Why do you use your left finger for exploring the rectum? Student—Because I am keeping my right one for examining the vagina.

What do you notice on examining the vagina? Student—That the cervix is far forwards close behind the symphisis pubis instead of far back near the sacrum; 2nd. That it is lacerated bilaterally and covered with a velvety surface dotted over with cysts; 3rd. That I can run my finger along the whole posterior surface of the uterus until I reach the fundus which is lying in the hollow of the sacrum, and pressing on the rectum, and the organ is about twice its normal size.

Now, place your other hand on the abdomen, and as the patient is very thin you will probably be able to make out the tubes and ovaries; can you feel them? Student—I think I feel the left ones adherent to the side and slightly behind the uterus, and the right are rather more forward, but the examination causes her too much pain for me to make it thorough without an anæsthetic.

Can you by introducing your two first fingers behind the uterus lift it up into a position of anteversion? Student—No, the uterus seems fixed there hard and fast.

Now, gentlemen, let me give you the reasons for what we find. All this woman's troubles began with her first confinement, the first and second stages of which were either naturally or artificially passed through before the cervix and perineum had had time to dilate; the result was a laceration of both. The confinement unfortunately was an infected one, and the patient then had a metritis and salpingitis, the purulent discharge from which leaked out of the tubes by gravity and infected the ovaries, and dropping into the Douglas culde-sac, set up local pelvic peritonitis. During this time the patient had been kept rigorously on her back so that the heavy uterus fell backwards on to the sacrum where it was then firmly fixed by the pelvic exudation. At first this was only soft and flaky lymph thrown out as a guard wall by the peritoneum to save its whole extent from infection, but now that lymph has become firmly organized and will require considerable effort in order to tear through it. After this woman recovered from her pelvic peritonitis and began to go about, her intestines and in fact the whole intra-abdominal pressure had to be supported by the anterior surface of the uterus, instead of by the posterior surface, so that the tendency would be for the uterus to be forced more and more upon the rectum and sacrum. This pressure obstructs the return of the venous blood in the walls of the rectum, and hence the hemorrhoids. Then again the enlarged fundus uteri acts as a valve or stopper on the rectum, so that the more the patient forced or strained at stool the closer the rectum would be closed; defecation would be therefore so painful and difficult that it is not to be wondered at that she neglected her bowels for many days at a time. Her system is being poisoned by the gases coming from the decomposition of fæces. Moreover the sigmoid flexure has become loaded and is pressing so hard upon the left ovarian and left internal iliac vein that the uterus has become very congested, and the ovary so much so that it is exquisitely tender to the touch. When she walks the heavy uterus knocks against the sensitive ovary, so that she does not dare take exercise, while as for coitus she says she has to scream with pain when her husband attempts it. This has rendered her marital relations very strained. Now a word as to her miscarriages. The commonest cause of miscarriages is syphilis, but this disease she has never had. In her case they have been undoubtedly due to the retro-displacement; for when the uterus has reached the stage of three months of pregnancy it completely fills the pelvis, and if it cannot rise out of the pelvis it must burst the pelvis or expel its contents, which latter it of course does. This reminds me of a case which started one of my former students out into a fine