move the mass or not; and the question naturally arises whether it would be possible for you to determine the matter with absolute certainty. I do not hesitate to say with the greatest confidence that it would; and I will show you in what manner it could be done. In the first place, one is not able to make out the character of the mass by grasping it with the fingers. Some authorities have declared that an anæsthetic should never be given when you are about to remove a fibroid, on account of the value of the sensations of the patient in a diagnostic point of view. I am quite sure that all manipulations would in our nervous patient cause an outcry which would render this means of diagnosis very unreliable. How then shall we settle the diagnosis? The method that I employed in the examining-room was as follows: I first resorted to conjoined manipulation, the patient still lying upon the back. Now, by this means we ought to find simply a vacant space in the ordinary position of the uterus, in case the organ is inverted; but, instead of that, I could distinctly make out a firm, solid body in this situation. Next, I placed the woman upon the side, in Sim's position, and, after the adjustment of the speculum, endeavored to introduce the uterine sound. I had no difficulty in slipping it around past the tumor into a cavity, which there could be no doubt was the cavity of the uterus, to the extent of two and a half inches, and in the normal curve of the organ. Furthermore, I rocked the sound backward and forward while it was still in the cavity, and placing my disengaged hand upon the abdomen, I could very plainly feel the fundus moving under it. Then finally, in order to make assurance doubly sure, I passed the sound into the bladder, and, introducing the forefinger of my other hand into the rectum, I could again feel the same hard mass between them which I had detected on conjoined manipulation; while, if the uterus had been inverted, the end of the sound would have been separated from the finger only by the walls of the bladder and rectum. If you were so situated as I have intimated, and had obtained these results by your examination, you could be perfectly certain that you had a fibroid, and not an inverted uterus, to deal with, and need feel no hesitancy about operating.

Now as to the operation demanded here; what is the best method of performing it? As the patient lives in a remote part of the city, and is furthermore not altogether in a normal mental condition, I should not be at all willing to run the risk of operating at the clinic, unless I should put in a very firm tampon before sending her away, and could feel sure that she had some reliable physician to look after her when she had returned home. I want her to enter my service at the Woman's Hospital, so that I can operate under the most favorable circumstances; but she expresses herself as being entirely unwilling to go into the institution. I fear, therefore, that she will pass from our notice, and that these profuse hemorrhages will go on, and perhaps increase, until she will finally succumb to them. The method which I should adopt is this: I would place the patient on the side, and, having introduced the speculum, seize and make moderate traction upon the fibroid by means of a pair of vulsellum forceps. Then with a spoon made of steel, nickel-plated or covered with silver, and having a serrated edge, which I have described under the name of the "serrated scoop," and which I have found exceedingly useful in such operations, I would cut through the attachments of the tumor, completely severing it at the base. The separation is accomplished with the greatest rapidity and ease in this manner, and such a sawing movement is not accompanied by much hemorrhage, for the reason that the vessels are so much bruised during their division.

This instrument is especially adapted for the removal of fibroids with very large bases, and several times I have been able to accomplish this successfully by it in cases where I had previously failed by other means.—*Med. Record.*

ON DIGITAL DILATATION OF THE OS IN LABOUR.

By W. Stephenson, M.D., F.R.C.S.E.

When in normal labour the membranes are ruptured, whilst the os is not obliterated, the posterior part of the head clears the os first, the anterior being still held back by the rest of the cervical tissue. There is a clear gain by this movement, the head is more flexed, a smaller diameter is presented, and the rotation forward of the occiput becomes easy. This is the movement we must not disturb, but if possible facilitate. In aiding labour, therefore, at this stage the support and upward pressure must be exerted only so as to push, as it were, the lip of the cervix *over the occiput;* it must never be done over the forehead. A careful diagnosis of the position of the head must be made, and the direction of the support determined accordingly. The part selected should never be the *anterior* lip, as described by our authors. In the first position of the head the part corresponds with that opposite the left thyroid foramen, and comes readily to the fingers. In the second position it is opposite the right thyroid foramen. In the occipito-posterior position the treatment is carried out less readily, but can still be accomplished, the direction of the force being towards the corresponding illio-sacral synchondrosis. The success of the manœuvre is dependent upon aiding the occiput to descend first. If then it be practiced at haphazard, and always in the same direction, failure is certain to follow in many cases. By its