on each side of the neck of the bladder. Theoretically and practically the instrument is admirable, when neatly fitted and properly managed. Its expensiveness was the chief objection to its general use. Dr. Hodge modified his instrument for ante-versions, by placing a cross-bar on its front or open end, thus closing it up entirely, and making a sort of sigmoid parallelogram of it (fig. 112). This form of the Hodge instrument is commonly adopted by the profession in my own country, whether it be made of silver, block-tin, vulcanite, or gutta-percha. We seldom use the other one.

Hodge's instrument may be found in the shops variously modified. For instance, they are made of hard rubber, and sold in great quantities; but these are very dangerous, for they are generally too large, and are fashioned into anything but the right shape; and I have found it impossible to give them the proper equilateral curvatures by heating them in boiling water as is recommended. What is better than the hard rubber, but not so cleanly, is a copper wire covered with gutta-percha. But even here we have a right to complain of all our instrument-makers; for they have taken the common insulated telegraphic wire, cut it into slips of various lengths, and most clumsily fastened the two ends of these together in a ring, and then curved them as we find them. They do this to sell them a few pennies cheaper. This is poor economy; for they often get fractured where they have been joined; the secretions then enter the little cracked fissures, and the instrument becomes a source of irritation instead of comfort. Instead of this, the malleable copper wire should be first made neatly into a ring or parallelogram and then smoothly covered with gutta-percha, not varnished. I have persuaded at least two instrument-

makers (Mr. Weiss and Mr. Charrière) to remedy this evil. Away with cheap things! whether drugs or instruments, for our sick, especially for our sick women; and more especially still when they are afflicted with such fearful calamities as we are now considering.

But my country holds another name equally as honoured and respected, and equally as authoritative as that of Hodge, in advocacy of the mechanical treatment of uterine displacements. In 1853, Professor Charles D. Meigs published his report on uterine diseases before the American Medical Association, in which he promulgates the same views so long taught by his illustrious confrère, Professor Hodge. Dr. Meigs's instrument differs from Hodge's, but its principle of action is the same. While Hodge's is a curved parallelogram, Meigs's is simply a ring, acting upon the same principle of distending the vagina antero-posteriorly, by making the posterior cul-de-sac and the inner face of the symphysis pubis the points of support. It, too, holds the neck of the womb back in its proper place, and does not interfere with sexual intercourse. Meigs's ring pessary is made of watch-spring, fashioned into a circle, two, two and a half, two and three-quarters, and three inches in diameter, and then coated with gutta-percha (fig. 111).

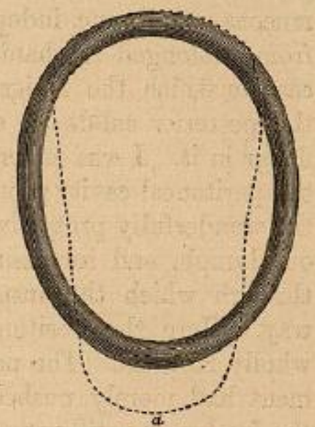

FIG. 111.

It is introduced with great facility, by compressing its opposite sides, thus elongating it in one direction,

—dotted line *a*, while its diameter in the other is diminished. As soon as it passes the arch of the pubes, it recovers its original form, but seldom ever becomes perfectly circular again, unless it is a very small instrument. If a large one, it takes an oval form after being worn for any length of time.

These are often worn for a good while; but in a general way, as before stated, I am opposed to the principle. I have often removed the Meigs ring-pessary after it had been worn continuously for ten or twelve months. In five or six weeks it becomes coated with a thick layer of brownish sordes, having a most disgusting smell. This, of itself, must irritate the vaginal mucous membrane, independently of mischief resulting from prolonged mechanical pressure. I have seen one case in which the Meigs ring had ulcerated a sulcus in the posterior cul-de-sac deep enough to hide the little finger in it. I was surprised that it had not perforated the peritoneal cavity; but a close investigation revealed the wonderfully protective powers of nature in throwing out lymph, and increasing the thickness of the tissues through which the instrument had gradually cut its way. Here the position of the womb had not been wholly rectified. The pelvis was deep, and the instrument had merely pushed the cervix backwards, while the fundus was still retroverted. Perhaps this was well for the patient, for the cul-de-sac of the vagina and the posterior wall of the uterus seemed to be agglutinated firmly together,—doubtless the result of the pressure and ulceration of the ring, for I had examined this case some months before the ring was applied, and there was nothing of the sort then.

I saw another case at the Woman's Hospital in 1861, where a Meigs ring had been worn continuously for

nearly twelve months. At first it produced great relief, but after a while there was an excessive muco-purulent discharge from the vagina, and it was for this that advice was sought at the Hospital.

We often see pessaries of this sort produce mischief by being too large, but here it was the contrary. The cervix and a portion of the anterior wall of the vagina seem to have gradually descended too far through the small ring, and to have become almost strangulated. It had cut a deep circular sulcus all around the cervix, deeper posteriorly and on the sides than anteriorly; and in this sulcus the ring was entirely hidden from view except just at the neck of the bladder, where it was more superficial. On the removal of the instrument, which was both difficult and painful, its bed was seen to be a deep suppurating chasm, with granulating edges that had entirely overlapped the ring behind and on the sides. The cervix uteri was also very granular, and greatly engorged, seemingly in consequence of the strangulating pressure of the ring. All of this disappeared with the filling-up and healing of the sulcus, which occurred in the course of a fortnight.

While I advocate, and daily use pessaries of some sort, it is but just that I should say all I know against them, simply as a warning of danger to others. In this case the fault was with him who applied the instrument, and turned his poor patient adrift without giving her instructions in its use. I have seen more mischief from the Meigs ring than from Hodge's instrument. I presume the reason is, that when it was first introduced it was a cheaper instrument than any other then in vogue; was therefore more universally used; and, consequently, presented comparatively larger opportunities for observation.

If the object be to cure the sterile state while we

treat the malposition, I always use an instrument on the same principle as those above described. Besides the Hodge and Meigs instruments, as we find them in the shops I often use rings made of block-tin softened by the addition of a little lead. These I introduced in 1856. They are made of different sizes, varying from two to three inches in diameter. The material, if tubular, may be a third of an inch in diameter; much less if solid. It matters not whether it be of block-tin or gutta-percha, so it is malleable. Select a ring to suit the capacity of the vagina; compress it gently between the hands till it takes an oval form. It is then in imitation of a Meigs ring, and may be so used; but sometimes it is better to give it the natural curvature of the vagina, after Hodge's plan, by making the distal end *b*, fig. 112,

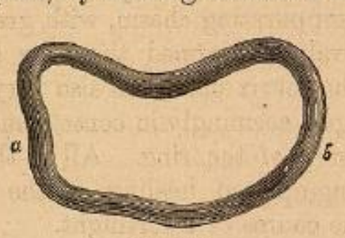

Fig. 112.

pass up behind the neck of the womb, while the proximal end *a* has a slight counter-curvature where it presses the neck of the bladder against the symphysis pubis. Great nicety is necessary in fitting an instrument so as not to injure by pressure the neck of the bladder, the posterior cul-de-sac, or the floor of the vagina, upon which rests the great curvature. It will be difficult to get one instrument with its exact proportions to fit any two cases; and it is often difficult to fit any given case. It has frequently taken me a fortnight, and sometimes much longer, to adjust an instrument

accurately; and sometimes it has been utterly impossible for me to do it at all. When I succeed in fitting the case exactly, *i. e.* in supporting the womb in its normal position without undue pressure on the vaginal parietes, I usually send the model made of this malleable material to the instrument-maker, to be duplicated in vulcanite or silver, if the patient is to leave my care wearing an instrument. The block-tin pessary is quite as good as a silver one; but then the patient in removing and replacing it may spoil its shape, and make it hurtful instead of beneficial. If, however, the patient lives near enough for me to see her occasionally, I seldom order any other instrument than the block-tin one.

As I said before, the case related on p. 266 gave me new views of practical utility, that were not lost; for a lady, twenty-six years old, soon after this came with her husband to consult me on account of her sterility (acquired). She had had one child six years before. It died early, and they were exceedingly anxious for more offspring. She had been treated at different times by several distinguished physicians, all of whom put her through "a course of caustic,"* but her symptoms remained the same, and her sterility persisted. On examination, I found the pelvis deep, the vagina capacious, the perineum relaxed, and the uterus completely retroverted, but not difficult to replace. The posterior wall was, as in all such cases of prolonged malposition, somewhat hypertrophied, and there was also some little engorgement of the posterior lip. Her symptoms of vesical tenesmus, bearing down, &c., were evidently the result of the error of position, and I told them it was

* It was unfortunately the fashion a few years ago in my own country to cauterize the neck of the womb, without reference to conditions or indications.

quite impossible for her to conceive with the uterus in its abnormal position. I concluded to treat the case entirely mechanically, but it was very difficult, for I did not then possess the tact in adapting an instrument to the peculiarities of the case, that observation and enlarged experience can alone give. It took me nearly a month to adjust it so that it could be worn without pain or undue pressure; but once fitted, there was no inconvenience from it; on the contrary, the greatest comfort. The ring, moulded as described, was fully three inches and one-eighth in diameter before giving it the form of a sigmoid parallelogram. A special injunction was that it should be worn during sexual intercourse. Conception occurred in three months. She continued to wear the instrument till after the third month, when the uterus had risen up above the brim of the pelvis, and then it was removed. She was delivered, at full term, of a fine healthy boy, which was turned over to a wet-nurse. She was in hopes that conception would soon occur again, but it did not; and at the end of eighteen months she returned to ask an investigation of her condition, and, if necessary to insure an early conception, the reapplication of the instrument.

I found the uterus precisely as it was when I first saw her. It had no self-adjusting power whatever. It could be replaced with facility, but dropped back as soon as the finger was removed. I gave it as my opinion that conception could hardly occur again with the uterus persistently retroverted. I therefore re-applied the same instrument with injunctions to wear it as before during coition. Conception occurred in eight weeks afterwards. About fifteen months after the birth of the second child, she came again, and I found the uterus precisely as it was at the first consultation.

I adjusted another instrument to prop it up, and gave the same injunctions, and in ten months afterwards she was again a mother.

Now, in this case, I believe that conception could have been brought about as easily five years sooner, if the same treatment had been adopted.

To establish the utility of the pessary during coition, in cases of sterility dependent upon retroversion, I must continue my notes. The case above was uncomplicated. There was simple relaxation of all the pelvic supports of the uterus, and it tilted over backwards, and will remain so always, unless it be propped up mechanically. Occasionally a malposition of this sort is cured by a pregnancy, but often it is not.

In 1856, a lady was brought to the Woman's Hospital, who had been bed-ridden for more than two years. She was thirty-two years old; was married at twenty; gave birth to a child in ten months, but she remained sterile afterwards. She became a widow, and married again at thirty. Twelve months afterwards she ran hurriedly into the garden to bring in some clothes that had been hung out to dry. On reaching up quickly, she felt something suddenly give way in the pelvis; she had great pain, and immediately went to bed, suffering also from nausea, vomiting, and excessive prostration. Her physician was sent for, and attended her for many months, but without much improvement. I found the uterus completely retroverted, and greatly enlarged, with the fundus directed towards the left sacro-iliac symphysis. The enlargement, or rather elongation of the organ, was due to a fibrous tumour growing from the fundus, which explained its diagonal direction, for it was too long to lie retroverted in the median line. To remove the fibrous tumour was

out of the question; to allow the uterus to remain where I found it, was to consign her to her fate without an effort for her relief. My only hope of affording her any permanent benefit was in elevating the uterus, supporting it in position, and giving her the possibility of a conception. When it was so elevated into position, the tumour could be distinctly felt on the fundus, above the promontory of the sacrum. But of course it would fall back into its old position, as soon as the finger and the uterine elevator were removed. By repeating this every day for a week, the uterus became sufficiently tolerant of manipulation to allow the use of an intra-vaginal support. A malleable block-tin ring, about two inches and a half in diameter, was fashioned into the form of a parallelogram, and curved on its long axis, as already described, so as to give it a slight sigmoid flexure. The vagina was rather small, and great care was necessary not to inflict injury by undue pressure in the posterior cul-de-sac, or against the neck of the bladder and the symphysis pubis. The instrument was worn at first for a few hours, but soon it was worn during the whole day, and after a short time she was able to walk. In two or three months she returned home, not cured it is true; but the uterus was elevated into a proper position, and there supported by the simple little contrivance already described. With the hope that conception would take place, she was directed to wear the uterine supporter always during coition. Six months after leaving the Hospital she returned for observation, and was found to be pregnant four months and a half, having conceived in six weeks after returning home. She had worn the instrument all the time except when she removed it for cleaning.

She went the full term and was safely delivered. I saw her some months after the birth of her child. The uterus was in its proper position, but the tumour was about the same. Without mechanical aid here, I do not see how it would have been possible to have done anything at all for this poor sufferer. There was nothing whatever attempted for her but the replacement of the dislocated uterus, with this vaginal splint, as it were, to support it in its proper relations. This case might be called cured, so far as the mere position of the womb was concerned. It is very probable that the fibrous tumour had existed a long time on the fundus, and that it assisted by its weight when the uterus was suddenly retroverted in holding it down in its abnormal position, and I have as little doubt that the same condition now assists in holding the uterus erect. The pelvis in this case was of ordinary capacity, while in the case previously related it was very deep, with a rather straight sacral promontory.

It might be supposed *à priori* that any instrument in the vagina would interfere with coition. I usually make it a rule to explain the necessity of the treatment to the husband as well as the wife. So far as our sex is concerned, the knowledge of the presence of a vaginal support might be an unpoetical association; but if it is properly adjusted, it is not at all in the way. Sometimes the wife has insisted that it was not necessary for the husband to know that the uterus was thus artificially braced up. The instrument should be neither too large nor too small, and should fit snugly up behind the symphysis pubis.

In 1861 I was consulted by a young widow, who had a proposition of marriage. During her first marriage she had had one full term labour, and three or four miscarriages at about the third month. Her physicians told

her that she would probably always miscarry at the third month. It was her opinion that few men would marry if they did not expect to be blessed with off spring, and she herself looked upon children as necessary to the complete happiness of married life. With these views she was unwilling to marry unless she could have some assurance that the habit of aborting could be broken up; and upon this point my opinion was asked. I found the uterus completely retroverted, with some enlargement of the posterior wall from long error of position. I explained to her that her miscarriages were almost certainly due to the retroversion; that conception would in all probability occur with her, and that the pregnancy would go to its full term, provided the uterus was kept in its normal position, till it got large enough to rise above the brim of the pelvis. On this assurance the offer of marriage was accepted; and in two months my patient was ready for its fulfilment.

Having adjusted an instrument to hold the uterus in proper position, and having instructed her in its management, the wedding day was fixed at the time she expected to finish the menstrual period. The marriage took place early in January, on the very day of the cessation of the flow. The happy couple immediately left for New Orleans, and in a month afterwards I received a note from my patient saying she was undoubtedly pregnant.

As she did not wish to consult any other physician, and as I was exceedingly anxious for her to pass the third month without a miscarriage, I directed her to wear the instrument till she quickened, and then to remove it. At the full term she was safely delivered.

Now here was a case in which the husband had no idea that there had ever been any uterine disease or any

mechanical treatment, and does not know it to this day. The case is valuable as showing the protective power of a normal position against the dangers of abortion. There is no more common cause of abortion than retroversion, if we except imprudent and excessive coition, and for the simplest of all reasons. A retroverted womb is impregnated; impregnation only aggravates the malposition; the uterus and its contents grow apace till it is jammed with the fundus under the promontory of the sacrum, from which it has no natural tendency to escape. When it gets to the third month, it must either rise above the brim of the pelvis, or throw off its contents. If it fail to do the one, the other generally takes place. If we do not detect the malposition, and rectify it in time, a miscarriage is the almost inevitable result. I am sure I have often prevented miscarriage by rectifying a retroverted uterus.

Here is an example. A lady, twenty-eight years old, had had two labours at full term. Afterwards she had a miscarriage at the third month. She subsequently became pregnant, and at the end of two months and a half she was again violently threatened with all the symptoms of a speedy miscarriage. I found the uterus retroverted, with the cervix against the pubes, and the fundus jammed under the sacral promontory. The uterus was gently replaced, and a Meigs ring three inches in diameter was introduced to hold it in its proper position. The rectification of the malposition was immediately followed by a relief of all uterine symptoms. The instrument was worn for a month, being changed every three or four days. She went the full time, and was safely delivered. This case serves very well as an illustration of a principle, and as an example of its class.

The cases already narrated as exhibiting the influence

of the pessary in facilitating conception, and, therefore, in curing the malposition, were such as had conceived previously. But I have frequently seen the same thing in the naturally sterile. In 1858 Dr. Silas D. Scudder, then house-physician at the Woman's Hospital, found amongst the out-door patients a woman married ten years without issue, who was very desirous of offspring. She had retroversion, but what the complications were, if any, I do not know. However he fitted a malleable block-tin ring to the vagina, and she conceived in two months afterwards. He allowed her to wear the instrument long enough to guard against a miscarriage (three months), and she went the full term.

In 1857 a lady from the South consulted me in reference to her sterility. She had been married fifteen years without conceiving. Her beautiful physique and fine general health were all that could be desired; but she had painful menstruation. The uterus was retroverted, and she had a fibrous tumour, as large as an English walnut, in the posterior wall, while the os was contracted and the cervix indurated.

The uterine sound, sponge tent, and bi-manual palpation, showed that the enlargement *a* (fig. 113) was

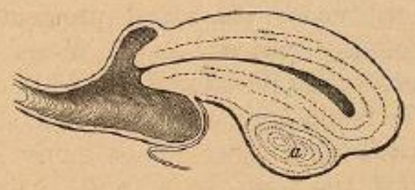

FIG. 113.

a distinct tumour, and not a mere hypertrophy of tissue, as we so often see in old retroversions. The indications

were the same as if there had been no fibroid tumour; viz., to enlarge the os and cervix by incision, and then to adjust an instrument to hold the uterus *in situ* during coition. From the contraction of the os and the induration of the cervix, I was satisfied that the case would have been sterile even with a normal position of the uterus. Besides, given a perfect state of the os and cervix, the malposition would militate against the probabilities of conception. Therefore the os and cervix were divided bilaterally in April, 1857. The ring was fitted after the next menstruation in May, and in August she conceived; but unfortunately a fall, three months afterwards, in November, produced a miscarriage; and she had another miscarriage in June, 1858, at about the third month. This, too, was associated with an accidental fall. It was accompanied by great loss of blood, and followed by a serious metritic inflammation, from which she did not recover for several weeks, during which time she was carefully attended by Dr. Griscom, of New York. As soon as she was able to leave the city, we sent her to Saratoga to recuperate, and she returned to New York in November, her general health being again very good. It was now eighteen months since we began to treat her case. She had had two miscarriages, which we might have attributed to the fibroid tumour, if the attending circumstances had not each time been sufficient to have produced the unfortunate result. But the worst feature of the case was that we were now precisely where we started, for the metritic inflammation following the last miscarriage had reproduced the contracted puckered condition of the os, which now looked as if it had never been subjected to a surgical operation; while the cervix felt, perhaps, more gristly than before. What was to be done? We were

all in a hurry for another conception. Her husband could not remain much longer away from home. I proposed to repeat the operation of incising the os and cervix, to which, like a true woman, she at once assented, and it was done after the next menstruation. In a few weeks (January, 1859), she was pronounced fit for the married life. The os was open, and the uterus held erect by a well-adjusted instrument, which, as before, she was directed to wear during coition. Conception fortunately occurred just after the next menstruation, and we watched her most carefully during the whole period of utero-gestation. She wore the instrument nearly up to the time of quickening, when it was removed altogether. She now acknowledged to having removed it as soon as she found out she was pregnant, each time before, which doubtless had much to do with the miscarriages that followed the falls. She went safely the full term, and was delivered by Dr. Griscom, of a son, on the 1st December, 1859.

We kept this patient in the horizontal position for five or six weeks after confinement, with the hope that a perfect involution would be effected before she resumed the erect posture, and that the uterus might stand a good chance of remaining in its proper position afterwards without instrumental aid. When she left for the South, two months after her delivery, the uterus remained in a normal position; but the best evidence of a perfect cure having been effected, is afforded by the fact that fifteen months after her confinement in New York, she was safely delivered of twins at her home in the South.

This case is interesting in many particulars:—

1st. It shows, what has been observed by others, and what I have seen many times before and since, that a fibroid tumour does not necessarily impede conception, gestation, or delivery, all other things being equal.

2nd. It shows that it is possible, even in very difficult cases, to understand the obstacles to conception, and to remove them by persistent continued effort, if our patient has sufficient fortitude and endurance.

3rd. It shows that it is possible to cure a retroversion, and even to cause the disappearance of a fibroid by the modified nutrition of utero-gestation.

I am aware that this reiteration of cases is irksome; but, as I have said before, I write mainly for the young and inexperienced; and how am I to impress upon their minds the truth of my views but by giving them the facts and circumstances that have gradually led my own convictions where I myself find them, without any prejudices or preconceived opinions on the subject?

I could here detail many, very many cases like those already related; but enough has been said, and I leave this part of the subject with the simple statement of the above facts, which strike me as having an important bearing on the subject under consideration.

It might be supposed from what I have said about pessaries, that every case of retroversion is capable of being rectified by an instrument. If so, let me hasten to correct the error. I am sorry to say that there are numbers of cases in which a pessary is absolutely out of the question. In many women the vagina is so delicately organized that it is perfectly intolerant of any hard substance, and in a few, about the time of change of life, it will not bear the presence of a soft sponge, or even a bit of cotton. In some there is a chronic metritis, which forbids mechanical means; and in

others peri-uterine inflammation or a prolapsed inflamed ovary.

We occasionally find a retroversion conjoined with an anteflexion. When this is the case, the infra-vaginal cervix is almost always too long; and we often find the supra-vaginal portion indurated, tender, and very sensitive, just above the insertion of the posterior wall of the vagina. In such cases it will be impossible for the patient to wear a pessary, on account of its pressure behind the cervix. I have not as yet amputated a cervix under these circumstances, but I am very sure that it would be better to do this, if we wish to treat the sterile condition successfully. I have been in the habit latterly of managing these obstinate cases simply by introducing a plug of fine cotton, or, as it is called in England, cotton-wool. I have alluded to this before, p. 245.

A pessary of cotton can be worn with great comfort if the vagina itself is in a normal condition. In preparing it, we must be careful not to pull the cotton in pieces, but let it be one compact mass of the desired size, carefully tied in the middle with a strong thread for its ready removal. We may use it simply so, or medicated with glycerine or tannin, or anything else we may wish. If it is unmedicated, it must not be worn longer than twenty-four hours. It is enough to wear it while awake. If we use glycerine, we may leave this tampon pessary two or three days, or till it falls out. The glycerine is disinfectant, and the cotton remains without odour. It is important for the convenience and comfort of the patient, to teach her to apply and remove the cotton pessary herself. For this purpose I have invented a porte-tampon, which answers a most admirable purpose.

Fig. 114 represents the porte-tampon. The requisite quantity of cotton, tied in the middle with a strong thread some eight or ten inches long, is placed in the porte-tampon; the lid is shut; the instrument is introduced like an ordinary speculum, the patient on the back; it is to be pushed firmly and forcibly backwards and downwards under the cervix to the posterior cul-de-sac. When we are satisfied that it can go no further without producing pain, then the piston is to be pushed forwards; the tampon is left in its place, and the instrument is withdrawn. The string previously attached to the cotton, hangs from the vagina, and with this the tampon is removed when necessary. One, and almost the only objection to the cotton nowadays, is its expensiveness. Tow is much cheaper, and answers tolerably well. I have had many patients who could not remain long enough under treatment to be radically cured of engorgements, &c., who have gone away with a porte-tampon and appropriate remedies, using it themselves, and getting well without further aid. I have had a few who suffered from hæmorrhages that demanded the tampon, and who were able to control these by applying it themselves by means of this instrument. Of course they had to charge the porte-tampon four, five, or six times, fixing a string to each bit of cotton. I only recommend this where the patient is far

Fig. 114.

removed from prompt medical aid, and where even a small loss of blood is to be carefully avoided.

I have had lately under my care two most obstinate cases of retroversion in which no sort of pessary could be worn except cotton; without the cotton pessary, the uterus in each was turned back to an angle of more than 100° from a normal line, but with this pushed snugly up into the posterior cul-de-sac, the organ was comfortably sustained in position. Each of these patients conceived during the time of using this instrument. They were taught to apply the tampon on rising in the morning, and to remove it on going to bed at night. These are the only cases in which as yet I have seen pregnancy follow the use of this sort of pessary. One of them was a patient of Sir Joseph Olliffe. We tried a variety of pessaries, and were compelled to give up all of them, and resort to the cotton pessary, and the result was as stated.

A year ago, I incised the cervix uteri in a case of dysmenorrhœa where there was a retroversion, with anteflexion, and elongation of the cervix, with induration and great tenderness of its posterior portion, just above the insertion of the vagina. The dysmenorrhœa and the engorgement of the organ were relieved; but the retroversion continued, with its attendant symptoms of pain across the hips, dragging sensations, &c. On account of the tenderness of the cervix when pressed above the posterior cul-de-sac, it was impossible for her to wear any of the instruments that I am in the habit of using. But she could wear a small tampon of cotton with the greatest comfort. She writes: "The uterine support has, I am sure, done great things for me. I now use it about every other day: last month every day. My idea is that it has quite succeeded in its purpose, and that I am as well as any one need be.

Sometimes the broad, flat porte-tampon above figured is difficult of introduction, even in those who have borne children; and then I have been compelled to resort to one made after this fashion (fig. 115). The cotton, which must be properly prepared, is to be pushed in at the open end of the instrument, and this is to be applied as before directed.

Fig. 115.

Of Procidentia.—Whenever the cervix uteri passes through the mouth of the vagina, we call it a procidentia, whether it be to a slight or a great extent. Thus a procidentia may be complete or incomplete: complete, when the vagina is inverted and protruded externally; incomplete, when the cervix uteri alone passes down without bringing the vagina with it. It is only occasionally that we see the cervix alone projecting between the labia for an inch or two, and remaining thus stationary for a long time; usually it goes from bad to worse, till it eventually passes entirely through the vulva, forming a tumour of great size, which, at its most dependent part, presents the os tincæ often ulcerated and bleeding. This tumour is a veritable hernial mass, consisting sometimes of the whole uterus, but oftener of its elongated cervix, the *bas fond* of the bladder, and occasionally intestine, with the inverted vagina as its outer covering.

Fig. 116 represents an incomplete procidentia, and is a type of its class. – See Dr. Bennet's case, on p. 220.

Fig. 124, p. 305, represents a complete procidentia, and may be taken as a type of its class.