two indications for curettement, a diagnostic a curative. Long continued hæmorrhage and a striking succulence of the mucosa indicated hyperplastic endometritis in which curettement was useful. It was not suitable for catarrh of the cervix as proposed by Sanger. The folds of the arbor vitæ were so small that even the finest instrument could not be got into them. Perforation was one of the dangers of curetting. Especially in puerpery the musculature of the uterus was in a state of fatty degeneration and the walls were so soft that the finger could be poked through. This fact should be borne in mind in passing a sound. This excessive softness of tissue extended far beyond the puerpery. In delayed involution it might last for months. Perforation by means of the curette was not by any means unknown. Five cases were mentioned at the Gynæcological Society's meeting in March last. Symptoms did not usually follow the aceident. If they did, opium should be given for a few days, when the patient could be sent home without any harm.

The danger lay in not recognizing the perforation at the time, and scratching round in the abdominal cavity. The results were horrible and generally fatal. How could such an accident be avoided? A steel instrument was dangerous. The most important points as regarded the avoidance of danger in curetting could not be described, they could only be gradually learned. The operator must have a subtle hand and must always bear in mind to be curetting and sounding at the same time, and this can only be learnt by practice. Curetting should not be done by everybody and anybody. Whoever was not accustomed to it had better undertake an amputation of the lower extremity than a curettement. One should bear in mind that gynæcologists in most operations could only work by feel. In his opinion, all perforation of he uterine wall were not blunders, but it was a blunder when the perforation was not noticed and the curette still kept on passing about in the abdominal cavity.—Prof. Olshausen, M.D., in *Med Press.*

CASTRATION IN HYPERTROPHY OF THE PROSTATE GLAND.

When Dr J. William White first suggested to the profession the operation of castration for the relief of hypertrophy of the prostate gland (Address at the Annual Meeting of the American Surgical Association, June 1, 1893, *Annals of Surgery*, August, 1893) on theoretical grounds, although strongly supported by experimental evidence, it is doubtful whether anyone appreciated the full value of the recommendation. Cases of prostatic hypertrophy are of extreme frequency. Sir Henry Thompson found that one man of every three over 54 years of age examined after death, showed some enlargement of the prostate; one in every seven had some degree of obstruction present; while one in fifteen had sufficient enlargement to demand some form of treatment. In this country to-day, as shown by the last census, there are more than three millions of men over fifty-four; of these, according to Thompson's estimate, which genito-urinary specialists consider a conservative one, about two hundred thousand are sufferers from hypertrophy of this gland. This number seems very large, but the assertions of Thompson unquestionably express a general rule, and in fact every surgeon must have seen men in whom some prostatic overgrowth existed *before* the fifty-fourth year. The lives of such patients are threatened because, if the obstruction is not removed, the health is rapidly undermined by the retention of urine and the consequent fermentative changes, the deleterious influence of backward pressure on the kidneys, the frequent use of the catheter, and the loss of sleep incident to the incessant demands to void urine. Heretofore the surgeon has been unable to afford distinct relief from the distressing symptoms of an advanced case of this affection. If the patient's general condition would warrant the very considerable risk, some form of prostatectomy was performed. The suprapubic method was recommended for a time, but the difficulties encountered in its performance, the frequency of suprapubic fistula as a sequel, and the high mortality following the operation, have led to its almost total abandonment. Perineal prostatectomy is also attended with considerable risk, on account of the free hæmorrhage, which cannot be controlled during the operation, and the prolonged anæsthesia which is necessary. In addition to this, the operation is a bungling one, in which the enlarged gland is removed by cutting, scraping, or gouging, while the instrument is out of sight, and much of the time it cannot be guided even by the finger. Combined suprapubic and perineal and prostatectomy enables the operator to reach and enucleate the gland with greater freedom, but it is an operation of such gravity that it would be contraindicated in the very cases in which the demand for relief was most urgent.

Perineal prostatomy is little more than a palliative measure, which does some good, temporarily, by draining the bladder and inducing slight contraction of the middle lobe of the prostate in the healing process. All of these operations confine the patient to bed for several weeks, which is, in itself, objectionable, and in addition requires the use of the bougie for a long time afterwards.

In view of these facts it is not strange that surgeons should have presented Dr. White's suggestion to patients suffering from the consequences of prostatic hypertrophy, nor is it unnatural that such patients accepted this chance for relief from