anatomical knowledge of the operator should always be equal to the recognition of these structures—that is the spine and internal abdominal ring. There are other apertures, as the aponeurosis, and a depression filled with fat below Poupart's ligaments that sometimes simulate the internal abdominal ring. Poupart's ligament below the intercolumnar fascia running across, and the spine at the inner side are sufficient landmarks. When in doubt a close deliberate survey of the position should be taken, and no gropings in the dark made, as these are certain to lead to failure."

"Having clearly isolated the internal abdominal wound, and tied or compressed any little vessels necessary to be attended to, the next step in the operation may be entered upon—viz.: to find the end of the ligament. The intercolumnar fascia, which is generally pushed forward by the fat and other structures beneath, is to be cut through over all the extent of the internal ring, and in the direction of the longest diameter, a nerve, some vessels, fat, some bands, and the round ligament springs out of the canal immediately."

"In stout people the quantity of fat conceals all the other structures. No grabbing at the mass is now to be practised, as some have recommended. By everting all the structures upwards the round ligament can be seen generally at the lowest part, and the white, easily distinguished, genital branch of the genito-crural nerve on its anterior surface and close to it. The ligament at this stage is more or less rounded in shape, sometimes rather delicate, but an always easily recognized *flesh* coloured structure, that might be easily destroyed by forceps rudely and blindly applied. Should the ligament seem very frail, or the operator be doubtful whether he has found it or not, he should take care not to displace the structures or to destroy them by searching or pulling. The best plan in such a case is to open up the inguinal canal a little, and then re-examine what he supposes to be the ligament. No difficulty in finding the ligament need thus ever be experienced, provided the operator knows what he is about. When the ligament is clearly identified the small nerve on its surface is to be cut through, without cutting any of the ligament, then gentle traction is to be made; either by the fingers or broad blunt pointed forceps. Care must be taken not to break the ligament by such traction. Bands will now be seen holding it to the neighboring structure. These should be cut through with scissors, the greatest caution being used to avoid notching the ligament itself at the same time. With a little patience and perseverance the structure is so far free that all resistance is at an end, and it comes out as easily as if broken inside, as Dr. Mundé thought it was in his first case. As soon as it begins to peel out, and without drawing it out further, I leave that side, after covering the wound with a clean sponge, and operate on the opposite side. To do so my assistant and I change sides, so that I always stand on the side opposite to that on which I am operating. I can look thus better into the canal and draw the ligament more conveniently towards me; but of course the operation could be performed without this change of position. Having freed the opposite ligament, the difficulties of the operation are at an end, and the second stage is finished. I cannot on paper give with advantage a more detailed account of how to perform the second stage. It must be seen to be thoroughly understood. The third stage consists in placing the uterus in position by the sound, and pulling out the ligaments until they are felt to control that position. The replacing of the uterus is first performed, and it is held in position by a third assistant. The operator pulls out both ligaments almost simultaneously and gently, until the sound is felt to be slightly moved. He then hands both to the first assistant to hold, while with the curved needle, threaded with moderately fine catgut, he stitches each to both pillars of the ring by two sutures on each side, and thus secures the closure of the internal abdominal ring and the fixation of the ligament, without injuriously strangling the latter structure as it lies between. The assistant can now let go, the chafed ends of the ligaments are cut off, and the remainder stitched into the wound, by means of the sutures that close the incision. A fine drainage tube is inserted, and the wound washed out with carbolic or other lotion, before these sutures are tied. In hospital I perform the operation under the spray, and use gauze dressings. In private I dispense with the spray, and sometimes use boracic lint or absorbent cotton wool. I always drain as I believe it to be much safer, preventing any collection of pus or danger of interfascial suppuration. It may retard, in some cases the healing of the wound, but as I never allow my patients out of bed under three weeks this is not of much importance. Before the dressing is applied, in simple cases of retroversion and prolapse, I insert a Hodge pessary, and keep it in at