left it presented an entirely different appearance: the two opposite lips of the os uteri slightly gaping open (fig. 12), thus rendering it possible for the semen to get to the

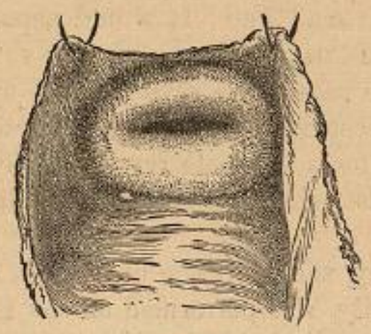

Fig. 12.

fundus uteri. Nine months after this lady left my care she conceived, and I have since heard that she was safely delivered of a fine vigorous child, after an acquired sterility of about nine years. The result is most gratifying, inasmuch as a purely rational surgical treatment effected the cure of both menorrhagia and sterility.

Of Menorrhagia from Fungoid Granulations.—When an old burn and other chronic ulcers refuse to heal, we often find the suppurating surface to be elevated above the level of the sound skin, and we call it "proud flesh," "exuberant granulation," "fungus," or "fungoid granulation." It is usually indolent or insensible to the touch, except, perhaps, just at the cicatrizing edge of the cuticle, and it often bleeds easily on being touched. It is a condition of things very much like this that we here designate "fungoid granulations," as sometimes the source of menorrhagia. These may be in the canal

of the cervix, or in the cavity of the uterus, or in both at the same time; but it is more common to find them in one or the other alone, and perhaps more frequently in the former. Wherever located, they are often the source of an increased flow, which may be remedied by local treatment. To diagnose their presence, let us suppose a case of menorrhagia for investigation. If the touch proves that there is no polypus or other source of it to be found in the vagina, then we must look to the cavity of the uterus for it. If it be from a granular engorged cervix, the speculum at once reveals the cause. But if the os and cervix be in a healthy condition, then it comes from some portion of the utero-cervical canal. Formerly we were left in doubt about the pathology of menorrhagia, but we now explore the cavity of the unimpregnated uterus with the greatest facility, and, no longer groping in the dark, we are able to treat most cases of it understandingly, if not always successfully. Compressed sponge is a very old surgical appliance, but in uterine therapeutics it is of comparatively recent date, and I believe we owe its generalization here to Dr. Simpson; but my own countrymen, Dr. J. P. Batchelder and Dr. W. C. Roberts, of New York, have both written very ably on this subject. Sponge tents are now to be had at most druggists; those that we see in the shops are large clumsy things, thickly coated with wax, tallow, or suet. They are difficult to introduce, and often slip half out of the cervix into the vagina, there exciting an unnecessary amount of irritation. To be sure they are well made, I have them manufactured under my own supervision. They are so indispensable nowadays that I may be pardoned for a little minutiæ on the subject. City physicians can order them from the druggist, but the country practitioner

cannot always do so, and this is my apology for dwelling on the subject.

The sponge should be of good quality, but not too soft and yielding. Of course, it should be thoroughly cleaned; but not bleached, for the bleaching process deprives it of all elasticity. It should be cut into slightly tapering conical pieces, from one to two inches long, some smaller and others much larger than the thumb. A pointed wire or a slender awl should be passed through the centre of the long axis of the sponge, which should then be thoroughly saturated with a thick mucilage of gum arabic. A small twine of cord is then to be closely wrapped around the sponge as it is held stiff by the wire, beginning at the smaller extremity and gradually winding on to the larger; then the wire may be withdrawn, and the new-made tent laid aside to dry. If we are in a hurry it may be dried in the sun or by a fire, taking care not to injure the texture of the sponge by too great a heat.

When it is thoroughly dry, the twine is to be unwound, and the little circular elevations made by it on the surface of the tent are to be rubbed down by fine sand-paper. Without further preparation it is then

FIG. 13.

ready for use. These diagrams represent the tents about the size and shape that I usually make them. I never allow them to project more than an eighth of an inch from the os uteri into the vagina. Being introduced

without grease, except a little suet just on the point, they seldom slip out of position. If, however, there is a disposition on the part of the cervix to eject the tent, a small pledget of lint or cotton laid on the cervix after the tent is introduced, will effectually prevent this accident. I have seen a great deal of suffering produced by sponge tents, and with all due deference to the dexterity of surgeons, I must insist that this is wholly unnecessary. The commercial tents, as said before, are too large, and being introduced without a speculum always induce more or less pain. My plan is this:—The

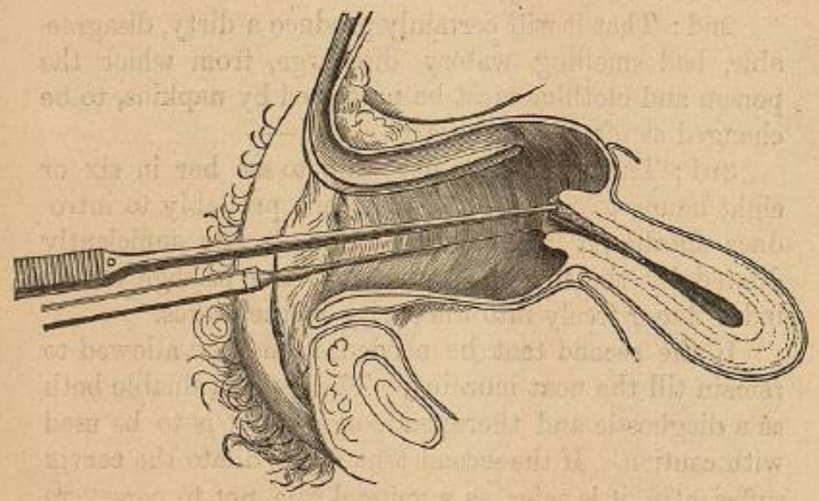

FIG. 14 represents the speculum elevating the posterior wall of the vagina; the tenaculum fixing the uterus by being hooked into its anterior lip; and the forceps holding the tent, which is introduced up to the os internum.

patient being on the left side, my speculum is introduced; the os uteri is pulled gently forwards by a delicate tenaculum hooked into the anterior lip, which fixes the uterus, while the tent held by the forceps is passed

easily and gently into the cervix to the required depth, without producing pain. I make it a point never to introduce a tent that is larger than the canal that is to receive it, and thus, if it be gently done, it is impossible to give pain; and why should we ever inflict one single unnecessary pang?

If we have the selection of the time for the introduction of the tent, let it be in the morning, say by or before ten o'clock. We should explain to the patient,—

1st: That it may possibly produce a little uneasiness, which is usually very bearable.

2nd: That it will certainly produce a dirty, disagreeable, bad smelling, watery discharge, from which the person and clothing must be protected by napkins, to be changed as often as necessary. And—

3rd: That it will be necessary to see her in six or eight hours, to remove the tent, and probably to introduce another, if the cervix be not already sufficiently dilated by the first one, to permit the passage of the index finger freely into the cavity of the uterus.

If the second tent be needed, it may be allowed to remain till the next morning. The tent is valuable both as a diagnostic and therapeutic agent, but is to be used with caution. If the second tent fail to dilate the cervix sufficiently, it is safer, as a general rule, not to persevere further for the time, but to wait a few days, and then resort to it again. I am thus cautious, because I have seen metritis follow its injudicious use. The tents of commerce have a loop of tape, three or four inches long, fastened to the large or outer extremity, for their easy removal.

I use nothing of this sort, because I always expect to remove the tent myself.

Its removal is a matter of some nicety.

Place the patient on the side as for its introduction; apply the speculum, and immediately we see the sponge projecting from the cervix and dilated from the size of *b* to that of *a* (fig. 15). It will be saturated with a

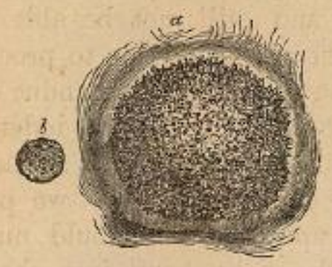

FIG. 15.

fœtid, serous, or sero-sanguinolent discharge, which is to be carefully wiped away. After this fix a pair of spring forceps firmly on the centre of the sponge, for the purpose of removing it. Then let the patient turn over on her back, with the forceps still fastened to the sponge. Now pass the left index finger into the vagina along the locked blades of the forceps, till it comes in contact with the sponge. The sponge is not to be suddenly or quickly withdrawn, but it is to be pulled gently first to one side and then to the other, taking care at the same time to support the uterus with the index finger, which is to be gently carried into the cervix by the side of the tent, first on one side, then on the other, to free its meshes or interstices from the cervical mucous membrane, which interlocks, as it were, with the substance of the sponge. When the sponge has been well loosened all round, and is found to slip down a little, then we should be ready to thrust the finger up into the cavity of the

womb, as we pull it away. If the finger does not pass at once and easily, it is better not to use much force, but, as before stated, to wait for another opportunity. The removal of the sponge is always followed by more or less flow of red blood, showing a laceration of tissue. The finger may pass the os externum with tolerable ease, and still not be able to pass the os internum, and here it is better to procrastinate a complete exploration than to use an undue degree of force. But if the second joint of the index passes the os externum, the point of the finger is already in the cavity of the uterus; and then, while we press the finger onwards and upwards we should make a counter-pressure with the right hand just above the pubes, grasping the fundus of the uterus through the parietes of the abdomen, and forcing it down on the end of the left index, as we would push a thimble down on it. Were it not for this outward counter-pressure, the uterus would necessarily be pushed upwards before the index, and we should seldom reach the fundus. There are good reasons for placing the patient on the side, and using the speculum for inspecting the sponge before its removal.

1st: It is satisfactory to know that it has remained precisely where it was placed.

2nd: It is well to see what amount of uterine or vaginal irritation it has produced.

3rd: As the sponge is saturated with a disagreeable discharge, it is well to clean it and the vagina thoroughly before the manipulations necessary for a complete uterine exploration.

All this accomplished, it is a temptation to almost any one to pull the sponge away while the patient lies on the side, with everything so nicely prepared for it

and seemingly inviting to it. But I must specially warn the surgeon against this temptation. 1st: Because if the sponge be removed under these circumstances, with the vagina widely open, the air rushes into the cavity of the uterus, and I am sure that in my early experience I had the misfortune more than once to see metritis follow this accident. 2nd: Because the finger cannot be passed far enough into the uterine cavity for a thorough exploration, unless the external counter-pressure be made with the other hand, which is neither easy nor effectual in any other position than the dorsal.

Having often to recommend the use of sponge tents, I shall necessarily be compelled to speak frequently of them in these pages, and I only regret that they are so disagreeable as remedies. I never use them if I can possibly avoid it, and I never apply them without apologizing to my patient for the very unpleasant effects they produce.

He who gives us an efficient, pleasant, and cheap substitute for sponge tents, will confer a great boon on Surgery. I know of no competent substitute, or I would be too willing to adopt it. Having said so much on this subject, we may now return to "fungoid granulations," as a source of menorrhagia.

To show not only the diagnostic value, but the wonderful therapeutic powers of the tent in such conditions, let me give a case.

Mrs. ——, of bilious nervous temperament, aged thirty-five, as a girl had occasional nervous attacks, and suffered from painful menstruation. She was married at twenty—was sterile—had yellow fever in 1853—and was compelled to leave the South, and go to New York on account of her health. She had menor-

rhagia from the time of the yellow fever, in 1853, till I saw her, four years afterwards. She was scarcely ever clear of a show for more than a week or ten days out of a month. It was not excessive on any one day, but its prolonged continuance had exhausted her strength and worn out her nervous system. She could not undergo the least fatigue—would faint easily, even from emotional causes; had tinnitus aurium and palpitation; and blindness was such a troublesome symptom, that she consulted an oculist, who told her that the condition of her eyes was wholly due to the enfeebled state of her general health. She had taken chalybeates, tonics, ergot, and sea-bathing, without improvement, and at last I saw her in September, 1857. I did not dally a moment with such general constitutional treatment as would be naturally suggested, but at once attacked the offending organ. The vagina was excessively tender to the touch from the ostium vaginæ to the cervix uteri. This was evidently the result of an ichorous sero-sanguinolent discharge that was ever present when the hæmorrhage, properly speaking, ceased. The uterus was retroverted—the posterior wall consequently hypertrophied; the os was very small; the cervix rather long and acuminated,—which anatomical peculiarities explained her symptoms previously to marriage and her subsequent sterility. From the history of the case, and from the volume and general condition of the uterus, I expected to find an intra-uterine polypus. However, the sponge tent alone would put all speculation at an end. I should have said that the irritability of the vagina was so great that I could only use the smallest or virgin-sized speculum; and I was obliged to resort to emollient vaginal injections and to glycerine applications, for a few days, to

render any speculum examination at all bearable. This done, a very small sponge tent, not more than an inch long, was passed into the cervical canal. It was worn without inconvenience for twenty-four hours. It was barely large enough to open the os uteri from the size of a No. 3 to that of a No. 8 bougie. But this was enough to permit me to look into the canal, where I could plainly see the source of the mischief. Fig. 16

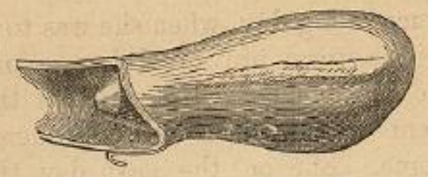

Fig. 16.

would represent the general outline and relative position of the uterus before the sponge tent was used; while fig. 17 would show a vertical section of the organ

Fig. 17.

after its removal, when I could easily see the vegetations on the posterior surface of the cervical canal, as shown in the diagram. These could have been scraped away with Recamier's curette; but I was anxious to open the canal more largely and further up, into the cavity of the uterus, with a view of more easily applying the curette, and with the hope of clearing away

whatever there might be above the portion that was visible. Accordingly, I introduced a tent two inches long, and large enough to fill completely the already partially-dilated cervix. Of course it passed over the crop of fungoid granulations, pressing them firmly down into the very surface from which they sprang. I directed this lady to call again next day. Her residence was not less than five miles distant from my own.

On the succeeding day, when she was to have come to me, a furious storm prevented her going out, and, as she felt no inconvenience, except from the fetor of the sponge-tent watery discharge, she determined to remain at home. But on the next day the weather continued in the same state, it being the time of the equinox, and I did not see my patient for seventy-two hours after the introduction of the tent. I need not say how anxious I felt, for I greatly feared the consequences of its prolonged retention. When I came to examine the vagina, the stench from the sponge was almost unbearable, and the patient declared that it had kept her in a state of nausea for more than twenty-four hours.

Its removal—by no means easy—was followed by a sudden profuse gush of bright red blood. I was so much alarmed that I did not dare to resort to the curette lest I might add to the irritation already set up in the parts. But of this I satisfied myself that there were no longer any vegetations in the cervix so far as could be determined by the touch. I did not permit this lady to return home for three or four days, but detained her in New York till I was sure that she was over the dangers, if any, of the prolonged retention of the tent. No medicine was given, and nothing

more was done, but she was sent home to await the return of menstruation.

This came in due time, and lasted three days, instead of seventeen or eighteen as before, being natural in appearance and quantity. She was thus cured by the sponge tent alone in three days, and subsequently became a mother.

A sponge tent is to us a sort of necessary evil. We cannot do without it. It is not to be denied that, while it is powerful to do good, it may also be equally powerful to do harm. From a very large experience of sponge tents in uterine disease, I am now firmly convinced that we ought never to apply them, under any circumstances, in the consulting-room.

Whenever they are to be used, the patient should make up her mind to remain in-doors, if not in her bed-room, for some days, and this even when used only for a day. In hospital practice I do not remember a single mishap from them, simply because the patients did not go out and expose themselves to the vicissitudes of the weather. Whereas, after applying them in the consulting-room, I formerly had several accidents from them before I could be convinced of their noxious properties. However, with ordinary care, the tent is as safe as any remedy capable of doing good. And, since I have adopted the plan of treating private patients as I do hospital ones, by keeping them in-doors during the time of sponge tenting, I have had no cause to complain of this agent. This course was forced upon me by more than one such case as the following :—

Mrs. ——, aged thirty-four, married twelve years, the mother of three children, the youngest five years of age, always had rather profuse menstruation, but since her last labour it became very profuse, lasting ten or

twelve days, and requiring the use of six or eight napkins a day, and sometimes many more. She also had leucorrhœa. She was of plethoric habit, but began at last to feel the effects of the unnatural loss of blood. She had been treated locally and constitutionally without improvement.

The uterus, somewhat anteverted, was much larger than it should have been, and the os and cervix were granular. I, like the physician who preceded me, attempted first the cure of this condition. In the course of three months my patient was better of the leucorrhœa and granular erosion, but the menstrual flow was as profuse as ever. I then determined to explore the cavity of the uterus, expecting to find there a fibroid or polypoid growth, as the body of the organ was evidently larger than it should be. Accordingly, a small tent was introduced, and she was directed to return the next day. She did so, having suffered no inconvenience from it. It was removed, and a longer and larger one introduced, and she returned home in a stage, a distance of about four miles. This was in January, and the ground was deeply covered with snow. She came to see me the next day, saying that she was chilly the night before. She was then feverish, seemed to be quite ill, and complained of pain in the hypogastrium, nausea, &c. I removed the tent, but made no effort at uterine exploration. She returned home, had metro-peritonitis, was dangerously ill for many weeks, and, fortunately, eventually recovered, but never again to place herself under my care. Now, if I had visited this lady at her own residence, and applied the same treatment, I am very sure that she would not have had the serious illness that was evidently produced by her exposure in snow storms, two days in succession, while

she rode each day, to and fro, a distance of at least eight miles, besides the exposure of crossing the ferry to Brooklyn in a boat heated to, perhaps 80 degrees, while the temperature outside was not more than 20° F. During this same winter ('58) I had two or three other cases similarly unfortunate. I then resolved not to use sponge tents again on riding or walking patients, and since then I do not remember an accident from them—and this is saying a great deal in favour of their innocuousness. However, I use them now with greater caution—for instance, when I knew less about them than I do now, I invariably allowed a tent to remain twenty-four hours; on its removal a second was usually introduced to be worn another twenty-four hours; sometimes a third was introduced for another twenty-four hours; but generally, indeed almost always, I subjected the uterus to this treatment for at least forty-eight hours. Whereas now, as I have already described (page 50), the whole process should not occupy more than from twelve to twenty-four hours at any one time.

The power of the sponge tent to modify the uterine surfaces with which it lies in contact is truly wonderful. It dilates the neck of the womb; it softens it by pressure, and by a sort of serous depletion; it reduces the size, not only of the neck, but of the body of a moderately hypertrophied uterus; it destroys not only fungoid granulations, but even large mucous polypi; and in one instance I saw a sponge tent destroy wholly a fibrous polypus as large as a pigeon's egg.

This was accidental, but it demonstrated clearly what the sponge can do by pressure and capillary drainage.

When introduced into the cervix, the tent soon absorbs moisture, and expands. It may produce a little pain, but it is of no moment, and ceases ordinarily

when the dirty serous or sero-sanguinolent discharge begins. The meshes of the sponge and the surface with which they are in contact become, after some hours, intimately incorporated. The sponge forces itself into the very structure of the cervix, and the mucous membrane of the cervix shoots out into the interstices of the sponge, so that it is somewhat difficult to separate the two if the tent has been worn for any length of time. On its removal, there is necessarily a laceration of the tissue incorporated with it. This lacerated surface generally heals smoothly over in a few days after, obliterating every trace of the original indolent fungoid growth that gave rise to the menorrhagia. Thus, it seems to perform the duties of M. Recamier's curette in a most efficient manner, but I do not pretend that it would always supersede it.

The curette is simply the adjuvant of the tent, and always to be preceded by it. But there are cases where their relationship is changed, the sponge becoming the adjuvant of the curette, and this is when the fungoid granulations are at the fundus uteri. Then the sponge is to dilate the cervix for the more easy application of the curette.

In cases of menorrhagia that resisted all other treatment, Recamier passed his curette into the uterine cavity, and raked it out as thoroughly as possible. This was before the days of sponge tents. But now we first dilate the cervix, pass the finger into the cavity, ascertain precisely the seat of the fungoid growth, pass the curette by the side of the finger, and thus operate more understandingly.

Fig. 18 represents the curette that I use; the handle is malleable and may be bent laterally, or backwards, or forwards, in the direction of the dotted

lines, *a*, *b*. Thus it can be used with equal facility on any portion of the uterine cavity. I have lately had it made with a ball and socket joint, in the middle of the shaft, but the simple instrument, as here delineated answers quite as well.

Fig. 18.

To show the power of the sponge to destroy mucous polypi, I will select one, and only one, of many cases that I might bring forward.

In November, 1862, I was consulted by a lady in Paris, who was seemingly a perfect specimen of health, but she was sterile. Menstruation had always been rather profuse, lasting eight or nine days.

The uterus was retroverted, but what would seem contradictory, it was also anteflected. Suffice it for the present to say, that the cervical canal was enlarged by a bilateral incision. The operation was performed in December, 1862, with the assistance of Sir Joseph Olliffe.

The parts as usual healed before the next menstruation, which, however, was not much influenced by the operation, for it went its usual course of eight or nine days. After it was over I was examining the condition of the cervical canal, and to my surprise, I saw the end of a mucous polypus or enlarged nabothian gland lying high up in the canal, as shown at *a*, in fig. 19. I passed a sponge tent in the morning along the canal of the cervix, above and beyond the seat of the polypus. In the afternoon I removed the tent and

introduced a longer and larger one, and allowed it to remain till the next morning. On its removal there was no trace of the polypus to be found. Menstruation

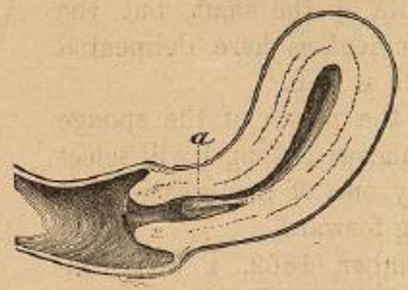

Fig. 19.

immediately became normal, and has continued so ever since.

This power of the sponge tent to destroy polypoid growths was accidentally discovered at the Woman's Hospital in this way. In 1856 a young unmarried woman entered the hospital with a menorrhagia that had bled her quite into a dropsical condition. The flow was almost continuous, but attended with no great degree of pain; she was perfectly anæmic from loss of blood; had general anasarca, and was of a waxy hue. We did not suspect the true character of her disease; and Dr. Emmet and myself agreed to give her a nutritious diet, with chalybeates; and so she went on bleeding for several days longer, and a sponge tent was then introduced. The uterus did not seem to the touch to be much enlarged, and it was only two inches and a half to the fundus. The cervix was small, and the os was correspondingly so. When the tent was removed there presented one of the most perfect specimens of fibroid polypi that I ever saw. The

diagram (fig. 20) shows its attachment and relations.

It had given me much trouble, and was a nice case for operation, which might have been performed at the

Fig. 20.

moment, but I was anxious to show it to the Consulting Board of the Woman's Hospital, and concluded to put off its removal till the next day, which was the day for their regular meeting. Accordingly I introduced a large sponge tent, expecting to remove it on the following day, and complete the operation in the presence of the Board. Singularly, they did not meet, and the poor patient with the sponge tent was completely forgotten. I expected Dr. Emmet to remove the tent, and he thought I had done it; and the nurse, who, by the by, never forgot a patient, supposed we had left it intentionally. However, about a week afterwards, the nurse begged to call my attention to the young woman with the sponge tent, saying she thought "it must be rotten by this time, as the other

patients in the same ward with her could not stand the smell of it any longer." My mortification at such neglect, added to the dread of serious results to the poor patient, may well be imagined. However, she was soon on the operating table, complaining of nothing but the intolerable fetor of the sero-sanguinolent discharge, which had been going on constantly for a whole week. The sponge and the tissue of the cervix seemed to be thoroughly amalgamated, and it was necessary to push the point of the finger up between the two, and gradually separate them all round before making traction on the sponge with the forceps. I never performed a more unpleasant operation than the removal of the sponge; the stench was such as to make one of the nurses vomit. When the tent was introduced a week before, the tumour was accurately measured, its volume, density, and attachment all definitely settled, and easily so. It was a dense, firm, fibrous polypus, about the shape of the diagram on page 63—a little larger, and having attachment to the fundus as there represented. My surprise may be imagined when, on introducing the finger into the cavity of the uterus, after the removal of the tent, there was not a vestige of the tumour to be found. The pressure and drainage by the sponge had eradicated it entirely. The patient speedily recovered, and was soon restored to a vigorous state of health. Notwithstanding the happy result of this accident, and the valuable principle thereby established, I would not recommend it as a rule of practice in fibroid polypi. For the danger of metritis by the prolonged contact of such an irritant, and the still greater danger of pyæmia from the disintegration of tissue, would render it too hazardous. However, the tent may always be trusted to

destroy fungoid growths and small mucous, or nabothian polypi, when they cannot be otherwise removed. Dr. Emmet, surgeon to the Woman's Hospital, whose experience with the sponge tent is very large, has the greatest confidence in their safety as well as efficiency. I have seen him repeat them day after day, and I have often heard him say that he has succeeded in doing more for general hypertrophy of the uterus by this means in a week than could be accomplished by any and all others in two or three months.

I have said a good deal about the disgusting discharge produced by the sponge tent. While at Baden-Baden in the summer of 1863, I had occasion to use a tent, and apologized to my patient for its bad effects. In her case I had been previously using glycerine dressings to the womb. As the tent showed a little disposition to slip down, I applied a pledget of cotton, saturated with Price's glycerine, over the neck of the uterus, simply because it was convenient to do so. When I went to remove the sponge in the afternoon, my patient told me that the discharge had no bad odour, and, on examination, I found the pledget of cotton and tent, after removal, perfectly devoid of any fetor. I have now often used this as a disinfectant of the sponge, and find it infallible in its results. The only objection to it is that it sometimes prevents the sponge from expanding to its fullest extent.

I have used tents of the Laminaria digitata, and think well of them, but they can never wholly replace the sponge tent. There is much trouble in retaining them properly in place. It is often necessary to prop them up with a tampon, and even then they slip out. Besides this, they require a much longer time to dilate the cervix. However, they are a valuable addition to

our surgical resources, and for them we are greatly indebted to the late Dr. Sloan,* of Ayr, Scotland.

Dr. Greenhalgh has improved the Sea Tangle tent very much, and it happened in this way. He had some trouble in getting a pair of forceps made specially for their introduction, and the idea occurred to him to perforate the lower end of the tent for the insertion of a stylet, which answered a good purpose. But he soon discovered that the perforated part dilated more easily and to a greater degree than the rest of it. He then had the perforation made through the whole length of the tent, when he found that it acted more rapidly and more efficiently than before. The tents of commerce up to this time were tied round with a thread at the lower end to facilitate their removal. This interfered with the dilatation, by preventing the expansion of the tubular perforation below. He then had the thread fastened to one side of the tent as shown in the diagram (fig. 21). I agree entirely with Dr. Greenhalgh that the tent should not, as a rule, exceed two inches in length.

Fig. 21.

Prepared after Dr. Greenhalgh's plan, it is much softer when removed from the uterus than the solid tent, and the perforation is found of be dilated in proportion to the expansion of the solid part, thus serving as a drain to facilitate the escape of any secretions from the cavity

* *Glasgow Medical Journal*, October, 1862.

of the uterus. Notwithstanding all this, I regret to say they do not fulfil all the indications of the sponge tent, and cannot wholly replace it.

Of Menorrhagia from Polypus.—Having spoken of menorrhagia as a sequence of granular erosion, of cervical engorgement, and of fungoid granulations, we now come to consider it as a concomitant of polypus. Accoucheurs and pathologists have described polypi as soft, hard, mucous, glandular, cellular, cystic, fibrinous, fibro-cellular, fibro-cystic, and fibrous. These several divisions are anatomically and pathologically correct; but as I am taking only a surgical view of the subject, I prefer to classify them topographically, that is, not according to their own structural elements, but simply according to their point of origin, which, by the bye, is the simplest method of arrangement. Thus, I would say that uterine polypi are naturally divided into three classes:—

1st. Those growing from or about the os tincæ.
2nd. Those growing in the canal of the cervix.
3rd. Those growing in the cavity of the uterus.

The first may be fibro-cellular or mucous.
The second are almost always mucous.
The third are almost always fibrous.

I propose to give clinical illustrations of these subdivisions.

In the first class they may be large or small. If of the fibro-cellular variety, they may attain an enormous size. I have seen them almost as large as the fœtal head at term. If of the mucous variety, they seldom grow larger than an English walnut, and are usually somewhat flattened by pressure between the cervix and