ing or sponging, and wearing woolen or silk underclothing.—Frank Woodbury, M.D., in *Times and Reg.*

PERINÆORRHAPHY.

I wish to bring before the notice of my gynecological brethren an operation I have designed for the restoration of a lacerated perineum, easy of performance, and which will, when properly executed, form a good perineal floor, and I might almost say practically a perineal body. The patient, having been prepared by the usual preliminary steps required for the old operation when under the influence of an anæsthetic, is placed in the lithotomy position, the left index finger being introduced almost its entire length into the rectum, a long straight double-edged bistoury is made to pierce the tissues in front of the anus at right angles to the vulva, and, guided by the finger in the rectum, is made to penetrate the septum for two and a half inches upwards, the incision being enlarged laterally to two inches as the knife is withdrawn.

The patient is then turned on her side, and on the points of incision being pressed together, a lozenge-shaped opening will be seen, and when all sutures required have been introduced and are properly adjusted and approximated, the two cut surfaces are brought into direct apposition. The sutures are introduced by a strong cycle-shaped needle with eye near point, mounted on a handle, strong silver wire being the suture preferred.

The needle is introduced at edge of incision, and, guided by a finger in the rectum, is to travel under the cut surface to its full depth above, describing the arc of a circle; and on point of needle appearing *directly opposite* it is threaded with suture and drawn through. On the ends of this being drawn together with the fingers, a good idea can be formed of how many original stitches may be required. When all considered necessary have been inserted and approximated, being first passed through perforation in leaden plate (see illustration), a finger of each hand passed into rectum and vagina will at once recognize the gain in thickness of septum, the external tissue being pushed fully an inch forward from anus, and forming a thick and solid perineal body.

The incision being a deep one, on union taking place beween the raw surfaces, a considerable amount of support must be afforded in cases where a pessary is required, or where there is much tendency to prolapse of uterus or vaginal walls. My experience of the operation has satisfied me with the results, and there being *no loss of tissue whatever*, should the operation fail, it cannot add any difficulty to a subsequent one.

Even should the perineum be lacerated to verge of anus, what I describe can be done. I find that leaving the sutures for ten days is generally sufficient, but if I am in doubt as to the union being strong, I cut the wire, but leave it in situ for a day or two longer, thus affording some support and relieving the strain on the edges of suture holes, and I also support the parts by long strips of adhesive plaster carried from hip to hip over new perineum.

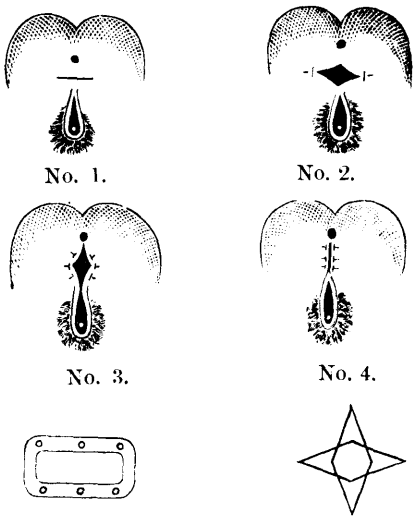
The wire should be stout and not too tightly twisted. My friend, Dr. More Madden, has kindly given my operation a trial, and was much pleased with the result, especially in one of his cases where the old plan of operation had been tried previously but failed owing to the patient's poor state of health and want of healing power. The advantages of my plan of operation are briefly these:

1st. The simplest of performance as yet proposed, no danger of hæmorrhage, the surfaces when dry being brought together.

2nd. No danger of sepsis, as the incision is not open for the admission of any discharge from either vagina or rectum during healing process.

3rd. No loss of tissue, and consequently no harm done should the operation fail.—Alexander Duke, F.R.C.P.I.

STEPS OF OPERATION.



SPLINT FOR SUTURES.

DIAGRAM OF REVERSED LOZENGE.

VOMITING OF GASTRALGIA.—

R.—Cocain,	10
Antipyrin,	1.00
Aq. destil.,	90.00

Sig.—A teaspoonful every one half hour to an hour.