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THE RELATION OF THEORY AND PRACTICE IN THE OPERATIVE TREATMENT OF GENITAL PROLAPSE

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MY first duty is to thank you for the great honour which you have done to the Irish school of medicine, and to that branch of it which is represented by the Rotunda Hospital, in inviting me to deliver this address. I can only say that I know the honour is appreciated by all connected with the Dublin school of obstetrics and gynæcology. I have next to thank you on my own account, and to express my pleasure at the great honour which you have done me personally. I cannot tell you how great a pleasure it is to me to have been able to come to this great country, even though the shortness of my visit enables me to see only the fringe of it. Already, I know that I shall carry back the very pleasantest recollections, and I can only hope that I shall leave some pleasant recollections behind.

The subject which I propose to take as the basis of my address is one which has interested me for a number of years, and which must have the greatest interest for every operating gynæcologist, namely, "The relation of theory and practice in the operative treatment of genital prolapse." It is a subject on which a volume might be written, and yet it has not always received the close attention of the operator. I think there are few subjects in operative gynæcology in which men are more inclined to be led by the

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fashion of the moment, and to adopt such fashion without due consideration of its ultimate results, and without attaching sufficient importance to its anatomical effects.

I trust I have not infringed the spirit of my directions which were to deliver an address on obstetrics. Personally, I regard obstetrics and gynæcology as more or less conjoined, but my inclinations lie more in the direction of gynæcological practice. I have therefore assumed that I may translate the word obstetrics in its freest sense. Even if one wishes to divorce gynæcology from obstetrics one can say of the subject I have chosen, that although prolapse may be cured by the gynæcologist, it is, alas, often produced by the obstetrician.

I think that in the past the frequent failure of the operative treatment of prolapse has been due to two causes. The first of these is an insufficient anatomical knowledge of the relations and supports of the uterus and the second is a desire to find a panacea which will be suitable for every case. The second cause is directly the result of the first. One can quite understand, for instance, how the routine treatment of uterine prolapse by ventral fixation appeals to one who does not recognise the abnormal strain to which a uterus once prolapsed is subjected in the future, and similarly one can understand the attitude of those who habitually recommend hysterectomy on the one hand, or extensive vaginal plastic operations—such as colporrhaphy and perineorrhaphy—on the other. It is such an obvious truism that if one removes the uterus, it can no longer become prolapsed, that it is little wonder some gynæcologists consider hysterectomy can cure prolapse. Again, it is so obvious that a prolapsed uterus ought to descend through the vagina, and cannot do so if the vagina is markedly narrowed that it is not strange that other gynæcologists think colporrhaphy and perineorrhaphy alone can cure prolapse. While as to ventral fixation, what is more plausible than to think that once the fundus of the uterus is fastened in an irremovable position to the abdominal wall, by no possibility can prolapse occur again? Yet each of these reasonings is based on fallacy. The extirpated uterus has prolapsed once and for all, and is gone, but that does not prevent subsequent prolapse of the vagina, and genital prolapse does not consist of prolapse of the uterus alone. Descent of the uterus through the vagina can be prevented by a narrowing plastic operation, but that does not prevent the vagina as a whole from becoming inverted. The fundus of the uterus can be moored permanently to the abdominal wall, but that does not prevent the

uterus elongating until its cervix and the vagina again appear outside the vulva. One might multiply other examples, but there is no need.

There are two cardinal points that one must remember in considering the treatment of prolapse. The first is that the exact lesions present differ to a very material extent in different cases. The second is that any treatment to be successful must follow such lines as enable us to alter and modify its details in order to suit the special lesions and complications of each individual case. I here show you on the screen a diagram which illustrates what I mean. Each and every one of these conditions will come under the head of genital prolapse, with the exception, perhaps, of the case of simple vaginal hypertrophy of the cervix. Here, although the cervix may appear at or outside the vulva, still the condition is not primarily prolapse, but one is justified in regarding all the other conditions as phases or varieties of prolapse, each of which will require differences in its operative treatment. With these points in mind, we come to the bed rock of all operative measures, namely, the anatomy of the pelvis, and when we understand it thoroughly, we shall perhaps be in a suitable position to criticise older methods, or even to devise new ones.

I begin, therefore, by calling your attention to certain points of importance in the physiological support of the uterus and vagina, and I do it in the shortest manner possible. In one respect I ask you to give me your consideration. There is a considerable amount of divergence of opinion in regard to many of the points which I bring before you, and I ask you to remember that, as time will not permit of a discussion of these differences, I bring before you what I regard as facts, and what are my own deductions from them. It is no wonder that much divergence of opinion exists in regard to matters which at first sight appear to be so very capable of direct proof. There is no one so coy as the anatomist who comes to deal with pelvic anatomy, and the reason is not far to seek. I understand that the intelligent anatomist who is a good dissector can demonstrate to his own satisfaction, and to the satisfaction of his audience, practically any ligament or structure in the pelvis that he chooses for the moment to create. He can harden connective tissue with formalin and turn it into ligaments; he can exhibit muscles which in the living are incapable of demonstration; and he can resolve strong fibrous bands into succulent connective tissue. I hope my audience will not think from this that I want to undervalue the work which has been done in pelvic anatomy. It is far from me

to desire to do any such thing, but I want to impress on you the great difficulty, if not impossibility, of demonstrating in the dissecting room subject the relations and structures of the pelvic floor as they are found in the living, and especially as they are found when modified as a result of the injuries of labour. The knowledge of anatomy is essential to the treatment of prolapse, but it is a knowledge which must be gained not alone in the dissecting room, but in examination of the living.

The two organs which are primarily concerned in genital prolapse are the vagina and the uterus, while secondarily, we find that prolapse of the bladder is very common, and that prolapse of the rectum sometimes occurs.

The vagina, under normal conditions, is kept in place by three different structures. First, it is supported below by the converging bands of the levator ani muscle, with the coincident help of the investing fascia. Secondly, it is fixed to the pelvic wall by the vaginal suspensory ligament, which is a fold of the pelvic fascia usually described as springing from the pelvic wall in the neighbourhood of the ischiatic spine, and passing inward and slightly forward to the side of the vagina, and slightly posterior to a coronal median plane. I do not think, however, that this description is quite accurate. Thirdly, it is supported by its attachments to the cervix, and by the parts of the endo-pelvic fascia which have an insertion both into the cervix and into the upper part of the vagina.

The uterus is supported, I refer now to direct support, by its vaginal attachment, by the uterosacral ligaments, and by the different layers of the endopelvic fascia which pass into it laterally and anteriorly. Its indirect support I will discuss in a moment.

Each one of these structures which I have mentioned can be demonstrated clinically, and can be definitely proved by any close observer to be responsible for the uterovaginal support. It is an easy matter to recognise the relation of the levator ani muscle to the lower part of the vagina, and to see how the approximation of its lateral bands supports both the perineum and the lateral vaginal walls. The suspensory vaginal ligaments are also capable of easy demonstration, and so are the uterosacral ligaments. To demonstrate them, one finger is passed into the rectum, and a bullet forceps is applied to the point of the vagina or uterus at which one wants to demonstrate the ligamentous attachment. Suppose, for instance, the forceps first catches the cervix. As one draws it down, one feels the uterosacral ligaments become tense at each

side, until finally their tension is sufficient to resist further descent of the cervix. If one then applies a second forceps to the upper part of the vaginal wall at the junction of the lateral and posterior wall and pulls upon it, the finger in the rectum will feel distinctly the fascial band which runs to that particular point becoming tense. If the forceps is then applied successively to a number of different points lower in the vagina, and on the posterior wall, and traction is made on each in turn, one can demonstrate that, beginning above at the uterosacral ligaments, and ending below about where the levator muscle crosses the vagina, there is a practically continuous ligamentous connexion between the cervix and the posterior vaginal wall, and the posterior pelvic wall, and that this band is sufficiently strong to prevent more than a certain amount of displacement of the cervix or vagina by traction. The position of this band is shown approximately in the next slide, which represents an illustration taken from Cunningham's "Anatomy." I say approximately, because it appears to me to run in too transverse a direction, and I think that anyone who examines the attachments for himself as I have described will have no difficulty in proving that it really runs in a more posterior direction. If the pelvic organs are hardened in formalin, either while still in position, or after complete removal of the entire contents from the body, and if they are then cut in a series of horizontal slices, as shown in the next slide, the position of the band will be very clearly seen. The following slide shows the surface of a set of these slices, and as I have said, the position of the band as seen here corresponds almost exactly with the position as demonstrated practically by the method I have pointed out. Such a method of examination, namely, by horizontal slicing of the pelvic contents, also demonstrates a very interesting and I think very important point, namely, that the uterosacral ligaments apparently form the upper limit of this band, and that from a practical point of view, one may consider the cervix and vagina as fixed to the pelvic wall by two strips of fibrous tissue, each of which begins above at the level of the uterosacral ligaments, and extends down as far, at any rate, as the levator ani muscle.

If anyone requires further demonstration of the existence and importance of this band, it will be obtained during the course of Wertheim's hysterectomy. In this operation the last step in the freeing of the uterus is the division of the uterosacral ligaments, and this allows the uterus to be drawn to a slightly higher level in the pelvis. One then has to cut firm fibrous bands which lie below the uterosacral ligaments, and which run between the vagina and

the posterior pelvic wall, and, when they have been cut to a depth of from a quarter to three-quarters of an inch, the vaginal fornices move forward, and with the uterus can be drawn to a considerably higher level, and one is able to reach points which up to this were inaccessible.

The remaining direct supports of the uterus and vagina are formed by the endopelvic fascia, and are not so easily demonstrated. This fascia forms two distinct sets of bands, one set of which passes anteriorly and forms the anterior false ligaments of the bladder, while the other set pass out laterally, surrounding and beneath the uterine vessels, and are known as the cardinal ligaments of the uterus, or as Mackenrodt's ligaments. The latter pair, as a rule, can be already demonstrated in cases of prolapse where they have become lengthened. It is, however, difficult to estimate the actual amount of support which they give normally to the uterus.

The foregoing comprise practically the entire support of the uterus and the vagina, with the exception of the ligamentous attachment of the lower part of the anterior vaginal wall to the urethra, and through it to the posterior surface of the pubic bones. The indirect support of the uterus is, however, also a matter of considerable importance. This support comes from the pelvic floor, and is mainly the result of the fact that the uterus lies horizontally in the pelvis, with its long axis almost at right angles to the axis of the vagina. It thus offers the maximum surface of resistance to the pelvic floor, while the non-coincidence of its axis with the axis of the vagina prevents any tendency to its descent through the latter.

We must now see how the injuries of labour affect both the direct and the indirect supports. The first and most obvious change is in the relation of the levator ani to the vagina. Deep tearing of the perineum destroys the slight attachments of the muscle to the central point of the perineum, and so allows its lateral bands to diverge outwards, while actual tearing of the muscle itself destroys the continuity of its inner edge. The result is that the lateral bands are widely separated, and that there is nothing to prevent the anterior or the posterior vaginal wall from bulging directly down through the vaginal orifice. Once the support of the lower part of the vagina is lost, there is a tendency for the middle part also to descend, because the posterior and lateral walls, instead of resting on the levator muscles, are unsupported, and have their pull transmitted directly to the suspensory fascia which

I have described. This fascia must be a very potent factor in supporting the vagina under normal conditions, but it is apparent that it does not possess great powers of resisting a continuous strain, and that when such strain comes upon it, it stretches, thereby allowing the middle portion of the vagina to descend. Clinically, however, I do not think that one often sees this progressive inversion. What happens, rather, is that first the lower part of the vagina protrudes, that then the vaginal fornices lose their support and descend, and that finally, as a result of continued traction, the middle portion descends also.

The earlier descent of the upper part of the vagina is due to the alterations that occur in the supports of the uterus, alterations which usually result in the uterine prolapse so to speak overtaking the vaginal prolapse, and eventually preceding it. The first direct step in the production of uterine prolapse so far as the uterus is concerned is backward displacement. This may occur as a result of the traction of a prolapsing anterior vaginal wall on the cervix, a traction which tends to pull the anterior cervical wall lower in the vagina, so carrying the body of the uterus back, or it may be due to simple falling back of a large uterus as a result of general relaxation of its ligaments. Whichever it is, the effect is very much the same. The axes of the uterus and of the vagina tend to come into coincidence, and the resistance which the uterus offers to its own descent is altered from a surface corresponding in size to its anterior wall to a surface represented by a horizontal cross-section (slides). In other words, practically all the support furnished to the body of the uterus by the pelvic floor is lost, and the weight of the uterus is thrown directly on to the uterosacral ligaments and the different parts of the endopelvic fascia. The uterosacral ligaments are strong bands, as can be easily proved clinically, but, like the vaginal suspensory ligaments, and indeed like all other fascial ligaments, once a direct pull comes on them, they yield. Their normal function is probably to keep the cervix in its proper relation to the posterior pelvic wall, and by so doing to keep the body of the uterus in front, and, once they receive the entire uterine weight, they fail, and stretch. Once they fail, the weight of the uterus is transmitted directly to its vaginal attachments, and to the endopelvic fascia, both of which are entirely unsuited to resist a direct strain. They too eventually yield, and so with the uterus the upper portion of the vagina comes down. It is probable then, that the most common sequence of events is, first, the prolapse of the lower portion of the anterior vaginal wall, with or without an

accompanying prolapse of the corresponding part of the posterior wall, then the prolapse of the uterus and the upper part of the vagina, and lastly, the prolapse of the middle portion of the lateral and posterior vaginal wall. This order may, however, be altered, and, as one sees in certain cases not associated with labour, the uterus may be the first part to descend, the inversion of the vagina being directly consequent.

There is a condition frequently associated with genital prolapse which probably affords an indication as to the order in which the prolapse has occurred. I refer to hypertrophy of the supravaginal portion of the cervix. This hypertrophy is not confined to the portion of the cervix between the insertion of the uterosacral ligaments and the vagina, but it is most commonly situated there, and it seems to indicate that there has been a conflict between the pull of a prolapsing vaginal vault below and the support afforded by the resisting uterosacral ligaments above. It is consequently reasonable, I think, to suppose that when one finds such hypertrophy present, the vault of the vagina has been the first part to prolapse, and the body of the uterus the last. In some cases, indeed, one actually sees this stage before uterine prolapse has occurred, that is to say, the uterosacral ligaments are of their normal length, the body of the uterus is in a practically normal position, the vagina is inverted and the cervix is at the vulva, being enabled to come to this position as a result of its supravaginal hypertrophy.

So far I have not referred to the alteration in the position of the bladder that accompanies genital prolapse. It is the direct result of the pull of the anterior vaginal wall and of the yielding of the ligamentous attachment of the base of the bladder and of the urethra to the posterior surface of the pubis. It may be the first step to follow injury to the pelvic floor, or on the other hand, it may be one of the later steps that result from the primary descent of the uterus. Once it has occurred, its action in hastening complete prolapse is considerable, because it leads to straining and increased intra-abdominal pressure during micturition and because it causes direct traction on the cervix of the uterus.

So much then for theoretical considerations. The more one studies prolapse, the more one sees how in its complete stage, it is the result in most cases of an initial fault, which, by altering the normal strain to which the suspensory mechanism of the uterus is intended to be subjected, throws the elements of that mechanism out of sympathy with one another. This is the most essential point to grasp in planning a successful operation for prolapse,

because just as the prolapse follows initially a single fault, so it will tend to recur after operation if a single weak point is left. Ventral fixation alone failed because the cervix was free to drop into the axis of the vagina, and so again to bring a direct pull on the uterosacral ligaments. Vaginal plastic work, alone, failed because the descending uterus was capable of again dilating the vagina and forcing the muscles apart. Hysterectomy failed because it took no account of the fixation of the vaginal vault.

We have now to see conversely if, when once prolapse has resulted, it is possible not alone to bring back the different structures to their normal relation, but also to abolish all abnormal strains which may be thrown upon them.

I think that one may consider rational prolapse operations as consisting of three parts:—First, the restoration of the normal direct support of the uterus and vagina so far as possible. Secondly, the placing of the uterus in such a position that it offers the maximum resistance to descent. Thirdly, the removal of complications and associated conditions, the result of prolapse. I will deal with these three parts separately.

THE RESTORATION OF THE NORMAL DIRECT SUPPORT OF THE UTERUS AND VAGINA. We have already seen that these supports are four in number: first, the uterosacral ligaments; secondly, the endopelvic fascia; thirdly, the suspensory ligaments of the vagina; and fourthly, the levator ani muscle. The shortening of the uterosacral ligaments with a view to restoring their normal action on the cervix is advisable in all cases in which they are stretched. It is essential when one is dealing with a small uterus, because such a uterus can not be made to offer sufficient resistance to its own descent unless its direct supports are also reconstituted. Wertheim was, I think, the first to recognize the importance of shortening these ligaments, and his operation is carried out by the vaginal route, but through the peritoneal cavity. I have also described a method of shortening the ligaments through the vagina at their point of attachment to the uterus, and this is the method which I usually adopt, as I consider it to be more easily worked in with the other stages of a prolapse operation than is Wertheim's method. It is unnecessary to enter into details here, though I hope, if time permits, to say a word about them later.

It is, however, necessary to say why uterosacral shortening is so essential in the small uterus, and the reason, if one thinks of it, is obvious. In a moment I shall go on to say that I consider Wer-

theim's interposition operation to be one of the best methods of increasing the resistance of the uterus to its own descent. In this operation, the uterus is placed between the anterior vaginal wall and the bladder. If the uterus is of sufficient size, it is then directly supported by the levator ani muscle, as well as by the vaginal wall, and, furthermore, since it is too large to allow its body to remain in position while the cervix rotates round it and comes down again to the vulva, the result of the operation is usually excellent. If, on the other hand, the uterus is very small, the cervix, if free, can drop down through the vagina, pulling the remainder of the uterus after it. If, however, we fix the cervix by shortening the uterosacral ligaments, it cannot rotate round the body and drop, while at the same time the strain on the shortened ligaments is slight, and they do not tend again to elongate.

The shortening of the band of endopelvic fascia, known as Mackenrodt's ligaments, has also been advised in cases of prolapse. Some of the advocates of this procedure support their views by saying that Mackenrodt's ligaments must give a great deal of support to the uterus, because their division during the course of Wertheim's hysterectomy allows the uterus to be pulled to a much higher level. This argument, however, in my opinion is based on an inaccuracy. It is not the division of Mackenrodt's ligaments that allows the uterus to be pulled to higher level, but rather it is the division, first, of the uterosacral ligaments, and then of the vaginal suspensory ligaments, as I have already mentioned. At the same time, although I do not believe that Mackenrodt's ligaments have all the effect on the uterus which is sometimes attributed to them, I think that when they are shortened, they are capable of adding to the general support of the cervix. Such shortening, to be effective, must be considerable, and, if it is to be a safe procedure, it must be done with the greatest care, because, as we know, this part of the endopelvic fascia is pierced by the ureters, and if it is drawn out too far, I think that it is quite possible that kinking of the ureters may result. A moderate degree of shortening is always brought about when supravaginal amputation of the cervix is performed, in consequence of the insertion of these ligaments into the upper part of the vagina as well as into the uterine cavity, and, personally, I am not inclined to try to shorten them to a greater extent than is done in this way.

The support given by the vaginal suspensory ligaments is of the greatest importance, and if it was feasible to restore them to their original condition, such a step would be most desirable. At

the present time, however, I am not aware that any operator has suggested any effective method of dealing with these ligaments, and for my own part, I can only say that I do not see that it is likely that such a method can be brought forward, owing to their position. The nearest approach to shortening them is the fixation of the vault of the vagina to the peritoneum covering the anterior surface of the sacrum, as was suggested by Stanmore Bishop some years ago. The only objection I can see to this procedure is that it necessitates an abdominal incision, and this adds on rather too much to an already prolonged operation. Personally, I have not performed Bishop's operation, and I do not think that it has received from anyone the attention which, on theoretical grounds at all events, it deserves. Further work on the fixation of the vagina is very necessary, and, if it is carried out, it is possible that an effective procedure for the restoration of the important fascial connexion of the posterior vaginal wall may be devised. For the moment, however, we must consider that our efforts to restore the direct support of the vagina break down at this point, and that we are not capable of restoring effectively the vaginal suspensory ligaments.

The restoration of the levator ani muscle to its proper position is, on the other hand, a matter of ease and simplicity. It is an essential part of all perineorrhaphy operations, and is a step of the utmost importance in prolapse operations. I do not propose to enter into the method of suturing it on the present occasion, but will confine myself to saying that it is always possible and usually easy, except when the muscle has practically disappeared on one or both sides in consequence of atrophy or excessive retraction.

THE PLACING OF THE UTERUS IN SUCH A POSITION THAT IT WILL OFFER THE MAXIMUM RESISTANCE TO ITS OWN DESCENT. We have seen that, under normal conditions, the uterus lies practically horizontally in the pelvis, and that its resistance to descent may be expressed as that of a surface corresponding in size to the anterior surface of the uterus. On the other hand, when the uterus comes into a position of retroversion, usually the first stage of prolapse, the resistance that is offered may be expressed as that of a surface the size of a horizontal cross-section of the uterus. Furthermore, when in a position of retroversion, the uterus descends into the pelvis as a wedge, point downwards, and so readily forces or dilates a way for itself through or between any opposing structures. Finally, when the uterus offers a maximum resistance to its own descent, not alone does this increased resistance directly hinder

descent, but it also lessens the strain which is shown on the direct supports, and this is a most important matter. I do not think that it is possible by any means to reconstruct the direct supports in such a manner that they will resist the entire strain of the unsupported uterus, but, if this strain can be brought back to its normal limit, then in association with the reconstituted direct support, the tendency to prolapse will be overcome. The simplest method of bringing back the resistance of the uterus to the normal is by fastening the fundus in a position of anteversion. This can be done either by the shortening of the round ligaments or by the direct suture of the uterus to the abdominal peritoneum as is done in ventral suspension, and, as neither of these procedures in any way interferes with a subsequent pregnancy, one or other of them is indicated in the case of women still within the child-bearing period. It is, however, possible to increase the resistance of the uterus beyond the normal, but such a course inevitably affects detrimentally a future pregnancy, and may lead to the most serious results. Therefore, it is obviously only permissible in women who are past the child-bearing period, or in women in whose case there is no objection to producing an artificial sterility. The most important and the most reliable of such operations is undoubtedly Wertheim's interposition operation, and I have no hesitation in saying that it is the most valuable procedure, which has been introduced of late years, for the cure of prolapse, because not alone does it increase the resistance of the uterus to its own descent, but it also helps to fix the vagina in position, and to remove the prolapse of the bladder that both complicates and tends to perpetuate vaginal prolapse.

I have stated briefly of what the operation consists, namely, the bringing of the body of the uterus to lie between the bladder and the anterior vaginal wall. In this position, it is entirely extra-peritoneal, and so, necessarily, could not undergo proper development during pregnancy. The bladder is brought to lie wholly above it, and, provided the size of the uterus is sufficient, and that the cervix is fixed by the shortening of the uterosacral ligaments, I consider the result cannot at present be surpassed. On the other hand, where the uterus is small, and the cervix is not fixed, recurrence of the prolapse is very liable to occur.

THE REMOVAL OF COMPLICATIONS AND OF CONDITIONS ASSOCIATED WITH PROLAPSE. There are a number of conditions which are either the direct result of uterine prolapse, or one or more of its

predisposing causes. In the cervix we may find hypertrophy—vaginal or supravaginal, so-called erosion, true ulceration, and laceration. In the body of the uterus we find endometritis and the different conditions which are usually grouped under the head “metritis”, and which lead to uterine enlargement, and tumours such as myomata. In the pelvic and abdominal cavity we find again tumours arising either in the uterine appendages or from other organs, and ascites; while, lower down, we find very frequently prolapse of the bladder, more rarely prolapse of the anterior rectal wall, and, most commonly of all, perineal laceration. It is so obvious that these conditions must be removed, if a successful result is to be obtained, that it is only necessary to say a few words about them. Erosion, laceration, and hypertrophy of the cervix are best treated by amputation, either vaginal or supra-vaginal, according to the nature of the case. Endometritis is treated by curetting. Uterine tumours and abdominal pelvic tumours call for removal, while increase in the size of the uterus, apart from tumour formation, calls for reduction in its size by the amputation of a wedge-shaped portion from the body. This procedure is particularly necessary if Wertheim’s interposition operation is to be performed, and, if it is omitted, trouble is likely to occur during the operation, owing to the impossibility of providing sufficient vaginal mucous membrane to cover the large uterine body, and also later owing to the pressure which the large uterus causes at the lower part of the vagina. In such cases, the excision of a wedge-shaped portion of the body is essential, and does not add much to the length of the operation. Prolapse of the bladder is cured whenever the interposition operation is performed, and, when the latter is contraindicated, it can be cured by the performance of anterior colporrhaphy, provided care is taken to push the displaced bladder back into its proper position before suturing the edges of the vaginal mucous membrane. The cure of a prolapsed rectal wall is directly associated with the cure of perineal laceration, and as this operation involves the suture of one of the direct supports of the vagina, namely, the levator ani muscle, I have already referred to it in its proper place.

Mr. President, Ladies and Gentlemen, I have tried to place before you the theories on which I think the proper treatment of uterine prolapse must be based, and to indicate briefly the manner in which one transforms them into practice. To suggest that the result of operating along these lines is uniformly successful, would be equivalent to saying that we had reached finality, and this is

very far from being the case. All one can say is that we are beginning to adopt measures because of their probable permanent result, as opposed to measures which merely give a temporary benefit. There is, however, much room for improvement. So long as the posterior vaginal wall is left, as it is at present, with its supports in an imperfect condition, so long must operative procedure be defective. There are other points, too, in which improvement must come. The interposition operation is excellent in a suitable case, but it is incompatible with pregnancy. The restoration of the pelvic floor is in most cases effective, but it may be again destroyed during a subsequent labour. The very means which we adopt to reduce an enlarged uterus to a normal size may subsequently result in producing uterine atrophy, and so in removing the most effective part of the modern prolapse operation, namely, the placing of the uterus under such conditions that it resists, not alone its own descent, but the descent of the structures by which it is surrounded.

I have thanked you on my own behalf for the honour you have done me, and I could only wish that, for the reputation of the school which I represent, you had selected one who was more suited to put before you some of the problems of modern obstetrics and gynaecology, and their solution.