on the bed; when the upper arm is paralyzed, an assistant is instructed to press on the upper hand with his or her two hands—to lean on it, as it were. It matters not whether the laceration is on the one side or the other, pressure is made directly downward. The hands are held in this way for half an hour, three-quarters, or even longer. A bag of sand or shot may substitute the upper hand. Harrison claims for it the following advantages: (1) The entire treatment is extravaginal; danger of infection by the procedure is consequently excluded. (2) The blood also, which would be certainly lost with suture or tampon, remains in the body. (3) The hemorrhage is controlled in the most rational manner from the fact that the bleeding surfaces are pressed together so firmly that there is no longer a space in which bleeding could take place. Provision is consequently made for adhesion and healing from the fact that the raw surfaces are on and into each other. (4) No after-treatment is necessary; when the hands are released, if no bleeding takes place, further manipulation is superfluous.

The Best Fixation Method for the Treatment of Fixed Retroversion with Flexion.—KUESTNER (*Zentralbl. f. Gyn.*, 1909, xxxiii, 41) states that reëxamination of the material at his clinic by Hannes showed that the Alexander-Adams operation gave most excellent results in those cases only in which the uterus was found freely movable. The Alexander-Adams operation should not be undertaken when any doubt of mobility of the uterus exists. Kuestner recommends the combination of the Alexander-Adams operation with laparotomy when adhesions are present. The former may be done unilaterally if desired. In cases in which careful examination fails to establish positively the presence of adhesions a suprasymphyseal transverse incision through the skin between the two external inguinal rings down to the fascia is made. The fascia is then divided longitudinally within the linea alba and the peritoneum opened. If no adhesions are found on exploratory incision of this kind one is justified in concluding the operation by the Alexander-Adams method.

Suprapubic Hysterotomy as a Means of Diagnosis and Treatment of the Uterus.—W. W. RUSSELL (*Ann. Gyn. and Ped.*, 1909, xxii, 90) advocates suprapubic hysterotomy for the following conditions: (1) It is of conspicuous service in cases of persistent uterine hemorrhage which is not controlled by any form of treatment and in which bimanual palpation of the pelvic organs has given an absolutely negative diagnosis. (2) In polypoid change of the mucosa in which frequent curettage has failed to stop the hemorrhage. (3) Small, submucous and pediculated myomas may be removed by this operation. (4) In cases in which the abdomen has been opened for some other purpose, and no explanation has been found. Russell reports 32 successful cases in which this procedure has been used by six surgeons. The technique consists of bringing the uterus out of the peritoneal cavity and, supported by gauze packed about it, a longitudinal incision into the uterus is made in the median line on the anterior wall half way down to the cervix, as well as through the fundus to the posterior surface. The entire uterus is split for a distance of two or more centimeters down into the cavity. In closing the uterine wall catgut or fine silk is placed through it about 0.5 cm. apart and a fine catgut closes the peritoneum.