Now what shall we do to cure this patient? That is what she has come for and what she is entitled to. I will ask you all in turn, what you would do for her if she consulted you in your private practice? You seem to hold a variety of opinions. One gentleman says he would remove the uterus to cure the prolapse. Would she then be cured? And would it be justifiable at her age?

Several operations will be required to effect a cure in this case, and if the patient was stronger they could all be done at the same time, but owing to her weak state I think it would be wiser to divide them, giving her ten days or two weeks between to enable her to recover her strength. On the next clinic day at the hospital I shall first fix both kidneys, and after curetting the uterus I will repair the cervix. This will be enough for her to endure for one day. Then two weeks later I will repair the perineum and do a ventral suspension. This will keep her in bed about four weeks.

I shall not attempt any plastic work on the anterior vaginal wall to overcome the cystocele, because when the uterus is drawn up and attached to the abdominal wall the vagina is drawn up with it and the cystocele will disappear. The result is more certain because the vaginal wall is now in a state of subinvolution. The patient will be cured, but the permanency of the result will depend largely upon the avoidance of pregnancy for at least five years.

The next case is also one of retroversion of the uterus with moderate rectocele. The patient is a widow, 38 years old, who was never pregnant. She complains of backache, bearing down pain in the pelvis, and menorrhagia. She has been treated with tampons before coming here, and has worn a pessary without permanent benefit. She says when the pessary is worn it irritates, and menstruation is more profuse and prolonged. You will observe on examination that the uterus is freely movable, and that it can be readily replaced, but that it does not remain so. You will observe also that there is complete relaxation of the utero-sacral ligaments, but the upper posterior vaginal wall is closely connected with the rectum and not separated from it, and relaxed as you so often find in these cases of retroversion in women who have borne children. The appendages are normal, but there is a chronic endometritis and the uterus is large and heavy.

On my next clinic day at the hospital, after curetting the uterus, I will do a simple operation in this case which I have under trial, and about which I have thus far said very little. It is unique in its simplicity, and in appropriate cases should prove very useful. Its object is to hold the cervix in the posterior cul-de-sac of the vagina and consequently in the hollow