advantage. The lower limbs should be extremely flexed upon the body.

2. *Dilatation* and *curettage*, to ensure cleanliness in the field of operation. Swab the uterus with gauze folded over the curette. Do not use the intrauterine douche. I have frequently found the douche fluid had passed through the tubes. When the recto-vaginal pouch was opened it ran out. One of my colleagues put more than a pint of bichloride solution in the abdomen in that way, although the os was fully dilated. The opening of the cul-de-sac saved the patient from peritonitis, but it is safer not to use the intrauterine douche.

3. *Posterior vaginal section* is not difficult and never dangerous. Bland Sutton says, "This is an extremely simple proceeding." Grasp the cervix at the sides with two pairs of bullet forceps (these are not removed until the hemisection is finished), and make traction towards the pubes. Cut the mucous membrane half-an-inch behind its reflection from the cervix with scissors; a scalpel should never be used to do this. Dilate by introducing the scissors closed and open them until two fingers can be pushed in easily. Put down the peritoneum with the fingers. Seize it with forceps and open it with scissors. Then introduce a large pair of curved forceps through this serous button-hole and dilate until four fingers can be inserted. Many operators fail in vaginal section work by trying to operate through a cul-de-sac opening that is too small. It may be widely dilated without the least danger. The wide opening provides also for better drainage, and is, therefore, an advantage after the operation. This opening is for exploration, and again permit me to quote from Bland Sutton, who says, "The surgeon is then able to ascertain the condition of the uterus and the ovaries and tubes." Now it can be determined whether both sides are disabled beyond repair, whether conservatism or radical removal is indicated. The latter is before our notice at present.

4. *Anterior vaginal section* is next done. The operator introduces the intrauterine traction forceps and pulls the uterus downwards and backward. The vaginal mucous membrane in front is opened in the median line, and the slit extended both ways to complete the circuit of the cervix by reaching the posterior opening at the sides.

Pryor was careful to leave a narrow strip of mucous membrane at each side between the anterior and posterior openings, his chief reason being greater safety to the uterine arteries. The anterior opening is easy to accomplish through