allowing the uterus to remain when it becomes necessary to remove both ovaries, seems to me to have but little argument in its favor. We know full well that in a majority of instances the inflamed conditions that lead to the necessity of most of these operations have their incipiency in the lining membrane and other tissues of the uterus. If then we stop at the removal of the ovaries we leave behind the real centre of disease as the nidus or hatching place of diseased germs, which are liable to prove disastrous in the future. In my opinion, much nonsensical argument has been wasted on this subject. The uterus is simply serviceable in the process of child-bearing. After the ovarian ablation, its usefulness as an organ terminates and it becomes a superfluous and foreign body. I have no sympathy for the sentimentality that weeps over the removal of a permanently diseased uterus. It is far better to make these operations thorough, speedy and complete, than to remove a portion and leave the remainder to cause years of suffering or perhaps necessitate the ordeal of another operation.

I have never removed a uterus for which I felt regret. I have allowed several to remain that I am sure ought to have been removed. I have never known vaginal hysterectomy to be followed by hernia. The vaginal vault seems as strong or stronger than when occupied by the weighty and diseased organ. The sexual function in the mature woman is certainly not immediately diminished. I know of several instances where the removal of the diseased organ has caused an augmentation of the sexual sensibility. As a rule it is therefore safe to say, when we have to remove the ovaries, remove also the uterus, and do it per vaginam. The operation may be divided into three stages: 1. The cervix is encircled by an incision and the entire organ is denuded anteriorly and posteriorly, as far as practicable; 2. the uterine arteries are clamped and the uterus is enucleated, or if that is impractical, it is removed by morcellation: the ovarian arteries are secured and the uterus, together with tubes and ovaries, is cut away.

The technique of the operation I have described in my article in the Journal of Feb. 8, 1896, where I reported the first twenty-two cases of this series.

After observing the German method of operating with ligatures and then witnessing the operation with clamps by Pean, I have not hesitated to adopt the latter method and have never deviated from it.

In my sixty-six cases I have never had occasion to tie a single ligature. Only once has hemorrhage followed the removal of the clamps at the expiration of forty-eight hours. This was from the right uterine artery, and was easily clasped by a clamp which was allowed to remain on forty-eight hours longer. In another case hemorrhage occurred during a dressing on the eighth day, caused probably by too great distension of the vagina with speculum by the nurse. It was not severe and yielded to hot douches. In another case an intestinal fistula manifested itself on the ninth day. This continued for about six weeks and then healed spontaneously. I am satisfied that many accidents of hernia, fistula, secondary hemorrhage, etc., are caused by unnecessary distension of the vaginal walls with dressings. Now, after the removal of the clamps, I never allow a speculum to be inserted until the wound is entirely healed. The cavity is douched once daily, taking care not to allow the fluid to enter the abdominal cavity, and the mouth of the vagina is distended lightly with two fingers and the parts dusted with powdered iodoform, and a small strip of gauze inserted to the depth of two inches. The external genitalia are again dusted with the powdered iodoform and a strip of gauze folded over the parts. A "T" bandage is adjusted and the dressing is complete. An early evacuation of the bowels expedites the progress of the case. This is usually done by an enema the day following the removal of the forceps. Menstrual storms are certainly modified