted it off, and removed it. Usually in these cases more difficulty has been experienced in removing the polypus, or other growth, through the narrow canal, than in twisting it off from its uterine attachment. It often has to be wire-drawn before its removal can be effected, and sometimes it will be found needful to enlarge the os uteri by a few nicks. Usually, when the menorrhagia has been free, the cervical tissue is so lax that, after dilatation, the index-finger can penetrate the canal and reach the fundus, but sometimes only its tip can be made to pass the os internum. Yet even this limited degree of penetration is commonly quite enough to decide the presence of an inside growth. If it be not enough, I invariably search for the growth with a small pair of fenestrated forceps, and I have repeatedly seized and removed one, the existence of which was merely suspected. After such operations the uterine cavity and the vagina are thoroughly washed out with a two and a half per cent solution of carbolic acid.

I am sorry to say that I have not kept full records of all my cases of rapid dilatation. For instance, I have rarely tabulated office cases of dilatation, in which ether was not given. Nor has any note been made of cases in which dilatation was performed under ether for curetting, for digital exploration of the endometrium, or for the removal of uterine growths. I have tabulated merely cases of dysmenorrhœa, in single or in married women. In the married, with but three exceptions which will be noted in the proper place, painful menstruation was associated with sterility.

Including all the cases of dilatation performed under ether, I must have had nigh three hundred and fifty cases. I have limited myself to these cases because the use of an anæsthetic implies full dilatation—one in which serious injury, if ever, would most likely be sustained; yet there has not been a death, or a case even of serious inflammation, in my practice, and the results have been most satisfactory—far more so than when the cutting operation was performed by me.

Let me read to you a brief abstract of the statistics of my cases of dysmenorrhœa: Of single women there were one hundred cases; of married, one hundred and nineteen, making in all two hundred and nineteen. Of the unmarried, twenty-four were unheard from after the operation, leaving seventy-six from which any data could be obtained. Of these, forty-five cases were virtually cured, twenty-four more or less improved, and seven were not at all improved. Of these seven that were not benefited by the operation, five subsequently had their ovaries removed—one of them by another physician, and four by myself; of the latter, one died. In each one the ovaries had become so changed by cystic or by interstitial degeneration as to make the dysmenorrhœa otherwise incurable. Of the twenty-four improved, there was one on whom oophorectomy was also performed; for, although the dysmenorrhœa was partly relieved by dilatation, ovarian insanity and menorrhagia were not. The operation was a successful one, and my patient was not only cured of her hemorrhages, but she regained her reason. Out of these cases, the