on the left side, and for partial dilatation the latter position offers many advantages.

2. *Conditions to which the operation is applicable.*—(*a*) Dysmenorrhœa. This condition may be due to stenosis of the cervical canal, or flexion with stenosis, or flexion alone. It seems to me impossible to differentiate these conditions by subjective symptoms. It is generally stated that where stenosis exists alone, the pain is excessive before the flow and gradually ceases as it becomes thoroughly established; whereas in flexion the menses are discharged in gushes, caused by the pent-up fluid straightening out the canal. All subjective symptoms are unreliable, simply because the excessive pelvic and ovarian hyperæmia, consequent on the obstruction, tends to mask the naturally concomitant symptoms of either stenosis alone, or when combined with flexion. Where obstruction exists the vaginal portion of the uterus usually becomes elongated and pointed, with, sometimes, the os externum exceedingly small. Likewise, the fundus becomes enlarged, and the sound frequently gives a measurement of three or three and a half inches. In stenosis, Dr. Barnes says, the seat of obstruction is generally at the os externum, and where obstruction exists at the os internum, it is due to flattening of the walls by flexion. Whether this be true or not as a rule, rapid dilatation of the cervix will rectify the flexion and cure the stenosis at the same time, when these conditions are found to exist together. The consequences of obstruction are thus given by Barnes: "(1) Congestion and enlargement of the body of the uterus, disposing to menorrhagia, and causing uterine spasm and colic. (2) A similar condition of the fallopian tubes. (3) Congestion, enlargement and inflammation of the ovaries. . . . (4) As an ulterior result continued obstruction may entail, through the action of inflammation or long interference with function, atrophy of the ovaries and extinction of the menstrual phenomena." When we consider the consequences which must ensue from the long continued congestion of the uterus, fallopian tubes and ovaries, and when we consider the fearful suffering entailed on those in whom obstruction exists, we cannot magnify too highly any means calculated to afford relief. To overcome the condition of stenosis the operation of incision of the cervix was devised, and to accomplish this, various cutting instruments have been invented. Simpson's and Greenhalgh's metrotomes and Küchenmeister's scissors, with others of the same kind, have been and are still used. The results, however, from the cutting operation are not nearly so successful as those from rapid cervical dilatation.

(*b*) Sterility. Where sterility is due to stenosis or anteflexion, then this operation will frequently bring about a cure. Marriage, as a rule, increases the dysmenorrhœa arising from obstruction, and often this symptom is developed after marriage in women who did not suffer from it previously. On examination the fundus will often be found pressing on the bladder, and it will be almost impossible to introduce a probe on account of the flexion. In such a case, rapid dilatation will not only widen out the cervical canal and thereby facilitate fecundation, but it will straighten the flexion, and, in consequence, overcome the obstruction to pregnancy. Where obstruction has existed for years, it cannot be wondered at that the general disorganization in the lining membrane of the uterus, fallopian tubes, and in the ovaries, resulting from the prolonged hyperæmia, renders fecundation doubtful, even after the first cause has been removed. If the operation cures the dysmenorrhœa, however, and allows a free flow for the menstrual fluid, and if the operation is repeated if contraction occurs, there is every reason to hope that time will rectify the other conditions and fertility will ensue. Fortunately statistics show that pregnancy frequently occurs soon after the obstruction has been removed.

(*c*) Intra-uterine Medication, etc. Frequently it is necessary to make a digital examination of the interior of the uterus, and this operation renders easy what is a difficult proceeding where dilatation is produced by tents. Again, in cases of menorrhagia suggesting a growth springing from the interior of the uterus, the operation of rapidly dilating the cervical canal not only gives a means of diagnosis, but if a polypus is discovered, materially facilitates its removal. Generally in cases of menorrhagia the laxity of the tissues of the cervix, resulting from the depletion, renders easy the operation of dilatation, and usually the physician can dilate the cervix and remove the polypus, if present, at one operation, contrasting favorably with the long, tedious waiting of dilatation by tents. Lastly, for using the currette and