rest in the recumbent position, attention to the state of the bowels, the application of local astringents, and the administration of general tonics.

In the course of a week, all irritation having been subdued, three lines of treatment seemed open. 1st. The astringent vaginal tampon. 2nd. Some form of pessary. 3rd. An immediate resort to surgical operation.

Considering the very doubtful manner in which treatment by pessaries is spoken of on the part of many eminent gynecologists, and the high recommendation of the first method by one of the ablest living authorities (*vide* Paul Mundè), the latter method was adopted, and an astringent vaginal tampon carefully placed *in situ*.

Strange to say, notwithstanding the maintenance of rest, tampons annoyed the patient, and that form of treatment was abandoned.

As an experiment, and before resorting to surgical procedure, it was determined to try a pessary.

The pelvis being capacious, and the parts lax, a very large ring pessary (soft rubber) was introduced. It never seemed to cause annoyance, and the patient, after a few days further recumbency, was allowed to go about the house. She was able to do so with great comfort, and attended to the house work for many weeks. There was no descent of the uterus, no inconvenience of any kind; the only precautions taken being attention to the state of the bowels, the dilligent use of the vaginal syringe, and an occasional inspection of the pessary to see that it was producing no injury.

About three months ago, however, it was considered advisable to remove the instrument. This was an operation of difficulty, requiring considerable manipulation, as well as some force. On examining it after removal, the soft rubber was found eroded in some places, the mucous membrane having become firmly adherent in these erosions, so that small portions of epithelium had come away with the pessary. Otherwise, the vaginal walls were in good condition.

After a few days of rest and astringents, a hard rubber pessary (Hodge) was introduced. Owing to the size of the cavity, it was considered advisable to supplement the Hodge by a small tampon. But, again, it was found that the tampon was ill borne, while the pessary seemed to produce no irritation.

With the Hodge in position the patient was allowed to rise, and the next day expressed herself to the following effect: "I was in misery for eight years. I have had comfort in my life this summer."

She wore the Hodge comfortably for a month, and I was sanguine of success for the internal pessary; but, about a month ago, she began to complain. The Hodge was removed, and a Cutter (with stem curving over perineum) introduced. She expresses herself now as completely at ease. Of course, she removes and replaces the instrument night and morning.

Perhaps the most interesting point in connection with this case is that in reference to the use of internal pessaries in the treatment of procidentia (Thomas' third degree). While admitting that, in some cases of prolapse, in the first and second degrees, internal pessaries may be successful, Thomas says "in one of the third degree others, which are in part internal and in part external, should be employed." Again, he remarks, "I rarely attempt to use an internal pessary for complete prolapse, because I usually despair of success, and because evil consequences may result." Now, in a case such as this, the uterus greatly atrophied, so that little weight has to be sustained by the pessary, theory would indicate that the danger must be slight. Certainly, the patient should be kept under surveillance long enough to make sure that no injury shall result. But, with this precaution, the above case points to two conclusions: 1st. That suitable cases of procidentia can be successfully treated by