the endometritis which so often co-exists with and perhaps may be one of the causes of the pain.

Sometimes the dilatation and curetting either fail completely, or only relieve for the immediately succeeding period. What shall we do in these cases? My custom is to repeat it at least once more; some repeat dilatation twice. If the cervix is very long and conical, I have occasionally amputated it by Schroeder's method, and with good results. Should we employ a stem pessary in order to keep the canal open? I am entirely opposed to its use; if they are employed it must be only with the greatest precautions, the patient being kept in bed, and carefully watched for symptoms of peritonitis.

What should be our course in those rare cases which after all this treatment still remain unrelieved? My experience has been that in nearly every case which has been carefully treated during a year's time with these various measures unsuccessfully, there is some incurable disease of the ovaries and tubes which will demand their removal. I place the duration of treatment somewhat arbitrarily at a year, because on the one hand I am opposed to removing the ovaries until ample time has been devoted to other measures of treatment, and on the other I like to give my patients some definite promise of cure, as without some hope being held out they will become discouraged, and abandon treatment altogether. In only five per cent. of my cases, or about forty times, have I been compelled to fall back upon this *dernier ressort*, when on opening the abdomen I have found more than enough to explain why the case resisted all ordinary measures of treatment. In most of them the tubes were found to be bound down with adhesions, and closed at one or both ends.

In eight cases I have found a hydrosalpinx of one or both sides, and in about twenty the ovaries were sclerotic, so that the follicles were unable to rupture without great pressure. The result in all the operative cases has been very satisfactory; care was taken to tie the pedicle close to the corner of the uterus, and to remove all of the ovarian tissue, as neglect of these precautions would have caused the operation to fail to attain its object, namely, the immediate and complete arrest of menstruation. I must not forget to mention a remarkable little group of six cases of severe dysmenorrhœa, due to retroversion with fixation, the ovaries being buried in adhesions and the fimbriated ends of the tubes closed. At the urgent request of the patients who were married, not to remove the ovaries, I have in these cases carefully freed the uterus, then dug the ovaries and tubes out of Douglas' cul-de-sac, in some cases lacerating them in the process, then tearing the pavillion of the tube off the ovary and opening it up, and finally fastened the uterus to the abdominal