

its normal oblique direction, and its long axis will make the necessary acute angle to the long axis of the uterus.

*Hysterectomy*, if indicated, should be performed by the vaginal route. As an operation for procidentia, hysterectomy is open to the following comments: Procidentia, as already shown, is hernial descent, not merely of the uterus, but also of the vagina, bladder and rectum. Complete prolapse often occurs after the monopause, when the uterus has become an insignificant rudimentary organ and, therefore, may be removed easily. Cases are numerous in which, after vaginal hysterectomy, the pelvic floor and, with it, the vaginal walls have protruded again through the vulva—a result which may be expected unless the operation has included anchorage of the upper end of the vagina to its normal location by stitching the severed ends of the broad ligaments into the wound made by removal of the uterus. The indications for perincorrhaphy, as a supplement to hysterectomy, is the same as after anterior elytrorrhaphy.

As laid down in the foregoing paragraphs, the utilization of the broad ligaments is the essential factor in the treatment of complete procidentia. The operation of elytrorrhaphy above described unfortunately may either fail to bring the lower edges of the broad ligaments sufficiently in front of the uterus to enable them to hold up the uterus and vagina, or the ligaments having been stitched in front the stitches may not hold.

Consequently, in complete procidentia elytrorrhaphy even though well performed may fail, at least, this has been my experience in a number of cases. Therefore, the completely prolapsed uterus may have to be removed in order to secure the entire cut ends of the broad ligaments to the upper part of the vagina, and thereby give absolute support. As before stated, the operation should include the treatment of the hernial factor in the lesion, that is, removal of the redundant portion of the anterior vaginal wall. Generally speaking, the indications are somewhat as follows:—

1. Extreme cystocele not associated with the most extreme procidentia should be treated by anterior colporrhaphy and perineorrhaphy.

2. Cystocele associated with complete procidentia properly may be treated by hysterectomy, anterior colporrhaphy and perincorrhaphy. Anterior colporrhaphy in all cases.

3. Conditions intermediate between the two indicated above, and cases of very feeble or very aged women will call for special judgment whether hysterectomy be omitted or performed. It is, however, a fortunate fact that the completely prolapsed uterus, even in aged women, is removed usually with ease and with safety.

Other operations designed to decrease the weight of the uterus by removal of a part of it are of questionable value. Amputation of the cervix to lighten the weight of the uterus has been practised much for