

freely scraping and gouging away the friable rotting diseased surface, and then vigorously searing with Paquelin's cautery the raw tissue exposed. The hæmorrhage and stinking discharge cease for a time, the patient's pain diminishes, she puts on flesh, and frequently buoys herself up with false hopes of cure. But at best the respite is short; and in many cases when the disease again manifests itself it advances with fearful rapidity. When the growth is strictly limited to the cervix or the endometrium, we should offer the patient the more certain hope of cure afforded by vaginal extirpation of the uterus. If the disease be too far advanced for this operation, the less we interfere with it the better.

(4) Lastly, curetting is occasionally demanded for diagnostic purposes. Where we suspect that the patient is suffering from early cancer or sarcoma of the uterus we may obtain, by curetting, fragments of tissue for microscopic examination, and may thus diagnose malignant disease in its early and most remediable stage.

*Armamentarium.*—The armamentarium for curetting the uterus should include the following: Anæsthetics, antiseptics, Clover's crutch, razor, speculum, vulsellum forceps, a set of uterine dilators, a set of curettes, including a "flushing curette," uterine sound, scissors, six Playfair's probes (or some substitute) armed with absorbent wool, Paquelin's cautery or a bottle of iodized phenol, iodoform gauze, sponges or gauze compresses, catheter, douching apparatus. I shall presently refer in detail to the use of these various instruments.

*Asepsis.*—It is of the utmost importance that everything that comes in contact with the genital tract during the operation must be aseptic. The instruments should be made entirely of metal and should be boiled for fifteen minutes in soda solution (one per cent.) immediately before each operation. Instead of sponges I use gauze compresses made of a square of gauze folded into eight thicknesses. These should be sterilized before the operation by boiling or steaming for an hour. They are not quite so absorbent as sponges, but they are cheap, easily prepared and easily sterilized. The same compress should never be used twice; and after the operation all that have been used should be destroyed. For the disinfection of the hands of the surgeon, his assistant and the nurses, I believe in prolonged scrubbing with soap and lysol solution (1 in 100), using a nail brush and loofah, followed by immersion in corrosive sublimate solution (1 in 1000).

*Preparation of the patient.*—The preparation of the patient is important. When we can choose our time the operation is best performed about midway between two menstrual periods. In many cases, however, as when the hæmorrhage is continuous or the symptoms are urgent, we must

operate without delay. For twenty-four hours before the operation she must rest in bed. The bowels must be freely opened the day before; and on the morning of the operation an enema should be given to ensure an empty rectum. The vagina should be well douched the evening before, and again on the morning of the operation, with some reliable antiseptic solution—lysol, iodine, or corrosive sublimate. Immediately before the operation the nurse should pass the catheter and empty the patient's bladder.

The patient having been anæsthetized, she must be placed in the lithotomy position, and this is most conveniently effected by Clover's crutch. Even in cleanly women the hair about the genitals is laden with micro-organisms and hence should now be shaved off with a razor. The vulva should be scrubbed with soap and lysol water (1 in 100), care being taken to remove the sebaceous matter that is apt to collect in the various folds.

The vagina should be similarly cleansed and as far as possible rendered aseptic. It should be vigorously wiped out with pads of sterilized gauze, in order to remove as far as possible the thick mucous discharge that besmears it. This mechanical scouring is more effective in freeing the vagina of germs than is mere douching with antiseptics.

Before commencing the actual operation a final bimanual examination should be made in order to make sure that there is no disease of the appendages and that the uterus is not fixed by perimetric adhesions.

*Insertion of speculum.*—The perineum should be pulled back by some form of speculum. Sims' duck-bill speculum is the form usually employed for this purpose, but it necessitates the employment of an assistant. I can strongly recommend, in place of it, the use of Auvard's speculum. This is heavily weighted with a ball of lead, so that the instrument is self-retaining, and by its own weight pulls back the perineum and posterior vaginal wall. I have found it of great service when I have had to perform curetting without assistance. It can only be used, however, when the patient is in the lithotomy position.

*Dilatation of the cervix.*—The next step is to dilate the cervix. This is not always necessary. For instance, in puerperal cases the os is usually widely gaping and the canal patulous. There are numerous methods of effecting dilatation, each of which has its own peculiar drawbacks, though some are much more objectionable than others. Of all methods, that involving the use of tents is the most dangerous. The risk of sepsis, with all its disastrous consequences, is so great that the tents may at once be dismissed from consideration.

Mr. Lawson Tait's method of dilating the cervix by slowly forcing through it a series of conical