by an early and prolonged administration of ovarian extract. The patient usually makes rapid recovery. There certainly is no other capital operation known for women to which we may so conscientiously and truthfully after our treatment apply the term "cure." There is not a day or a week that by letter or conversation I do not hear expressions of gratitude for complete relief from suffering following the operation.

How often we all have been chagrined and disappointed by the opposite expressions that so frequently come to us after having done our best to relieve the patient by removing a tube, an ovary, or both, through the abdominal route. In many of these cases the removal of diseased structures was not complete and disease still lingered. If I should formulate the rules indicating the operation of vaginal hysterectomy, they would be somewhat as follows :—

1. In all cases of malignant uterus where the disease has not advanced too far in the pelvic walls.

2. In naturely developed women where we determine to remove both ovaries and tubes.

3. In removal of one ovary when also the uterus shows evidence of long standing inflammatory action.

4. In all cases nearing the menopause suffering from chronic painful displacement.

5. In all cases of fibroid not to exceed the size of a child's head and involving seriously the integrity of the uterine walls.

6. In double pyosalpinx and in single if uterus is badly diseased.

7. Whenever from any cause, specific or otherwise, the uterus has been chronically diseased, has long resisted other treatment and proved a centre of serious reflex symptoms.

It is not infrequently the case that we begin a vaginal hysterectomy, and, owing to adhesions or other causes, are compelled to abandon this method and finish the operation through the abdomen. But it is certainly not detrimental to have made this beginning. In fact, whenever we perform abdominal hysterectomy the most rational procedure is to begin or terminate the operation by clamping the uterine arteries and removing the cervix through the vagina. Twice I have attempted the vaginal operation and been compelled to open the abdomen. In one case the entire pelvic viscera were cemented in a mass of chronic inflammation. I removed a greater portion of the mass with the uterus per vaginam and ruptured the bladder, which I subsequently closed by producing occlusion of the vagina. Again, I attempted to remove a myoma the size of a child's head through the vagina. I took away by morcellation the cervix and greater portion of the body of the uterus and clamped the uterine arteries, but the hemorrhage from above became so profuse that I was compelled to finish through the abdomen. I only had to ligate the ovarian arteries, dissect the anterior and posterior flaps, and then close the opening into the vagina with catgut sutures. The clamps remained, as usual, forty-eight hours. Neither of these cases is numbered in this series of vaginal hysterectomies. Both recovered. In these sixty-six cases there was but one death.

No alcohol was allowed to any of these patients before, during or following the operations. My experience during the last twenty years, both with and without alcohol, leads me to believe that when other anesthetics are available surgical cases do far better without its administration. Hypnotic suggestion was used in most of these cases as an aid to the anesthesia of chloroform and ether. I regard suggestion as one of the most powerful fortifiers of the nervous system, and I strongly believe there is no one single thing more calculated to insure the successful termination of a surgical operation than the employment of suggestion as the patient passes into the sleep of anesthesia. It is interesting to note that in the case of the one death occurring in this series, and the other cases of post-