I have at present a number of cases under treatment of hyperplasia uteri, and of chronic metritis and endometritis, in many of which the most urgent symptoms was hemorrhage, which the positive galvano cautery has never failed to cure, on the one condition however of using it strong enough.

In obstructive dysmenorrhœa it affords a safe, easy and almost painless method of opening the stricture at the internal os. I hope shortly to publish a number of these cases in detail.

It has often been stated that the dangers of specialism are to be found in the tendency of its devotees to so concentrate their attention on the diseases of their special organ that they fail to see the general disorders of the whole system, on which very often the special disease depends. It is a healthy sign therefor of the progress of Gynecology to see in the *Centralblatt fur Gynecologie*, March 31, 1888, an article by a leading writer entitled "the Cure of Prolapsus Uteri by *Exercise* of the *Pelvic Muscles* and Methodical Elevation of the Uterus." It is known as the method of Brandt of Stockholm. The movements are of three kinds, elevation of the uterus, opposed movements of the hipjoint, and percussion of the lumbar and sacral regions. The patient is placed on a couch in the lithotomy position; the operator stands at her left side facing her, and presses the palms of his hands deeply between the symphisis and the fundus uteri, while at the same time an assistant keeps the uterus anteflexed by his finger introduced into the vagina. The operator grasps the uterus and draws it upwards, then allows it to sink back into its place; at the same time the finger of the assistant follows the organ upward, and by pressing on the anterior fornix, prevents it from becoming retroverted. This manœuvre is repeated three times at each séance.

The patient being in the same position, adducts the thigh, bringing the knees and heels in close contact; the operator, sitting beside her, abducts the limb, while the patient opposes him as strongly as possible. When abduction is complete, he seeks to adduct, the patient opposing as before. The percussion movements consist in light taps given with the edge of the open palm.

A successful case is reported of a woman with complete procidentia of 31 years standing. Pessaries had been tried in vain, and the patient would not consent to an operation. From the first day on which this treatment was adopted the uterus remained within the vagina, after three and a half months the uterus remained in its normal position, and the cure was apparently permanent. (I reported a case a month ago in *American Journal of Obstetrics*, in which the same result was obtained by putting the pelvic muscle through a course of gymnastics, by means of the faradic current of quantity.)

The writer's observations led him to the following conclusions: the opposed movements of the hip are the most important factors in promoting a cure. Elevation of the uterus tends simply to correct the retro-displacement which is always present in cases of prolapsus, and not to fix the organ in its natural plane in the pelvis. During opposed adduction there is an undoubted contraction of the muscles forming the pelvic diaphragm. This may be readily demonstrated in the case of the levator ani, especially when the patient's hips are elevated. When this muscle contracts strongly, not only is the vaginal opening in the diaphragm narrowed from behind forward, but the distance between the portio vaginalis and this opening is increased. Through the action of the levator ani the vagina is separated into an upper horizontal and a lower oblique portion; the former sustains the cervix, so that the more horizontal and elongated it becomes, the firmer is the support furnished to the cervix. In other words the contraction of the levator not only narrows the vagina, but prevents the uterus from sinking downward. If the uterus becomes retroverted, the abdominal pressure will tend to force the cervix forward until it reaches the oblique descending portion of the vagina, when any considerable increase of the *vis a tergo* will cause the uterus to become procident. When on the other hand the organ is anteverted, the abdominal pressure will simply crowd the cervix downward more firmly upon the barrier formed by the contracted levator; hence the importance of keeping the uterus anteverted while practising the opposed movements, the latter tend directly to restore the tone of the relaxed levator in cases of long standing procidentia.

Another writer in the same Journal recommends the following method of diagnosing and treating peritoneal adhesions of the displaced uterus. It may be performed at the office without an anasthetic. The anterior lip of the cervix is seized with a volsella and is drawn downward and forward, being held in position by an assistant. The examiner can then map out the entire posterior