veal conditions previously obscured, and at the last moment influence the operator to select the abdominal route, or perchance, during the vaginal operation, hemorrhage from the ovarian artery might require a higher section for ligature. Double preparation is not lost time. It is an excellent maxim to cover your retreat.

For the performance of this method, the patient is placed in the lithotomy position, with the foot of the table slightly raised, so that the intestines may gravitate away from the field of operation. The limbs covered with aseptic blankets, are supported by assistants on either side, who also manage two lateral and one posterior retractor.

The uterus is invariably curetted, irrigated and packed with gauze. If anterior section is indicated, the cervix is drawn downwards and backwards, with a tenaculum, preferably Orthmauris' forceps, as the lower blade holds the uterus steadier than the ordinary instrument. The anterior cul-de-sac being stretched, a vertical incision, about an inch and a half in length, is made through the vaginal membrane and muscle. The edges of this incision being held apart, careful dissection is made with the knife handle and fingers, through the tissue between the cervix and bladder, keeping close to the cervix to avoid wounding the bladder. I find it convenient at this stage to keep a large sound in the bladder, so that its limits may be more easily defined. The visico-uterine fold of peritoneum is soon reached and and perforated when a retractor is inserted, thus effectually raising the bladder out of the field of operation. The pelvic cavity is now open ; the incision may be extended, laterally if necessary, in order to obtain more space for exploration, severing of adhesions, examination of the tubes and ovaries. The fundus of the uterus can be anti-verted through the incision, fibroid enucleated, cystoleated or tapped, and summarily disposed of ; in fact, the pelvis with its contents is open before the operator. The parts are irrigated with sterilized water, and the incision closed with continuous gut suture. If prolapse or retroversion has been a prominent feature of the case, it is well to attach the body of the uterus to the anterior vaginal wall. This is done by passing three Kangaroo, chromotized, or curnol gut sutures through the margin of the vaginal incision, then through the uterine structure and out through the opposite side of the incision. These being drawn tight, force the uterus against the vaginal wall, a running suture of catgut then unites the vaginal incision. Gauze is packed into the vagina, and the case managed upon the same general principles as after perinsplasty. If the section is to be posterior to the cervix, the mucous membrane is taken up upon a tenaculum and an opening made with scissors, enlarged by opening of the blades,