up to the vaginal lateral fornix; then these two lateral incisions were joined by a transverse one front and back, so as to make an anterior and posterior flap. These flaps were pushed up by the finger, the bladder detached and the peritoneum opened, front and back. A pair of powerful clamps were placed on the uterine arteries on each side, and the lower half of the uterus amputated. The rest of the uterus was split up the middle line, each half dragged down, bringing the pus tube and ovary with it, and the broad ligament on each side secured with two more powerful clamps, and the pus tubes and ovaries, each with half of the fundus attached, were cut off. Any other bleeding points were clamped, and the space between the three or four clamps on each side was packed with iodoform gauze, care being taken not to introduce more than a small quantity of the latter, for fear of the iodoform being absorbed. If more was required, sterilized gauze was used. One of the cases reserved for Segond was supposed to be a fibroid, which had been treated by electricity, but it turned out to be a pus tube, to the disappointment of many who were anxious to see Segond perform *morcellement*. The three cases which I saw Segond operate on were well suited for the method, because the vagina was capacious, and there were no adhesions; but I have been informed by those who have seen him operate much in Paris, that he frequently meets with cases in which, owing to the adhesions, he is unable to remove the pus tubes, in which case he merely opens them and drains them through the vagina, after having removed the uterus. From what I saw of the operation in Segond's hands, and also in the hands of Polk last year, I would still prefer the abdominal route for bad cases of pus tubes, for, with the patient in the Trendelenburg position, and a free abdominal incision, we can remove every vestige of the diseased appendages, put ligatures on bleeding points, and leave the peritoneum clean and dry and closed. By the vaginal route one must work in the dark, and by touch to a great extent, and the opening into the peritoneal cavity is left open. The one great advantage of the vaginal route is that there is no abdominal cicatrix, and no danger of hernia. Hernia, it is true, is becoming more and more rare, but it is an unfortunate result when it does occur, and in Europe these two considerations carry so much weight that even Martin, of Berlin, who was steadily opposed to