passed it for a long time. Digital examination found the vagina tender, but normal in its anatomical relations, and the cervix uteri the same, while in front and a little to the left of the latter, occupying the vaginal junction, an opening which admitted the tip of the finger was easily recognized. By the use of the speculum and sound this proved to be a vesico-vaginal fistula. The opening was about three-fourths of an inch in length, and a little less than half as much in breadth, its borders rather thin, indurated, smooth and pale. The patient was informed that an operation afforded the only hope she had of benefit; and its full consequences, possibilities and probabilities were carefully explained. After consulting with her husband and family an operation was decided upon. Some time was occupied in placing the parts and system in as good condition as possible, and when this had been accomplished, assisted by Drs. Robert Mitchell and E. H. Lowerison, I proceeded to operate.

The patient was placed upon a table, etherized and secured in the lithotomy position, Sim's speculum and retractor introduced, and a strong silk thread passed through the cervix—by which to pull the uterus down—and so bring the fistula to light. This we expected to easily accomplish from the history of prolapsus (" falling of the womb ").

But in this we were only partially successful, as the uterus was very firm in its position, and from this fact and other reasons we concluded that her former difficulty had been due to cystocele and not prolapsus; and subsequent events tended to substantiate that opinion. We were consequently compelled to use the Sim's speculum and retractors; but the uterus was still held down as much as possible by means of the cord to which a weight was attached and allowed to hang over the foot of the table, thus saving the hand of an assistant for that purpose. The borders of the fistula were pared, being well levelled at the expense of the vaginal wall and underlying structures, down to the mucous membrane of the bladder. The bevelled margins of the fistula when completed, presented a denuded surface about one-third of an inch wide all round the orifice. This part of the operation was performed with a Sim's bistuory and forceps. Sponges were not used very freely, but a boro-salicylate solution was frequently played upon the wound from an irrigator arranged for that purpose. The fistula was then closed by nine points of silk-worm gut sutures; the proper needles —curved and without cutting edges—being employed for the purpose. The patient was placed in bed, and a self-retaining catheter, to which a rubber tube was attached, leading to a vessel beneath the bed, was introduced.

Although every precaution was observed to avoid injury to the vesical mucous membrane, nevertheless for the first twenty-four hours the urine was tinged with blood, and the catheter had to be twice removed during that time on account of its being stopped with clots. Furthermore, the catheter produced considerable pain and irritation in the urethra and neck of the bladder, and led to the conclusion that the constant retention of the instrument was of doubtful utility.

The patient who was much reduced and quite weak at the commencement of the operation, manifested considerable prostration for some hours afterwards, and on the second day suffered from a complete suppression of urine for the space of twelve hours. It was not retention, as not a dram of urine was secreted during that time. I could not ascribe any cause for this, other than the effects of the ether. Chemical and microscopical examinations of the urine had given no evidence of any renal affection. The patient's condition was serious during this period, but it ultimately yielded to active treatment and the urinary secretion again became established.

From this time forward there was satisfactory and progressive improvement.

On the fourth day the catheter was removed and only used as occasion required, which was for a space of about a week, during which time there was both, some retention and incontinency. After this the urine was under the patient's control, and could be held comfortably and passed at will.

On the eighth day the stitches were removed, and the fistula found to be completely closed—not a drop of urine passing from the time of its closure, so far as could be ascertained.

Warm vaginal injections of creoline, which, as a matter of course, were used from the first, were continued throughout.

A week later a few granulating spots occupying the site of the wound, were touched with nitrate of silver, and in a few days more all was