

rus to the latter by two fine buried silk sutures, most carefully sterilized. The disasters following ventrofixation were two hernias and one relapse, all of which were subsequently remedied by a second operation. At the present time Alexander's operation has no death rate, while ventrofixation, while it has not any death rate in simple non-adherent cases of retroversion, yet it must have a small death rate, at least when it follows the removal of very bad pus tubes.

He had performed both Alexander's operation and ventrofixation for prolapse as well as for retroversion, and as the results were excellent provided the pelvic floor was at the same time repaired, he much preferred these operations to vaginal hysterectomy for prolapse, an operation which he had performed a few times, and found easy, but which he hardly felt justified in doing.

Although several of the Alexander's had subsequently become pregnant, in no case did any untoward accident happen. But he had heard that some one on whom he had performed ventrofixation had subsequently become pregnant and aborted, but he had so far been unable to verify it. He was not aware that any of them had even become pregnant. This was probably owing to the fact that he had in most of them removed the tubes and ovaries, while in those in which he had left one or both ovaries and tubes, they were diseased and unable to functionate. He was frequently asked which of the two operations he preferred. This was difficult to answer. Alexander's was safe, but he preferred ventrofixation, because it had given him the best results. He would probably continue to do Alexander's operation in young married or marriageable women in whom the ovaries and tubes were perfectly free from organic disease; while he would reserve ventrofixation for women who were sterile or who had marked adhesions, and who had suffered so much and so long in spite of treatment that the appendages had to be removed.