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urethral fistulae, partial or complete obstruction of the urethra, chronic over-distension of the bladder, avulsion of the urethra, loss of the micturition reflex and persistent infection of the urinary bladder. Haematomata around the bladder and infection in the retropubic space may also occur.

As a sling operation is done as a rule only after a previous operation has failed to cure stress incontinence, the surgeon tends to pull the sling too tight, as he dare not fail to cure the condition by allowing it to be too loose. Efforts are being made at present to devise some means of measuring the tension required in individual cases, which varies with the resistance produced when the urethra is lifted upwards and forwards.

There is little doubt that whatever method of sling operation is performed the final result is produced by fibrosis around the operation area, which keeps the urethra in its new position. In cases in which the sling has had to be removed owing to suppuration around it the ultimate result is usually as good as if the sling was still in place.

In this respect it is interesting that good results are claimed both by Mulvaney,<sup>9</sup> who frees the bladder base and urethra through a suprapubic extra-peritoneal incision and does nothing else, and by Everard Williams,<sup>10</sup> and by Marshall

Marchetti and Krantz,<sup>11</sup> who recommend a freeing of the urethra and bladder base in the same way followed by suture of the urethra, bladder base or lateral vaginal fornices to the periosteum behind the pubic bones, thus lifting up the urethra and reconstituting the posterior urethro-vesical angle.

This brief résumé of the modern operative treatment of stress incontinence demonstrates clearly that the problem has not yet been solved and will not be so until more is known of the dysfunction of the bladder which occurs in cases of stress incontinence.

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Testosterone is a more popular form of therapy in Great Britain, but in the main it can be only palliative in its action, for size and duration of dose must be limited by fear of unwanted side effects. It is noteworthy, however, that Macafee (1954) has caused complete resolution of a lesion in the perineum with testosterone. X-ray induction of the menopause is of value only when surgery has already been undertaken, as the diagnosis must of necessity remain presumptive until the abdomen has been explored. There are two types of case where such treatment is indicated, first in the older woman in whom complete extirpation of ovarian tissue has been impossible due to technical difficulties, and secondly in the younger woman who has a recurrence of symptoms following conservative surgical intervention, and for whom radiotherapy is preferred to a further difficult surgical venture.

The aetiology of the condition has been discussed at length by many authors and so will be mentioned but briefly here. The main theories are:

1. Cullen's direct invasion theory, which most authors agree accounts for many cases of adenomyosis uteri, although there are some who believe the myometrium capable of forming both glandular and stromal cells.

2. Sampson's implantation spill theory, which, after a period of rejection, is now again being more widely accepted, particularly in view of the experimental evidence furnished by Scott and Te Linde to show that in monkeys menstrual endometrium can implant in the abdomen and give rise to endometriosis.

3. Iwanoff's serosal metaplasia theory has many supporters and ingenious explanations are offered to explain all the reported lesions by this one theory. However, there seems to be no convincing explanation why there is never any transitional form seen and why the metaplasia should be so focal in nature and not more generalized.

4. Halban's lymphatic theory has few adherents; although lymph nodes have been found with endometrial structures in them, they are not common.

Whilst endometriosis is not a true neoplasm, it bears many close resemblances to one and therefore it might not be unreasonable to suppose that the spread of viable endometrial cells to ectopic situations could occur in a number of different ways and that, in differing circumstances, any one or more of the above theories might account for the various lesions of endometriosis.

I wish to thank Mr. A. J. Bailey for preparing the photomicrographs from material belonging to the Department of Pathology, Chelsea Hospital for Women.

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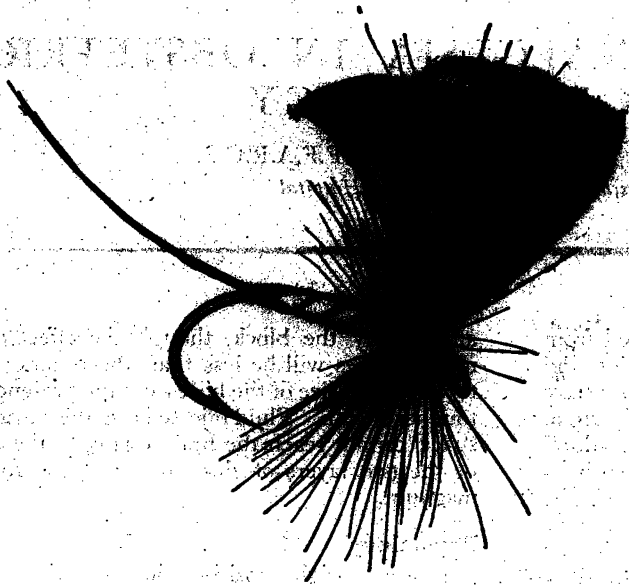
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ening of the second stage as the normal impulse to push out the foetal head will not be appreciated by the analgesic patient and in a primipara it will be necessary to extract the baby with forceps, but with the relaxed perineum forceps extraction is considerably easier than it would otherwise be, and if episiotomy is necessary it will be painless. In a multipara who has had a previous delivery under light general anaesthesia, forceps are rarely necessary as the mother knows what to do when she is told to bear down. The advantages of the method are summarized in the accompanying table.

### Disadvantages

The somewhat complicated technique requires the services of a trained anaesthetist, and failure to achieve analgesia cannot be ruled out owing to possible abnormalities of the sacrum or even inability to locate the hiatus owing to obesity of the patient. Repeated blood pressure readings are necessary and a hand must be kept on the fundus of the uterus in order to recognise the onset of a contraction. Gross anaemia, low blood pressure, skin sepsis over the sacrum and a history of rapid delivery at a previous labour are contra-indications. Errors in technique include accidental puncture of the dura mater, insertion of the needle posterior to the sacrum (which can be recognized by keeping a finger over the sacrum during the injection and feeling the occurrence of surgical emphysema) and the injection of too great a quantity of solution with resultant paralysis of the motor nerve supply of the uterus followed by uterine inertia. The safest form of treatment of this complication for mother and child is an immediate Caesarean section.

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#### Acknowledgment

I would like to acknowledge my debt to St. Bartholomew's Hospital, where the facilities to undertake this study were provided.

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Professor Alajouanine, Paris.  
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Dr. Stanley Bradley, New York.  
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'Circulation through the limbs,'  
Professor Barcroft.  
'Vascular Innervation,' Professor  
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'Pathology of vessels,' Professor  
Dible.  
Professor C. Rob.

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