in introducing the finger was that both the anterior and posterior walls of the vagina were prolapsed to a marked degree. With the former the base of the bladder was dragged down, and with the latter the rectum, constituting what is known as a rectocele, so that two distinct tumors were formed at the vulva, the presence of which the patient says she has noticed for some time. On conjoined manipulation the body of the uterus is found to be abnormally large, and as the probe passes into its cavity for three and a half inches we judge it to be in a state of subinvolution. Furthermore, the examination reveals that there is no perineum. No cicatricial tissue is present, and we naturally ask what has become of it? The fact is it has become completely spread out, as it were, by the rectocele.

Now, what has taken place? The vagina was weakened at the time of the last pregnancy. Being large and flabby it fell out of the body after the labor, and gradually carried down the rectum with its anterior wall. Subinvolution of the uterus also occurred, and it is now dragging that organ down too, and will soon have it out of the body. The process of retrograde metamorphosis after parturition was interfered with not only in the vagina and uterus but also in the perinæum. The perinæum always undergoes a process of preparation and development before labor, and it is just as necessary that involution should take place in it as in the uterus and vagina. The difference between the condition of the perinæum at ordinary times and at the close of pregnancy is very evidently shewn when we undertake to remove large fibroids, perhaps with the obstetrical forceps, as I have sometimes done. In such cases the perinæum invariably yields, while as you know, of course, it is very rare exception in parturition. The reason is that it has not undergone the necessary preparation for the strain to be brought upon it, which always accompanies utero-gestation. At present our patient is a fair candidate for prolapsus in the third degree, a complete *procidentia uteri.*

Such cases as these are difficult to treat satisfactorily. If the time of the menopause had arrived we could count upon the entire disappearance of the subinvolution of the uterus. But some years must yet elapse before that occurs, and I do not hesitate to say that there are no means at our command for reducing the organ to its normal size in such a case as this. I know it is claimed that this can be done by the application of the actual cautery or potassa fusa (after the method of Sir Henry Bennett) to the cervix, but it does no good whatever, and only endangers the safety of the patient. This prolapsus of the uterus is taking place by reason of the traction exerted from below, and there are two ways of preventing it from going on any further: the first is for the patient to wear a well-fitting and appropriate pessary to hold up the uterus at the same time that astringent injections are used upon the vagina. The proper pessary for this case is one made of hard rubber, such as I show you now, and consisting of a cup, to receive the hypertrophied cervix, and a supporting stem divided into two branches, one of which curves anteriorly towards the symphysis pubis, and the other posteriorly towards the anus. From the extremity of each of these arms passes an India-rubber band which is attached to an abdominal belt, and the uterus suspended in this way will be able to resist all the dragging force that is exerted upon it from below. The great advantage of this instrument is that the patient can apply it herself, and it should always be removed at night. After a time there will be almost no traction to overcome, for the mere retaining of the vagina in position will gradually remove the engorgement now existing, and its walls will become more and more strengthened by the persistent use of the astringent injections of which I spoke. If this plan of treatment is adopted I think I can show her to you very greatly improved in the course of a very few months.

The other plan to which I alluded is the operation for the removal of a portion of both the anterior and posterior walls of the vagina and the formation of a firm ridge of support in each. This would prevent any future prolapse of the vagina but not of the uterus.

ALIMENTATION IN SURGICAL ACCIDENTS AND DISEASES.

BY FRANK H. HAMILTON, M.D.

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If the food is not appropriate, the patient who receives it will not only suffer from lack of nourishment, but also from the irritation caused by the presence of undigested, and, consequently, irritating materials. *Such attempts at alimentation will certainly increase febrile action and aggravate inflammation.*

The fact is, however, that examples are exceedingly rare in which some feeble ability to digest food does not exist; and even in these exceptional cases, a judicious selection and timely administration of certain articles seldom fails to produce an appetite, or at all events to convey to the system some nutrition. A warm, well seasoned and well cooked cup of broth, or a fragrant cup of hot coffee and milk, will often relieve nausea and epigastric distress, assuage a colic, diminish the severity of a headache, lift the tone of the nerves suffering under shock; and the same or similar means will often abate sensibly febrile disturbance and soften the pains of inflammation. Who ever knew of harm from food under these circumstances, when carefully and judiciously administered? I am, at least, certain that for every case in which