border turned forward, its cubital edge backwards. The hand is then carried forwards following the internal and posterior face of the right thigh until the index finger touches lightly and rests upon the perineum. At this point the wrist should be made to describe the arc of a circle from the back forwards and the tip of the index finger will glide over the perineal plane and reach the fourchette which it passes and gently drops into the vulvar orifice.

After the finger enters the vulva, it is carried forwards following the anterior wall of the vagina, passing to its full length until it reaches the neck of the uterus. During this progression, the thumb is gradually relaxed in such a way as to lodge its length in the right crural folds; while the three disengaged fingers are gradually extended and directed forwards, the inter-gluteal folds and finally the commissure which separates the index from the middle finger comes to embrace the fourchette. This change in the position of the fingers is very advantageous and very important, for the index finger may be thus more deeply inserted; the perineum and soft parts may be forcibly raised, and it is rare, even with fingers of medium length, that we are not able to reach in this way the promontory of the sacrum (sacro-vertebral articulation).

The finger on touching the bottom of the vagina, meets the neck of the uterus, at which point it is easy to examine the anterior lip, the orifice, and the posterior lip in all their circumference, appreciate its size, situation, consistency, then the finger may be passed into the left lateral cul-de-sac, the posterior cul-de-sac, the right lateral cul-de-sac and finally forwards into the anterior cul-de-sac. During these various examinations the hand executes a movement of circumduction, in such a way that the tip of the index finger should be always turned towards the point to be explored.

It is often useful, at the moment of exploring the various cul-de-sacs, to press strongly upon the perineum in order to raise it up as high as possible, to the end of reaching the highest points, even those situated beyond the vagina and uterus, up to the entrance of the abdominal cavity.

When the exploration of the deep parts is terminated we bring the index finger forwards in order to learn the condition of the anterior vaginal walls, the bladder and the urethra; the finger is then carried backwards against the posterior vaginal wall, which surface is explored its full length, and the finger, finally, slowly withdrawn.

The touch practiced in this manner, is sufficient in the majority of the case; it is applied to all circumstances, to all diseases; it is an easy method of examination, applicable even to *virgins*. However there are certain cases where the introduction of two fingers, the index and the middle simultaneously, presents certain advantages by allowing us to explore more deeply, and thus permitting us to appreciate more exactly the size, weight and mobility of the uterus, when we resort at the same time to abdominal palpation practiced with the other hand.

Touch is generally practiced with the right hand; there are cases, however, where it is necessary to use the left hand, owing to the position of the bed or by reason of the seat of certain lesions; so a surgeon should be *ambidextrous*.

Information Furnished by the Touch.—In order to clearly appreciate the information furnished by the touch it is absolutely necessary that the physician should have had a long experience with examinations of perfectly healthy women; when this is the case the information desired is invaluable, and we reiterate the opinion that of all methods of gynecological investigations the touch is the most important, that it is necessary to resort to it in all cases, and which should, in case of need, supplant all others. In fact, by means of touch, there is no organ whose healthy or pathological condition cannot be completely appreciated and understood.

The sensibility of the vulva, its irregularities of surface, its congenital or acquired narrowness, spasmodic contraction, etc., are almost immediately revealed. The dimensions of the vagina, its length, temperature, spasmodic or fibrous contractions, sensibility, condition of tumefaction, softness, induration, dryness or moisture, and even the presence and nature of tumors, may all be readily discovered. The uterus may be almost completely explored, not only in its intravaginal portion, but also in the sub-vaginal portion of its neck and body. The finger carefully passed over its surface perceives the volume, consistency, sensibility, situation and the mobility or fixity of the uterus, as well as its smooth, wrinkled, depressed or protuberant characteristics. The orifice of the womb may be explored and all its peculiarities noted; we can even, in certain cases, penetrate its interior and discover the irregularities of its mucous membrane and of the tumors projecting from its surface, following pedicles to the seat of their implantation at points more or less close to the fundus. Across the various cul-de-sac, the finger perceives the condition of the body of the uterus, and we are often able to determine its size, its direction, more or less abnormal, its fixity, its adherences, and, in addition, various organic degenerations.

This method of exploration also enables us to determine more exactly than any other the condition of the large ligaments, the pelvien peritoneum, the fallopian tubes, and even the ovaries.

In a word, the vaginal touch is the arch-stone of gynecological diagnosis; the precious information it furnishes us is better, more complete, and more precise when, after having employed the method alone and learning all it teaches, we add to it abdominal palpation, and resort to what the English designate by the name *conjoined examination*, that which I shall term *bi-manual exploration*.

II. Bi-manual Exploration.—The woman lying extended on her back, the surgeon practices the