the cord was again brought down. No effort was now made to replace the cord, my only object being to rapidly complete delivery. The body to the neck was delivered with surprising ease, but the birth of the head required considerable traction (Prague method). The child was born in the second stage of asphyxia and required a half hour's efforts at resuscitation before it could be safely left alone. The case impressed me with the following points: 1. The advantage of the elevated hip position combined with extension of the thighs in increasing somewhat the antero-posterior diameter of the pelvis. 2. The ease with which a prolapsed cord can be replaced and kept back with the aid of a fairly large piece of boiled sponge pushed between the presenting part and the pelvic wall (as suggested years ago by Renshaw). 3. The ease with which the presenting head can be pushed up and a leg brought down. 4. The short time in which a version can be done. —*Jour. of Obstetrics.*

PAN-HYSTERECTOMY.

Dr. Christopher Martin read a paper on the above subject, in which the whole uterus, including the cervix, is removed by abdominal section. He referred to the surgeons who had performed it in Germany and America, and also to Jessett and Smyly, who were the first to perform it in this country. He had performed it eight times; six times for myoma, once for rupture of the pregnant uterus, and once in a case of occluded cervix with hæmatometra and pyosalpinx. All his cases had recovered. The patient is carefully prepared, and the skin and vagina are cleansed with antiseptic precautions. All instruments, silk ligatures, gauze sponges, and the water to be used are sterilized. An incision long enough to permit of the easy delivery of the tumor is made, and on its extraction sponges are pushed behind to protect the abdominal viscera. The relations of the tumor of the uterus, the ureters, and the bladder, the position of the ovarian and uterine arteries, etc., are ascertained and a double ligature is passed by a Galabin's pedicle needle through the broad ligament at a spot free from veins about the junction of the middle and upper thirds and midway between the uterus and pelvic wall. By pulling one of the two ligatures forcibly inwards and the other outwards a transverse slit is torn about an inch in length, or it can be made by inserting and expanding a pair of forceps inserted into the ligature opening. The ligatures are tied and the intervening tissue cut through. The ovaries and tubes are removed if possible. The middle third of the broad ligament is similarly treated and the bladder detached from the anterior surface of the uterus uutil the vagina is reached. This is now opened close to the anterior lip of the cervix. The posterior fornix is next opened. The uterus is now only attached by the lower third of the broad ligaments containing the uterine artery. The tying of these arteries is the most difficult part of the whole operation; usually there is not room for a double ligature, and the ureters must be carefully avoided. After securing the ligature the uterus and its growth are free to be lifted out of the pelvis. Bleeding points should be searched for and secured, the pelvis sponged clear of clot, and all the ligatures cut short except those of the uterine arteries, which are to be drawn into the vagina. Gauze is passed into the vagina and the bladder and other parts allowed to fall over it, but no attempt is made to draw the parts together by sutures. The abdominal wound is closed with silkworm gut sutures. The gauze in the vagina acts as a drain, and is removed on the fifth or sixth day. Dr. Martin does not use the Trendelenburg posture. The uterine ligatures usually separate during the third week and the patient leaves the hospital during the fourth week. There is little shock if the patient is kept warm and the intestines not exposed or handled during the operation. Pan-hysterectomy is a difficult and tedious operation; its dangers consist in chill and shock, slipping of the ligatures with hæmorrhage, damage to bladder or ureters, adhesion of the bowel to the raw surfaces, infection through the vagina, and weakening of the pelvic roof. The last is purely theoretical, and with care other objections are largely obviated. In estimating the value of this operation it requires to be compared with the five other procedures employed for a similar condition: 1. Removal of the uterine appendages is safe in small myomata, but unsatisfactory in large ones. Dr. Martin had removed the appendages in twenty cases for small myomata with one death, and in eight cases for large ones with two deaths. In 90 per cent. of those who recover a cure results, menstruation ceases, and the tumor shrinks. In the other 10 per cent. the patient is not cured, the tumor grows, and the symptoms increase. If a low mortality could be assured, small myomata should be treated by vaginal hysterectomy and large ones by abdominal pan-hysterectomy. 2. Hysterectomy, with extra-peritoneal treatment of the pedicle (clamp cases), has a high mortality—from 15 to 30 per cent. Those who recover pass through the dangers of septicæmia, peritonitis, secondary hæmorrhage from the stump, and ventral hernia afterwards. Sometimes it is impossible to get a safe pedicle if the myoma invades the broad ligament or cervix. Recovery is prolonged. In all these respects pan-hysterectomy is superior to the clamp operation. 3. Hysterectomy with intra-peritoneal treatment of the pedicle is attended with such great risks of hæmorrhage,