the course of which the base of the bladder and a large portion of the urethra were eaten away. Since that time the woman has menstruated but twice. Last spring she came to me to have the operation for vesico-vaginal fistula performed. This I found to be utterly impossible; there was nothing from which a flap could be made. So I passed the galvano-caustic wire (insulated completely except at its point) into her rectum, and made an artificial recto-vaginal fistula with the intent of converting the rectum into a bladder. At first the rectum objected to the presence of the urine, and as a result she was constantly obliged to go to stool. Afterwards, however, it became more accustomed to its new office, and she only had a passage two or three times daily. I took this first step in my operation some months ago with a purpose. Artificial recto-vaginal fistulæ are very loath to close up again, and the success of the operation for the closure of the vagina depends primarily, of course, upon the integrity of the opening into the rectum. I am going to perform an operation that, so far as I know, has been successfully performed but once before. You will find a note of this case on pages 43, 44, of Dr. W. W. Keen's Toner Lecture for 1876. The case he gives occurred in his own hospital practice. I intend to-day to close up this woman's vulva by sutures. Dr. Keen had to perform some thirteen operations to secure accurate healing of the sides, but the woman upon whom he operated was vastly improved.

I shall begin by shaving off the hair from each side of the vulva where I intend to put in my stitches. Now that the hair is out of the way I proceed at once to snip off the skin with a pair of curved scissors, beginning below so that the parts may not be obscured by blood. Every now and then a little artery spurts, which I secure at once by a *serre fine*. Scissors do not always behave well under such circumstances; the edges may not be perfectly true; still I prefer their half crushing action to that of a knife. They do away with a great deal of bleeding. You notice that I have been snipping off the skin and mucous membrane well into the vagina on each side. Every now and then I ask the assistants to relax their hold so that I may fit the sides accurately together and see where I am. Just here at the entrance to the meatus I must work with great caution. If any of the veins of the bulbs were cut I might cause very serious bleeding. I think I have pared off all the mucous membrane needful on each side now, and am ready to put in my sutures. But first I must cut off these "aprons," nymphæ, for they are no longer of use, and will only interfere with the accurate healing of the sides. These plastic operations are tiresome, but I must resist the desire to hurry through them for the woman's sake. I put my first suture in on a level with the lower margin of the arms, and pass it through one side with a sweep. Always bring out the stitches on the edge of the denuded surface. I do not expect this to be nearly as successful an operation as that for perinæum. I have passed eight sutures through. I have included plenty of tissue in my stitches so that they won't tear out. For this purpose I thrust the needle straight back at first and then bring it round. If these sides do not heal completely I shall have to open the wound again. At the last stitch and that nearest the symphysis pubis I have passed my needle and wire all the way round The great difficulty always is to see that the points of exit and of entrance of the sutures are exactly opposite. Now I am ready to draw the sides together. As I tighten each suture I syringe out the part carefully so as to wash away all the urine from the sides of the wound. In clamping the sutures I must use very large shot in order to make the fastenings secure. I will use two clamps for each of these lower stitches. The most difficult stich for healing is the last, that just at the symphysis pubis. All the sutures are now fastened. It makes, you see, a very clean apposition. I shall have a sigmoidal catheter passed through the rectum into the woman's bladder, and the rectum drained by a flexible gutta-percha tube. Of course her knees must be bound together, and she must be given opium enough to dull the pain and keep her bowels locked for eight or nine days. Be sure that you always put a pad between the knees before binding them together. [When the stitches were removed on the ninth day, the union of the sides were found to be complete except the site of the meatus urinarius. At this spot a small fistulous opening remained, through which the urine trickled out. The doctor attributed this opening to the fact that, underestimating the strength of the sphincter ani, he had used a flexible catheter instead of a silver tube to drain off the urine, and that the contraction of the muscle had closed the catheter and so forced the urine to find another means of egress. He further stated that he would attempt the closure of the fistulous opening by cutting flaps from both sides. This secondary operation he would postpone for a couple of weeks. until the patient had time to regain flesh and strength.]—*Boston Med. Journal.*

THE EMPLOYMENT OF ANÆSTHETICS IN LABOR.

M. Piachaud read a paper before the International Medical Congress of Geneva, in which he advanced the following conclusions:

1. The employment of anæsthetics is, as a general rule, advisable in natural labor.

2. The principal substances which have been