the spurious hypertrophic elongation already described. Since this condition is rare, if not indeed unknown, it follows that it seldom will furnish an indication for amputation of the cervix uteri.

Alexander's operation and abdominal hysterorrhaphy belong to the surgical treatment of retroversion and retroflexion, not of procidentia. The object of those operations is to suspend the uterus from above. Hysterorrhaphy, which perhaps fulfils this indication better than shortening the round ligaments, may be indicated in cases of extreme relaxation of the uterine supports and greatly increased weight of the uterus. The results of it in complete procidenia, however, usually will not be permanent unless it is supplemented by adequate surgery in the vagina.

INTRA—ABDOMINAL ANASTOMOSIS.*

By A. GROVES, M.D., Medical Superintendent Royal Alexandra Hospital, Fergus, Ont.

MR. PRESIDENT and Members of the St. Thomas Medical Association,—When you kindly honored me with an invitation to address your honorable and learned body, I was in doubt as to what subject in particular I should take up; but in view of the great importance of anastomosis within the abdomen, it appeared that the discussion of this would not be inappropriate. It might be permitted me to say that I shall not aim at giving a compilation of what is found in text-books, but rather an account founded upon our own work with a description of the methods we employ.

Taking up first, cases of cancer of the pylorus, if they have gone beyond the stage when a resection can be done,—and too often this is the unfortunate state of affairs,—then an anastomosis should be made.

In doing this operation, I make an incision either in the median line or to the right of and parallel to it through the sheath of the rectus but not splitting the muscle, which is drawn outwards. Having examined the stomach and decided upon the point at which the anastomosis is to be made, a loop of jejunum is drawn up and fastened to the stomach by a line of Lembert sutures, then a McGraw ligature is passed and tied as tightly as possible and the Lembert suture continued so as to completely close the site of the anastomosis. In order to prevent the possibility of a vicious circle, the two limbs of jejunum are joined by a McGraw ligature and Lembert suture.

The Point I usually choose to make the anastomosis is the lowest part of the lower border of the stomach anteriorly, in order to secure thorough drainage; this point is comparatively near the pylorus, the

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