moved her bowels naturally, and could have left the bed in less than a week, she felt so well. But it was deemed prudent to enforce rest in bed for two weeks, at the end of which time she was allowed up. Apart from a slight attack of cystitis, which kept her in bed for a few days, she made a good recovery, and is now entirely free from the pain which she had suffered from for years. In her case at least the operation was quite as easy and her recovery quite as good as though she had been operated by the abdomen, and she enjoys the immense advantage of having no abdominal incision either to pain her or to cause her the risk of a ventral hernia. Although one case is not enough to base an opinion upon, and although my opinion is not based upon that one alone, I feel satisfied from the progress that this method has steadily been making, in the face of keen opposition, that in certain cases, such as the one I have related, and in still easier cases, where the ovaries are removed in order to bring on the menopause, this operation will be employed more and more. For bad pus cases and large fibroids, I still believe that the abdominal route has many advantages. For instance, where the adhesions are so bad, as we often find them, that the bowel is torn in liberating them, it is certainly much easier to repair the bowel as it lays on the abdomen than to sew it through the opening in the vagina. And even Segond admitted that he had had a considerable percentage of faecal fistulae following bad pus cases removed by vagina. The question as to whether the uterus should come out in every case in which both appendages are removed is still *sub judice*. Segond admits that the abdominal route should be employed when only one ovary and tube has to be removed; he only advocates the vaginal route in conjunction with hysterectomy, for without removing the uterus he considers vaginal removal of appendages too difficult. Some maintain that even a diseased uterus is better than no uterus at all; and others claim that even a diseased uterus can be cured by repeated curetting and drainage. Howard Kelly has gone so far as to employ the vaginal route for tubal pregnancy, but his and the experience of others was disastrous; in such cases the tying of the ovarian artery, from which comes the hemorrhage, is ever so much easier by an abdominal incision. In the course of a few years the indications will be more thoroughly established, and in the meantime what work that is done in this direction must necessarily be more or less of a tentative nature.