third day and every day subsequently. There was a good deal of straining, but no return of the prolapse whatever. Notwithstanding the difficulty of keeping the urine from soiling the dressings, the wound healed throughout by first intention, and the stitches were removed on the seventh day. Some ulceration of the stitch holes and the lower part of the wound occurred subsequently and gave trouble for a time, and the child had a rather sharp attack of bronchitis, with a temperature of 103.4° F. on the eighth day. Otherwise recovery was satisfactory.

Remarks on Procidentia Recti.

The various methods which from time to time have been advocated and practised for the cure of this condition may be divided into three classes:

1. The use of caustics and irritants to the outside of the protruded mass, such as the application of fuming nitric acid or acid nitrate of mercury; the injection of carbolic acid, ergot, etc.; and the use of the actual cautery as originally advocated by van Buren. For mild cases the latter is an excellent and efficient operation, but all the others may, I think, be discarded as being unsurgical and either inefficient or dangerous.

2. *Excisions and Amputations.*—Roberts excises a diamond-shaped mass, having one point 4 inches up on the posterior aspect of the rectum, the other at the tip of the coccyx and its broadest part at the sphincter. Mikulicz and Treves amputate the whole of the extruded mass with the knife, and Kleberg effects the same result by means of an elastic ligature.

3. External fixation by perineal section, "recto-coccypexy," as practised with various modifications by Verneuil, Panchet, and Marchant. Lange removes the coccyx and narrows the lower portion of the rectum by doubling in its posterior surface, stitching it almost exactly as is done on the anterior surface in my method. His case was a severe one of twenty years' standing, and the operation resulted successfully.

4. Internal fixation by abdominal section. Though previously recommended by Allingham, this procedure was perhaps first practised by K. McLeod, of Calcutta, in 1890, by a method which seems now to be crude and unnecessarily complicated. However, he successfully sutured the sigmoid flexure to the anterior abdominal wall above Poupart's ligament. Variously modified, this operation has since been done by Berg, Allingham (who at the same shortens the mesentery), and others.

The method which I adopted in the case herein described differs from any other in that its essential features consists in (1) narrowing the lumen of the lower dilated portion of the rectum so as to make it practically impossible for the original apex of the protrusion to fall into it, and (2) at the same time converting the part doubled in into a strong vertical fleshy column, the lower end of which is supported by the perineum, while the upper in turn supports the apex of the original protrusion. The rational character of this procedure is, it appears to me, well sustained by the observations of Ludlow and Marchant, who have shown that the yielding of the wall of the rectum occurs first at the level of the recto vesical *cul-de-sac*. The anterior wall first protrudes into the rectum and in course of time drags the lateral and posterior walls with it.

But I desire to point out that though this point may be the apex of the protrusion in the initial stage, it does not continue to be so, as the bowel unfolds itself downwards as the mass de-