lum, the stem being first bent just below its upper termination so as to adapt the instrument, more or less, to the utero-vaginal curve. Before being used, the medicated portion is dipped into cold water in order to remove the powdered talc with which it is coated externally; its action will also be rendered more efficient if the cervical canal is well cleaned out as a preparatory step. The instrument is left in position for from fifteen to twenty minutes, by the end of which time the medicated coating will have dissolved. It is then withdrawn, by the patient herself if necessary, and the recumbent position is to be continued as long as may be convenient, an hour or more if possible, so that the application may remain in contact with the uterine mucous membrane sufficiently long to be productive of benefit.

The frequency with which these bougies are to be used will vary with individual cases, and according to the nature of the coating of the bougie. When iodoform is used, one bougie a day may be passed in most cases; with nitrate of silver, especially if a stronger percentage than that mentioned above be used—as it often might be with advantage—every second or third day will be sufficient. In connection with the bougies, other curative measures may of course be adopted: local depletion by puncture about the os, or by means of vaginal glycerine pledgets of cotton wool; painting of epithelial erosions of the vaginal portion of the cervix, when present, with tincture of iodine or nitric-acid. With respect to the passage of the bougies, however, in some cases a difficulty will arise from smallness of the os and narrowness of the cervical canal. The commonest cases, in my practice at any rate, are those dating from childbirth, either endo-metritis and endo-cervicitis combined, or the latter alone. In such cases the canal is of fair size, and the os usually patulous, and so, as noted before, the bougie can be passed with ease. But in another important clinical group of cases—viz., those occurring chiefly amongst nulliparous married women and reputed virgins, in whom, nevertheless, I believe that the metritis is most frequently but the upward march of gonorrhœal vaginitis—a different condition of things prevails. Here the fundal inflammation is more marked than the cervical; the vaginal portion of the cervix will be seen to be swollen and congested, the os itself small. The discharge, flowing freely from the os as the Fergusson's speculum is pushed home, instead of presenting the viscid opaque characteristics of abnormal cervical secretion, will be comparatively thin and of greenish color, resembling, in fact, the "laudable pus" of the older surgeons, and so indicating the fundus of the uterus as being its principal source. In these cases, then, the smallness of the os will present some difficulty, but in them I have nearly always succeeded in introducing an instrument, after rapid dilatation with a three-bladed dilator if necessary. This preliminary dilatation of an inflamed os is, I believe, in itself more or less of an evil. But what alternative is there? From no drug whatever, administered internally, can we hope to get the slightest relief. The patient's general condition may, it is true, be improved by iron or other tonics, but the disease itself will remain. The inflammation is a local disease, and amenable only to local treatment. If, on the other hand, it be neglected, it too often (though insignificant as far as life itself is concerned) entails an immense amount both of mental and bodily suffering, reducing the patient ultimately to a miserable state of hypochondriasis.

In connection with the foregoing remarks, I wish it to be understood that I do not place any great importance on an exact differential diagnosis between endo-metritis and endo-cervicitis, so far at least as regards treatment. In many cases we can safely infer that the cervical canal is alone affected; but in at least an equal number it is almost impossible to say for certain that the disease is limited to above or to below the os internum; quite impossible to localize a particular spot in the area of the fundus as being alone the seat of inflammation. Examination of the cavity by endoscopy might perhaps give us more precise information on this and other points. This much, however, I think can be said: that after a general inflammation—following gonorrhœal infection, for instance—of the uterine mucous membrane has all but subsided, there is a tendency for the disease to perpetuate itself as chronic cervical catarrh, in the same way that, after acute urethritis, the bulbo-membranous portion of the urethra so often becomes the seat of a chronic indolent ulceration. This tendency of the inflammation to linger in a chronic form about the cervix after it has subsided in the fundus, may perhaps be explained by the normally rugose condition of the lining membrane of the former, and by the abundance of glands and mucous follicles opening on its surface, conditions which together would greatly favor this result.

In conclusion, I would claim for the bougies that they possess certain advantages over most of the methods in general use for applying drugs to the interior of the uterus, whether by syringes, insufflators, or ointment repositors. They are easy of introduction, could scarcely be made to inflict mechanical injury on the uterus, and the application used is distributed thoroughly and uniformly throughout its cavity. An additional point in their favor is that they contain the drug required in a very portable and cleanly form, and are always ready for immediate use. When, however, liquid caustics, as nitric or carbolic acid, are required, the bougies are necessarily out of the question. It is also suggested that in midwifery practice the daily passage of an iodoform bougie after parturition would be an efficient means of keeping aseptic the