and dorsally until it curves around posterior to rectum. Should the muscles have been so ruptured and its ends so retracted that its edge cannot be distinctly felt, the incision is made along the line which the muscles should occupy, and careful dissection made for separated ends. The ends of the muscle will be found connected by cicatricial tissue. I have not yet failed to find the remains of the muscle even when badly torn, and the ends widely separated.

The muscle may vary considerably in thickness, and, when very thin and ribbon-like, it may be torn by a careless dissection. When multiple small lacerations are present, the muscle will not be entirely separated at any point, but will be lengthened, loose and relaxed. In width or distance laterally, the muscle may be dissected from 3 to 5 cm. When it has been well freed, forceps should be placed on either side of the portion to be resected, so that the ends when cut shall not retract out of reach. The portion resected should correspond to the point of laceration if found, or when no distinct separation is found, to about the centre of the muscle. The extent of the piece resected will depend on the amount of separation or the degree of lengthening and relaxation. It should be sufficient so that when the ends are drawn together the floor of the pelvis will be restored to its normal position and degree of tension. The ends of the muscle are then sutured together with an interrupted or continuous catgut stitch which, of course, remains buried. The opposite side is treated in a similar manner, when the incisions in the lateral walls of the vagina are closed by a catgut suture. This latter suturing should be thoroughly done so that no openings will remain through which fluids or infection may reach the deeper parts. When the perineum has been torn, this is closed in the usual way. I generally close the deep portion with a buried catgut suture, and then use silkworm gut for the cutaneous surface. The hemorrhage, in dissecting and dividing the muscle, is sometimes free but never great. It is very essential that all hemorrhage be completely controlled before closing the wounds, so that a hematoma may not develop in the deep parts and compromise the results of the operation. The subsequent care is that usual after a perineorrhapy.

This operation restores the pelvic floor to its normal position. The vaginal opening is carried ventrad, the angularity or perineal flexure of the vagina returns, the posterior wall of the vagina loses its sagging and becomes more nearly horizontal again, and a good support is re-established. The clinical results have been very good. The muscles retain their active contractile power, and their elevating and sphincteric action at the vaginal opening is again restored and well maintained.