plete relief of symptoms or improvement in health as a result of the operation, the conclusion is warrantable that this particular method of performing ventro-suspension is completely satisfactory and its results most gratifying. Its mortality being one-fifth of one per cent. in our experience, makes it practically free from danger to life, and no objection can be offered for this reason. Its performance is most warrantable and its sequelae less frequent than the extra-abdominal operations, such as the Alexander-Adams."

Personal experience makes stronger impressions upon the mind than text-book literature. I have performed the operation of ventral suspension of the uterus 24 times in my own practice, and have probably assisted my colleagues in an equal number, making in all an experience of about 48 operations. I have carefully preserved notes of all my 24 cases. In three of them I had occasion to re-open the abdominal cavity at a period of nearly three years after the suspension had been done: one for appendicitis, one for ovarian cyst and the other for disease of the ovary. In each case the uterus was in good position with a suspensory ligament from two to four inches in length still present and apparently on duty. In one of these three, the young lady had got married and had a child at term, the labor was normal, both mother and child did well. On opening her abdomen the second time, I had the opportunity of demonstrating to my private gynecological class a uterus in normal position and a suspensory ligament, of between three and four inches in length, which had evidently participated in the involution of the uterus which normally followed her delivery.

In only one instance, so far as I can learn, has re-displacement occurred. This was in a stout lady, 44 years of age. The uterus was large and heavy, the sound passing 3½ inches. There was also prolapus uteri, and a long, thick, lacerated cervix protruded 1½ inches outside of vulva. It was of long standing. She was curetted, cervix repaired and ventral suspension performed. The patient did well for over one year, when a sudden fall on the buttocks was blamed for causing re-displacement.

Personally I feel that in her case the special operation was not well chosen. I should have amputated the cervix, tied off the tubes and performed a positive ventral *fixation*. A long cervix has not sufficient room in the vagina to lie comfortably across that canal, so, aided by the action of intra-abdominal pressure on the long cervix, the latter gradually assumes a position in the axis of the vagina, the fundus uteri falling backward, and in this way retro-displacement and prolapse again occurs.

Choice of Operation.

In putting experience, practice, theory and study of the literature together I come to the following conclusions:—

That the conscientious, resourceful operator will be bound by no rule, but will aim to suit the operation to the particular case in hand.