the vagina close to the hollow of the sacrum. This function of the post-uterine ligaments having been temporarily impaired, the upper extremity of the vagina is displaced forward so that the uterus, having sufficient space between itself and the sacrum, instead of maintaining its normal anterior position, may fall backward into retroversion and, thereby, bring its own axis into line with the direction of the vagina. Frequently, the change in the direction of the vagina, from the normal oblique to the abnormal vertical, is still further increased by injury to the vaginal outlet. The perineum may to torn in any direction and, what is more serious, it may be torn away from its public attachments, and, in this way, may be displaced backwards toward the tip of the coccyx. In fact such displacement is so common, as the result of injuries to the perineum, as to suggest the propriety of a change in terminology from laceration to displacement of the perineum. The upward extremity of the vagina being displaced forward, the lower extremity backward, and the direction of the over-stretched, dilated vagina, now being vertical, the heavy uterus, having its long axis in the same vertical direction, has all the condition favorable to progressive descent.

If the puerperium progress favorably with prompt involution of the pelvic organs, and if the relaxed vesico-vaginal wall and other parts of the pelvic floor, especially the utero-sacral supports and the broad and round ligaments, recover their normal tone, then the whole pelvic floor, including the uterus, resumes its normal relations. But if the enlarged, heavy uterus remains in the long axis of the vagina, especially if the fundus uteri be incarcerated under the promontory of the sacrum with the sacral supports stretched so much and for so long a time that they cannot recover their contractile power, and normal involution of the pelvic organs be arrested, then descent may not only persist but may progress with constantly increasing cystocele and rectocele until the entire uterus has extruded itself through the vulva.

It is most important to remember that complete prolapse of the uterus is only an incident to prolapse of the pelvic floor. The whole mechanism is that of hernia and the condition is hernia; for the extruded hernial mass drags after it a peritoneal sac which, hernia-like, contains small intestine. This sac forces its way to the pelvic outlet and extrudes through the vulva, having the inverted vagina for a covering.

The prolapsing uterus may be related to the vaginal walls in either one of two ways: The prolapsing vaginal walls may drag the uterus down after it; or the uterus itself may descend along the vaginal canal by force of its own weight and drag with it the re-duplicated vaginal walls. Extreme prolapse of the uterus, the organ being covered thus by reflected vaginal walls, has given rise to considerable confusion in pathology, and by many standard authors has been wrongly called hypertrophic elonga-