may be given per rectum, and, if the bleeding has ceased, a blood transfusion. A watch should be kept on the amount of blood lost, the pulse rate and the height of the fundus. As the patient's condition improves labour usually sets in spontaneously, but if it does not labour should be induced by pitocin or by the artificial rupture of the membranes.

Concealed accidental haemorrhage is a rare and very grave condition. The patient is shocked, and the first essential is again to *treat the shock*. As a rule, when it is diagnosed, a large quantity of blood has escaped into the uterine cavity, the uterine muscle fibres have been ploughed up by haemorrhage, and the uterus is completely inert. Haemorrhage will continue into the inert uterus until it is emptied. Abdominal section is necessary, and if after the uterus is emptied it fails to contract either the uterus should be packed or a hysterectomy should be performed. The maternal mortality of this condition is about 50 per cent of all cases.

PROLAPSE

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Prolapse is one of the commonest conditions necessitating surgery for its treatment. Diminution of tone of the body muscles and loss of tensile strength of the fibrous supporting tissues are predisposing factors, but the outstanding cause is undoubtedly child-bearing, which results in the stretching of all the pelvic connective tissues, especially the cervico-pelvic ligaments, utero-sacral ligaments, and the sub-vesical fascia, and also the fascia that supports the vagina laterally.

During pregnancy the vagina undergoes growth and great hypertrophy, enabling it to expand and transmit the foetal head. Frequently this growth is not followed by complete involution, and the vaginal walls remain hypertrophied and lax. Also during delivery of the foetal head the levatores ani muscles may be torn apart, and become stretched and attenuated.

Occasionally the ligaments supporting the uterus and vaginal walls are congenitally lax, and in such cases even in vigorous women who have neither been pregnant nor borne children, prolapse, extending to complete procidentia, may be found.

Prolapse is always associated with some feeling of disability, lassitude, and a sense of insecurity; the patient complains of a feeling of "bearing down" and general discomfort, and when cystocele is present there is sometimes frequency of micturition, and often an inability to empty the bladder unless pressure is exerted on the bulging wall. There may be discharge, often blood-stained, due to ulceration caused by rubbing of the clothing against the protruding part. When prolapse is associated with rectocele there is often difficulty in defaecation.

The different forms of prolapse with which we propose to deal are cystocele, a bulging downwards of the anterior vaginal wall; rectocele, or bulging of the lower part of the rectal wall; hernia of the pouch of Douglas, which is a protrusion of the viscera through the posterior vaginal fornix, between the rectum behind and the cervix in front; and descent of the vaginal vault, or true utero-vaginal prolapse, which may be of any degree up to complete extroversion of the vagina. These different forms of prolapse, however, seldom occur alone. They are usually associated with complications such as uterine haemorrhage or growth, uterine backward displacement, with prolapse of the ovaries, laceration or chronic infection of the cervix, or inflammations and degenerative changes of the vagina.

In this paper it is proposed to deal with the different types of prolapse, together with their complications and the surgical treatment for their relief.

One of the commonest conditions is general relaxation of the pelvic floor and stretching and attenuation of the levatores ani muscles, together with a greater or lesser degree of bulging forwards of the lower part of the posterior vaginal wall and the adjoining portion of the anterior

rectal wall. This condition is almost invariably produced by child-bearing, and is associated with a "bearing down" feeling in the pelvis, sometimes accompanied by pain, especially when an effort is made such as coughing, lifting a weight, or any other form of bodily exertion. The condition is often associated with lassitude of varying degree which does not respond to ordinary restoratives and tonic treatment.

A deficient pelvic floor and lax levatores ani muscles are very frequently the cause of complete or partial lack of gratification during the sexual act, and this has undoubtedly a detrimental effect on the patient's mentality, which again has a bearing on her general health. It seems that a certain tonicity and capacity to contract the levatores ani muscles are essential to the complete sexual orgasm. This important point is one which is frequently overlooked when dealing with prolapse, and is seldom sufficiently stressed by those writing upon this subject. It should also be pointed out here that a very lax vagina and incapacity to contract the levatores ani muscles properly are extremely liable to prove unsatisfactory to the male partner also, and may lead to marital dissension.

A satisfactory state of the pelvic floor and levatores ani muscles is, therefore, of far-reaching importance. Operation alone affords any prospect of cure, and the essential part of the operation is the approximation and tightening of these muscles so that they may be powerfully contracted. The procedure (which is known as posterior colpo-perineorrhaphy) will entail the removal of a varying portion of the posterior wall, depending upon the degree of its laxity and is frequently performed subsequent to one of the other repair operations upon the vaginal vault or the anterior vaginal wall.

The operation may be conducted from below upwards or from above downwards. The latter method is an excellent procedure when there is much laxity of the posterior vaginal wall in the upper part. An Auvarud speculum is inserted into the vagina, and the cervix is steadied with a vulsellum and drawn forwards. The vaginal wall is grasped with two pairs of Allis forceps about an inch and a half behind the external os, and usually about half to one inch from the midline on each side, depending upon the degree of laxity. An incision is started in the midline about half an inch behind the external os and carried down on each side to the points grasped by the forceps. The portion of vagina thus circumscribed is dissected free from the underlying tissues. The forceps are now placed about an inch and a half below the point previously grasped, and each lateral incision is carried down to the new points. The intervening portion of vagina is dissected free, and the two sides of the incision are approximated with chromicised catgut stitches, either continuous or interrupted. If continuous, the stitch should be tied after every two loops have been inserted, to prevent the whole suture giving way in the case of too early dissolution of any part of the catgut.

The pairs of Allis forceps are moved down the vagina in this manner until the perineal body is reached, and the intervening portion of vagina is dissected free all the way down to the skin of the perineum. The lateral cut edges of the vagina are approximated from above downwards to within an inch of the vaginal entrance.

The levatores ani muscles are now approximated in the midline with two or possibly three interrupted stitches of chromicised catgut, the first being inserted low down at the vaginal entrance, and passing backwards and laterally through the muscle and its covering aponeurosis, is finally directed forwards. The needle is then carried across the midline and passed through the medial edge of the levatore ani muscle on the other side, in the same manner, but from within outwards, passing postero-laterally at the side of the rectum. When this stitch is tied the anterior edges of the muscles can be seen to come forward to meet in the midline, and can be felt to bulge medially against the lower part of the vagina on each side. The second, and possibly the third, stitch in front of this is passed and tied in a similar manner. Usually two stitches suffice to form a new perineal body with sufficient forward advancement to make the vagina of normal size, that is, to admit two fingers easily.

The unsutured portion of the cut edges of the vagina are now sewn together with interrupted stitches which pass sufficiently deeply to penetrate the approximated levatores ani muscles. The divided edges of the skin of the perineum are sutured with catgut, or preferably silkworm gut or proofed silk. These stitches pass through the co-opted muscles and should be of sufficient tension merely to effect approximation, or subsequent swelling will render them unduly tight. They obliterate all spaces and prevent post-operative oozing. There is one point to be observed, namely, that undue tightening of the skin of the vaginal entrance should be avoided, as this is liable to cause dyspareunia. The tightest portion of the vagina should

be the point where the levatores ani muscles are approximated at about one to one and a half inches from the vaginal entrance.

When the operation is conducted from below upwards, a triangular wedge is outlined by placing one pair of Allis forceps on the posterior vaginal wall about an inch and a half up from the entrance, and two pairs at such a distance apart on the posterior edge that their approximation will indicate a vaginal entrance of desired size. This triangular wedge of vagina is dissected free; the cut edges are sutured, and the levatores ani muscles co-apted as in the procedure just described.

When the vagina is not redundant but the muscles are very lax, a vertical incision will suffice, through which the muscles may be sutured and the incision closed without removing any portion of vaginal wall.

It is a point worth noting that it is much better to remove too little vaginal wall than too much, as a moderate degree of redundancy is not necessarily an undesirable condition, provided that the levatores ani muscles are approximated and restored to a good state of tension.

A very common condition is the one in which there is a considerable degree of cystocele, laceration of the cervix, and descent of the vault, extending sometimes to complete procidentia, in which case there is always considerable elongation of the supra-vaginal portion of the cervix. When there is a moderate degree of descent of the vault there is very often retroversion of the uterus and prolapse of the ovaries.

A type of operation which gives very satisfactory results when there is no uterine bleeding or other condition demanding hysterectomy, is the Donald-Fothergill. An Auvard speculum is inserted, the cervix, steadied with a large vulsellum, is pulled downwards and the external os, and the cervical canal are cleansed by swabbing with an antiseptic solution of picric acid in absolute alcohol or methylated spirit. A sound is passed to determine the length of the uterus, the cervix is dilated, and curettage may be performed.

An incision, beginning immediately behind the urethra and following the vaginal entrance on each side to the perineum posteriorly, is carried downwards and outwards through the depth of the vaginal wall. This following of the vaginal entrance is a good indication of the amount of protruding vault to be removed. The portion of vagina thus outlined is dissected free from the subvesical fascia in front of the cervix, from the connective tissues laterally and behind, and the triangular flap attached to the cervix is thus freed.

The bladder is separated from the front of the cervix by gauze dissection and pushed upwards. This separation and upward elevation should be carried out thoroughly on each side near the edge of the incision, for it is here that the ureters enter the bladder, and in this way they are freed and pushed well up out of danger from clamping or inclusion in the stitches.

The connective tissues on each side are grasped with strong forceps as near as possible to the cervix, and divided medially to the forceps, leaving a sufficient amount of tissue to ensure the security of the subsequently applied ligatures. This grasping and dividing should be carried upwards for a distance of an inch to an inch and a half, depending on the degree of elongation of the cervix. A stout ligature of chromicised catgut, or a double strand of No. 2, is passed at the tip of the forceps very close to the side of the cervix, and as the forceps are released this stitch is tied securely in the groove which the clamps have made. This procedure is carried out on the opposite side.

The cervix is then amputated transversely, sufficient being removed to reduce the uterus to its normal length.

This triangular area is closed in a special way. A stitch is inserted in the midline posteriorly carried up into the cervical canal and passed through the posterior wall and central part of the vagina near its cut edge. When this is tied it will approximate the cut edge of the vagina to the amputated end of the cervix. Another stitch is passed on each side, thus approximating a further portion of these edges, and similar stitches are inserted all around towards the midline anteriorly, thus forming a new external os. As these stitches are tied, the cervix will pass upwards and backwards, and the fundus, unless adherent in the pouch of Douglas, will be rotated anteriorly.

When the midline anteriorly is reached, the sub-vesical fascia is pleated with one or two interrupted stitches of catgut carried from side to side. The cut edges of the vagina near the cervix are approximated with a stitch which is passed up into the canal of the cervix and through its anterior wall. This stitch is drawn tightly and will infold this portion of the vagina towards the cervical canal. Interrupted stitches are employed to approximate the lateral cut edges of

the vagina from the cervix forwards to the urethra. When the third suture is inserted it is tied securely to the one which was passed through the cervical canal, anchoring this stitch and pressing the approximated portion of the vagina firmly against the cervix. As these sutures are inserted, the newly formed external os passes further upwards and backwards. Before this anterior suturing is completed, the tissues on each side of the urethra should be approximated in the midline to tighten and support the neck of the bladder when the structures in this region have been very lax, and the condition has been accompanied by stress incontinence of urine. The operation is completed by performing posterior colpo-perineorrhaphy. The vagina is packed tightly with gauze soaked in liquid paraffin flavin, 1 in 2,000, and a self-retaining catheter is left in the bladder for two or three days to obviate retention of urine.

The operation thus described is one of the most satisfactory of all vaginal operations, and has done much to overcome many of the difficulties in the treatment of prolapse, as at the same time it cures descent of the vault, and cystocele in all its degrees, corrects retroversion of the uterus with elevation of the ovaries out of the pouch of Douglas, and permits the removal of a lacerated, infected, and elongated cervix, which by this procedure is held high up and far back in the best anatomical position. There is seldom any undue shortening of the vagina as a result of this procedure; in most cases of prolapse the vagina is considerably lengthened, and in cases of procidentia, when the extroverted vagina is pushed back to its normal position the vault can be lifted to an unusual height. This entails a certain disadvantage, as pressure upwards on the vault is definitely conducive to the production of the sexual orgasm. A certain amount of shortening is therefore advantageous.

Cystocele is frequently encountered in elderly women with a healthy cervix and uterus and no descent of the vault, but with rather a thin and atrophic vaginal wall. An excellent operation for this condition is interposition of the uterus between the bladder above and anteriorly, and the anterior vaginal wall below and posteriorly. The body of the uterus affords a firm, solid support to the base of the bladder, and can be put and kept in place without undue tension on the stitches. When conducting this operation the cervix is steadied with a vulsellum and an incision is made transversely through the anterior vaginal wall about half an inch above the external os. The point of a pair of blunt-nosed scissors is inserted and the blades opened. The blades are pushed upwards and opened at intervals in the space between the anterior vaginal wall in front and the sub-vesical fascia posteriorly until the region of the urethra is reached when the vaginal wall is divided in the midline from the cervix to the urethra. The two flaps are caught along the edge with Allis forceps, drawn laterally, and the wall separated from the sub-vesical fascia on each side by gauze dissection.

The bladder is swept upwards off the front of the uterus by gauze pressure, and held with a narrow bladed retractor; the peritoneum where it is reflected from the bladder on to the front of the uterus, is identified and divided transversely for a distance merely sufficient to permit the fundus uteri to come through this opening.

A pair of Allis forceps is passed through the opening and the front of the fundus is gripped and pulled forwards. Another pair of forceps is secured to the front of the uterus at a higher level, and this hand-over-hand method is applied until the fundus is pulled well forwards through the opening. The divided flap of peritoneum need not be sewn to the back of the uterus against which it will fall and lie closely, forming a natural flap valve which prevents any obtrusion of omentum or bowel.

The fundus uteri is anchored well down under the neck of the bladder and urethra by a stitch of catgut which secures it to the sub-pubic fascia on each side of the urethra. The two vaginal flaps are now sewn together in the midline and to the interposed fundus, which is pierced with each stitch, thus securing it to the co-adapted flaps.

Another extremely useful operation for procidentia combined with a very lax and attenuated vaginal wall is a combination of the Donald-Fothergill procedure and interposition of the uterus. The steps of the operation are almost identical with those given under the Donald-Fothergill technique, with one exception. The peritoneum is opened, the uterus brought forward, and a long stitch is passed through it so that it may be pulled into the desired position at a later stage of the procedure. It is then pushed backwards until the operation reaches the stage where the vaginal wall is to be sutured. The fundus uteri is pulled forwards through the opening in the peritoneum, sewn down to the fascia in the pubic region on each side of the urethra, and the vaginal flaps are sewn as described in the foregoing interposition technique. Where

necessary, all these operations are finally completed by perineal repair on the lines already described.

A common combination of disorders is prolapse of variable degree together with some condition demanding hysterectomy, such as uterine haemorrhage due to functional disorders or to a fibroid of moderate size. When this obtains an excellent way of dealing with the case is to perform vaginal hysterectomy and vaginal repair as one procedure. This is usually quite an easy undertaking, as the perineal body is almost invariably deficient and the vagina large and capacious.

The procedure is very similar to that described under the Donald-Fothergill operation. The vagina is incised, the incision beginning near the urethra, and being carried posteriorly through the extroverted vaginal wall on each side along the line of the vulval margin. This circumscribed portion of the vagina is dissected from the underlying sub-vesical fascia in front, the para-cervical tissues laterally, and the peritoneum of the pouch of Douglas posteriorly.

The bladder is separated by gauze pressure from the front of the uterus and pushed well upwards, especially at the lateral angles where the ureters enter. The pouch of Douglas is opened posteriorly, and the utero-vesical pouch anteriorly. Each broad ligament is clamped closed to the uterus and divided so that a small portion of uterine muscle is left distal to the clamp, thus securing the integrity of the stitch which is now passed at the point of the forceps. While the clamp is being removed, this stitch is tied tightly in the groove made by the instrument. The last clamp on each side grasps the round ligament, ovario-uterine ligament and Fallopian tube, and usually a loop of the ovarian artery, where it becomes continuous with the uterine artery. Two ligatures are applied on each side in this latter portion, the first, which is cut as soon as it is tied, more laterally, and the second, which is tied firmly in the groove made by the clamp, more medially. The ends of this latter stitch are left long to be drawn down and tied together after the vaginal vault is closed. This procedure is repeated on the other side. When these last clamped portions of tissues are divided, the uterus is free and is removed.

If there is a fibroid of any considerable size the lower parts of the broad ligament will be inaccessible. In such a case the uterus is pulled well downwards until the fibroid can be felt, and the overlying uterine muscle is divided, even if this entails complete splitting of the uterus. The capsule of the fibroid is freely incised and the fibroid is drawn well into the wound with pairs of vulsella or Littlewood's forceps and cut away piecemeal, care being taken not to injure the bladder, ureters, rectum, loops of bowel, or folds of omentum. Provided that it will come easily into the pelvis, a fibroid of almost any size can be removed by this method, which goes by the term "morcellation."

After the uterus has been removed the sub-vesical fascia is pleated from the vault downwards with interrupted stitches of chromic catgut. The cut posterior edge of the vagina, together with the peritoneum of the pouch of Douglas, is oversewn with a continuous stitch of catgut from side to side, as this part is very vascular and bleeds freely. The edge of the peritoneum reflected from the top of the bladder is secured with two or three pairs of forceps, and the anterior vaginal wall is restored. The first suture, of heavy chromicised catgut, is passed in the vault in the region of the cervico-pelvic ligaments. It is inserted through the vagina a short distance from its edge, carried two or three times through the edge of the peritoneum where this is reflected from the top of the bladder, and continued through the vaginal wall on the opposite side. As this stitch is tied the vault of the vagina must be pushed well upwards before the edges can be approximated. A series of sutures from the vault forwards and downwards to the urethra, secure the two sides of the cut vagina in the midline. Finally a stitch is inserted, first through the cut edge of the restored vaginal wall in front, and then through the oversewn posterior wall. These sutures are tied, closing the opening in the vault. The two long stitches securing the upper part of each broad ligament are pulled downwards and tied, drawing the divided edge of broad ligament inwards against the new vaginal vault in the midline. When healing takes place a strong, firm, fibrous support for the vaginal vault is secured.

The operation is completed by performing posterior colpo-perineorrhaphy.

When cystocele occurs in a young woman of child-bearing age, it is important for future conception that the cervix be conserved. Lacerations should be repaired, and if the canal is dilated it should be reduced to normal calibre.

When cystocele is pronounced, but there is no excessive descent of the vault, it can be corrected by performing anterior colporrhaphy. The cervix is steadied with a vulsellum, and

the vaginal wall is divided transversely about an inch anterior to the external os. The points of a pair of scissors are passed into this space and pushed upwards between the vagina in front and the sub-vesical fascia posteriorly, the blades being opened at intervals to effect separation of these structures. This is easily carried out if the proper plane is followed. The anterior vaginal wall is divided along the midline, and the two lateral flaps are retracted with Allis forceps and separated on each side from the underlying sub-vesical fascia. The bladder is stripped from the front of the cervix and uterus by gauze dissection and pushed well upwards. Lateral pleats, which are picked up by a needle carrying strands of chromicised catgut, are sewn together in the midline to restore the sub-vesical fascia to normal tension. Two or three stitches will suffice to secure the pleats. The stitch near the cervix is also passed through the front of the uterus at the reflection of the peritoneum from the bladder. The two lateral flaps of vagina are co-apert with two or three mattress stitches, redundant portions being cut away and the two edges oversewn with a continuous stitch of catgut.

Another procedure which may advisedly be employed when there is cystocele and descent of the vault in young women in whom it is most desirable that the cervix should be conserved, is a modification of an operation introduced by Hunter, which is similar to the Donald-Fothergill procedure. The cervix is pulled downwards and a portion of the anterior vaginal wall and vault is outlined as in the Donald-Fothergill technique. The cervix, however, is not removed, but a second incision is made around it about half an inch above the external os, which, with the surrounding mucosa, is conserved. The portion of vaginal wall between these two incisions is dissected free and removed. The procedure is now identical with the Donald-Fothergill technique. As the cervico-pelvic ligaments on each side are clamped and cut away from the cervix, ligatures of catgut are tied firmly in the groove made by each clamp, and are held for the moment with pairs of forceps. Starting in the midline posteriorly, the cut edge of the vagina on the outer side of the raw area is sewn all around to the cut edge of the mucosa left at the top of the cervix with interrupted stitches of catgut. As the suturing proceeds from behind forwards, and as each succeeding suture is tied, the cervix must be pushed further back and higher up. When the anterior part of the cervix is reached and the cut edges of the vaginal wall in this region are being brought together, the divided cervico-pelvic ligaments on each side are drawn together in the midline and sewn to the front of the cervix. This forms a strong support, holding the cervix backwards and high up, and not only supporting the vaginal vault, but tilting the fundus of the uterus forwards. The two sides of the divided vaginal wall are sewn together in the midline from the cervix forwards to the urethra.

As in all these operations where the pelvic floor is at all deficient, posterior colpo-perineorrhaphy completes the operation.

Hernia of the pouch of Douglas is a protrusion of viscera through the space defined by the cervix in front, the rectum behind, and the utero-sacral ligaments on each side. It sometimes follows ventro-fixation of the uterus, in which the cervix is drawn far forwards, leaving a long space between it in front and the posterior pelvic wall behind. Inter-abdominal pressure is liable to cause bulging in this space. Usually such a protrusion can be cured by operation from the vaginal aspect, but if, for any reason, the abdomen is opened, the condition can be corrected by approach through the peritoneal cavity.

The uterus is drawn forwards and upwards to render taut the utero-sacral ligaments, which, in such cases, are usually very thin and attenuated, and sometimes difficult to identify. The utero-sacral ligaments are first shortened by passing catgut or silk stitches through each, beginning at its insertion into the cervix. One end of these stitches is then passed back and forth through the ligament to within about half an inch of the rectum and the two ends are tied together firmly, thus forming a greatly shortened ligament. When this has been done on both sides, a series of stitches is passed from side to side, at such a distance in front of the rectum as to avoid the compression and obstruction of its lumen. Each stitch is carried through the plicated utero-sacral ligament on one side, taking up several bites of the peritoneum of the pouch of Douglas together with the underlying fascia, and continuing through the utero-sacral ligament on the opposite side. A series of such interrupted stitches is passed and tied until the back of the cervix is reached. This forms a strong, firm cord in the bottom of the pouch of Douglas, which is thus satisfactorily supported.

The condition may be treated by vaginal operation, either as a separate procedure or as part of a posterior colpo-perineorrhaphy. When the procedure forms part of a posterior repair, the operation is conducted on the lines described under posterior colpo-perineorrhaphy from

above downwards. The cervix is drawn forwards, the bulging portion of the vagina is outlined, and an incision is carried from the back of the cervix, sweeping round the protruding part on each side, care being taken not to injure the rectal wall. The pouch of Douglas is opened and the portion of lax vaginal wall and peritoneum is removed. The two sides, beginning near the cervix, are firmly sutured together with chromic catgut, and if possible the utero-sacral ligaments near the uterus should be identified and included in the stitches. This suturing of the vaginal wall is carried backwards until the posterior part of the protrusion is reached, when the operation is completed as described under posterior colpo-perineorrhaphy.

The operation may be conducted as a repair of a hernia only. In such a case the perineum is well retracted and the cervix drawn far forwards. The bulging portion is outlined on each side by a curved incision which begins behind the cervix, sweeps round the protruding part on each side, and meets the opposite incision behind and below. The redundant portion of vagina, together with the lax peritoneum, is dissected away, and the pouch of Douglas is opened. The two cut edges are sewn together in the midline with interrupted stitches, one or two of which near the cervix should include the utero-sacral ligaments. This tightening of the utero-sacral ligaments makes for great security, and also has the advantage of holding the cervix well upwards and backwards.

Occasionally cystocele, rectocele, and descent of the vaginal vault may be present when there is carcinoma of the body of the uterus. In such cases the first consideration must be removal of the growth, and a more effective ablation can be effected by the abdominal route. Sometimes, without greatly increasing the extent or time of the operation, cure of some degree of cystocele and descent of the vault may be effected when total hysterectomy together with bi-lateral salpingo-oophorectomy is performed. When the growth is advanced it is better to isolate each ureter, tie the uterine artery lateral to it, and separate it from the top of the vagina. When the bladder has been freed and pushed well downwards, the uterus is removed by cutting the vaginal wall all round, and a V-shaped portion is excised from the front of the vaginal vault, extending downwards for about one-third of its length. The cut edges of the V-shaped portion are approximated with catgut stitches, and the opening in the vaginal vault is closed by sewing the cut edges together from side to side. These steps greatly tighten the tissues that support the vaginal vault.

Occasionally a complete procidentia may occur after total or sub-total hysterectomy. In a case of sub-total hysterectomy where the stump of the cervix is left, this is pulled downwards and the protruding portion of the vagina is circumscribed by an incision similar to that made when the Donald-Fothergill operation for complete procidentia is performed. The outlined portion of the vagina is dissected from the underlying tissues; the para-cervical tissues are divided on each side, and when the stump of the cervix is removed, these are tied together in the midline, forming a strong, firm sling. The lax connective tissues at the apex of the protrusion are infolded and tightened by a series of purse-string stitches of No. 1 chromic catgut, passed fairly superficially so as not to injure the ureters. As each succeeding stitch is passed and tied, the vault is pressed upwards and backwards. The sub-vesical fascia is rendered taut, and lateral pleats are sewn together in the midline. The divided edges of the vagina are secured together with strong catgut sutures from above downwards.

When total hysterectomy has been performed, the apex of the protrusion is drawn downwards, and an incision similar to that just described is made, the vaginal vault being dissected from the underlying tissues which are sutured in the manner outlined in the preceding operation.

After such an operation the patient should remain quietly in bed for three to four weeks, and avoid all strenuous exertion for three months.

Prolapse is too often regarded as a local disease, but it seldom occurs uncomplicated, and it always has a very considerable bearing upon the patient's bodily and mental well-being.