back and drawn to the edge of the bed, each knee being supported by an assistant. The light must be good, so that the operator can see what he is about. My bivalve speculum being now introduced, the vagina is well swabbed out with a five per cent solution of carbolic acid. By the aid of a strong uterine tenaculum the cervix is steadied, and the smaller dilator is introduced as far as it will go. Upon gentle stretching open that portion of the canal which it occupies, the stricture above so yields that, when the instrument is closed, it can be made to pass up higher, Thus by repetitions of this manœuvre, little by little, in a few minutes' time a cervical canal is tunneled out which before could not admit the finest probe. Should the os externum be a mere pinhole, or it be too small to admit the beak of the dilator, it is enlarged by the closed blades of a pair of straight scissors, which are introduced with a boring motion. As soon as the cavity of the womb is gained, the handles are gradually brought together, and allowed to stay for one or two minutes. The small dilator being now withdrawn, the larger one is introduced and the handles are then slowly screwed toward one another. If the flexion be very marked this instrument after being with drawn should be reintroduced with its curve reversed to that of the flexion, and the final dilatation then made. But in doing this the operator must take good care not to rotate the womb off its axis and not to mistake the twist for a reversal of flexion. The ether is now withheld, and the dilator kept *in situ* some fifteen minutes, when it is closed removed, and the vagina well syringed out with the same solution of carbolic acid. Occasionally a slight flow of blood will last for several days after the operation, stimulating the menstrual flux. Often the flux is precipitated, or it is renewed, if the operation follows or precedes it too soon. The best time for dilatation is, therefore, midway between two monthly periods. Were the case before us a retroflexion, I should, after the dilatation, put in a pessary long enough to span the ankle of flexure. This never fails to straighten ot the womb, and in time to restore it.

Although this operation looks like rough work when compared with the neat but dangerous cutting one, the patient will probably need not more than two suppositories, and she will complain merely of soreness for one or two days. To forestall any tendency to metritis she will be kept in bed until all tenderness has disappeared. Pain will be met by rectal suppositories of opium, and by large poultices laid over the abdomen. From this operation I have seen only slight pelvic disturbance, but it has always been readily controlled and has not given alarm. In one case of dilatation, complicated by a fibroid of the womb, a uterine colic lasted for several days, but it was finally subdued by asafœtida in large doses, and never became inflammatory. Should the temperature rise, and symptoms of pelvic inflammation appear, the ice-bag should replace the warm poultice. But I have not yet met with a temperature high enough to need this energetic mode of treatment.

In the great majority of cases I dilate the canal not to the fullest extent of the larger instrument, but, as in the case before us, to one and a quarter inches. Sometimes, in an infantile cervix, which does not readily yield, and might give way, the handles are not screwed closer than three quarters of an inch or an inch, but this is exceptional. Tearing of the cervix has happened in four of my cases—in two from the sudden slipping out of the beak, and in two from sheer stretching. Three of these were unmarried, and the cervix of each was split posteriorly, nearly half-way to the vaginal junction. The rent looked exactly like the incision of the cutting or bloody operation, but it was only half the length of the latter. As it kept the os externum patulous, and could not do any mischief, I did not sew it up. The fourth case was that of a multipara, whose uterine canal had been nearly closed up by applications of silver nitrate, made by her physician, with the view of curing what he supposed was an "ulceration of the os," but which was a bilateral laceration. The tissues, rendered cicatricial and brittle by the caustic, were torn by the dilator for about half an inch on the right side. Here the hemorrhage was free enough to need styptic applications and a light tampon. I could have stopped it by wire sutures, but this was not done, as it would have defeated the object of the operation.

For slight dilatations, such as for the office treatment of anteflexions and of stenosis, or for the introduction of the curette, or of the applicator armed with cotton, the more delicate instrument is quite strong enough, and an anæsthetic is not needed. I also use it in women who object to taking ether, but the operation is then very painful, and it has to be repeated several times, while the results are by no means so good as when the canal has been dilated by the larger instrument and under ether. Occasionally in virgins, in order to save the hymen I have dispensed with the speculum, and have dilated with the more slender instrument, passing it in along my finger, but this can not always be done, and it is usually unsatisfactory. I was led to this because, on one occasion, I was asked to give a certificate of virginity—in other words, to write and sign a paper stating that before the operation the hymen was intact. I also had to do this in the case of an unmarried woman, whose perineum, in spite of lateral cuts, was badly torn in my efforts to deliver with the obstetric forceps a very large fibroid tumor of the womb. When she returned home the village crones got up such a buzz of scandal that I had to go to her defense. Sometimes, in a very sharply anteflexed womb, the dilator can not be made to pass the os internum. This difficulty is overcome by first passing in a surgeon's probe, and then, along it as a guide, the dilator.