and actual syncope, together with more or less pain referred to the groin or sacrum. The retroflexion increasing or becoming permanent, produces some pain and difficulty, or frequency in micturition, though it never leads mechanically to retention of urine. The patient complains likewise of a dull, aching, constant pain in the sacral region, probably arising from the pressure of the fundus on the sacral nerves, since it is often immediately removed on raising the fundus; the pain often shoots down one of the thighs, there is also a sense of weight and bearing down towards the rectum, much increased by the act of defœcation. Advice not being sought at this period, or the deplacement being overlooked, other more serious symptoms manifest themselves; menstruation becomes highly painful, the discharge is generally increased in quantity, and clots and shreds denoting irritation are voided—in short, dysmenorrhœa is set up. In the intervals an abundant leucorrhœal discharge is usually present.* These symptoms cannot exist without the patient's general health suffering more or less; the stomach, which has an intimate sympathy with the womb, becomes disordered, the appetite is capricious and irregular, the tongue loaded, the bowels constipated, the patient's spirits are depressed and irritable, and a variety of nervous hysterical affections are apt to occur. Such symptoms as these, though they do not prove the existence of a displacement of the womb, yet evidently localize the affection there, and warrant further examination per vaginam, which alone can enable us to determine with certainty the existence of this displacement, and to rectify it.

In examining a case of retroflexion of the uterus during life, the finger can frequently reach a firm globular mass, situated behind the cervix uteri, between the rectum and vagina; this is the fundus uteri, which is bent downwards and backwards, the os uteri instead of being forcibly dragged upwards and forwards behind the symphysis pubis as in retroversion, is little, if at all, removed from its natural situation. At first we may not be able to determine this globular mass to be connected with the uterus at all; it may appear to be merely a scybalous collection in the rectum, hence we should always, if possible, before examining a patient, prescribe an aperient or an enema to remove this source of error. In other cases the tumour may be too high up to allow the finger to trace its continuity with the cervix, whilst in others again, the point of curvature being low down, the fundus is much below the os uteri, and its continuity is easily traced by the experienced finger.

The exact position of the retroflexion varies considerably in different individuals, and even in the same individual, at different times; the point of curvature may be so high up that a very small portion of the fundus is all that is bent down. On examination per rectum we feel the same globular mass through the anterior wall of the intestine, and being able to reach much higher up in this direction than per vaginam, we can frequently verify or correct our first impression.

It is, however, by the use of the uterine sound, that we can obtain sure and valuable information of the displacement of the womb. In a case of retroflexion, on passing the instrument in the natural direction upwards and forwards, it becomes almost immediately arrested: but on turning its point in the contrary direction, backwards and downwards, it will pass readily along the cervix uteri, and then glide downwards and backwards to its full extent of two inches and a half. The point can now be felt distinctly in the centre of the tumour, through the posterior wall of the vagina, or the anterior of the rectum, thus proving it to be the fundus uteri in this unnatural position. Nor is this all, by turning the instrument gradually and gently round, so as to bring the point upwards and forwards, at the same time assisting the elevation of the fundus with the forefinger of the left hand, we shall find that the tumour disappears, it can no longer be felt, the fundus is restored to its natural situation, and retained there by the sound without it; the patient will often be immediately relieved from the constant pain and uneasiness from which she has previously suffered in the sacral region.

In some instances the mere restoration of the fundus to its position is sufficient; it remains there permanently, even after the withdrawal of the sound; in others for a short time only; but in many cases, especially in those of old standing, the disposition of the fundus to return to its unnatural position is so great, that it requires the handle of the sound to be held pretty firmly to prevent its turning it round, and as soon as the sound is withdrawn, the fundus again retroflects, and we can again trace the tumour as before.

The examination and passage of the sound produces in many instances little or no pain, until we elevate the fundus, when the instrument, pressing on the ovary, which we shall afterward see is extremely apt to become congested and inflamed in consequence of the displacement, occasions severe pain, which, however, immediately ceases on our completing the restoration. In the examination per rectum the pressure of the finger on the fundus above occasions no pain, but if we elevate it, the patient immediately complains, and by passing the finger beyond the depressed fundus, we can discover the exact seat of pain to be the posterior and upper part of the fundus, in the situation of the ovary, which we can often feel as an oval body. These last symptoms are dependent on the inflammation of the ovary, and cannot, therefore, be regarded as essential to retroflexion of the uterus, but as the consequence of a complication. It occurs, however, sufficiently often, to render it advisable in all cases of oophoritis of long standing, to examine carefully into the position of the uterus.

In some cases the canal of the cervix is so small as to prevent the passage of the sound; in such a case the dilator must first be employed, until a sufficient passage has been obtained. Dr. Rigby is of opinion that this extreme narrowness of the cervix is rather owing to a congenital formation than to the bent state of the fundus, which last, however, he regards as sufficient not only to obstruct the free discharge of the catamenis, but to prevent conception.

I will here introduce to the notice of the Society the dilator which I am in the habit of employing, and which I believe to be the most efficient; it is that invented by Dr. Protheroe Smith. The power of the screw is the moving power, and it is capable of being regulated at the pleasure of the operator. After one or two dilations we shall be able to pass the sound through the cervix, and ascertain the state of the fundus.

If any of you are still sceptical of the benefits to be derived from the employment of the sound, let me quote a passage from a paper read by Professor Simpson before the Dublin Obstetrical Society, shortly after he proposed his instrument to the profession. He says, "In one of the first cases in which I recognized by the uterine bougie, the existence of retroflexion of the unimpregnated uterus, the patient had some years previously been doomed by the highest obstetric and pathological authorities in England, as suffering under the first stage of scirrhus uteri, the displaced fundus having been mistaken for a carcinomatous tumour. The uterine displacement was easily rectified by the use of a wire pessary, worn for some months in the uterine cavity, and the patient is now in the enjoyment of the best of health. I have seen other cases of the same mistake with the same curious but common form of uterine displacement."

* In cases immediately following abortion, reproduced by a too early recurrence to ordinary occupations or undue exertions, I have observed the hæmorrhage to continue a longer time than usual, and even become constant.