can be epitomized as follows: 1, inefficient operating; 2, insufficient operating; 3, excessive operating; 4, insufficient preparation; 5, insufficient convalescence. If gynecologists will take cognizance of these five factors in every case it will help to do away with failures in the majority of cases. The length, troublesomeness and seriousness of convalescence are in exact inverse proportion to the time the operator spends in getting his patient ready for operation. Adequate preparation means shorter and better convalescence. Hasty preparation means protracted convalescence, and frequently it means the drifting of the patient into a state of discouragement, and the operator is credited with a failure. Did the gynecologist pay sufficient attention to the preparation of the patients morally, mentally and physically, he would go far toward avoiding failures.

DR. J. T. WALLS, Portland, Ore., declared that lacerations following parturition are frequently overlooked; such patients should have early attention after confinement. If the physician knows there is an injury he should advise its early repair, because malignancy is likely to set in. Dr. Walls has found few cases of cancer of the cervix that could not be traced to an old laceration. Small lacerations should not be overlooked, as they frequently produce much systemic disturbance, and he makes it a rule to repair all lacerations when he has an opportunity. In cases of long standing the uterus should first be curetted, and the patient given time to recuperate and the endometrium to become normal before doing a trachelorrhaphy. The patient should be kept quiet until union is complete. Dr. Walls avoids using tampons of any kind; he prefers instead the use of antiseptic gelatin suppositories, using them at night only; he has the patient insert the suppository herself. This, he finds, serves the double purpose of tampon and douche. In the morning he has the patient cleanse the parts externally by the use of warm soapsuds, using a cloth, omitting the douche entirely.

DR. V. J. HAWKINS, St. Paul, Minn., said that no matter how much the cervix is lacerated, if it is covered by normal mucous membrane no symptoms will arise unless there is an infection. So far as consultants are concerned, patients should not be taken to the surgeon for the purpose of having a certain operation performed. If a patient of Dr. Hawkins is not getting along well, he asks for the privilege of a consultation, thus placing both himself and the surgeon in a good position, because their opinions of the case may differ. There is so much chance for a difference of opinion that it is unwise to tell patients that one will call in a surgeon to have a certain operation performed. That might not be the cause of the trouble. Dr. Hawkins said that the surgeon should not expect that every case brings with it a large fee; nor should he imagine that because the physician does not tell him everything, that he does not know. In many of these cases the trouble is caused by autointoxication or malnutrition, and that must be gotten rid of before results can be obtained. Physicians should get away from the belief that lacerations of the cervix cause cancer or other serious trouble, unless there is an infection.

DR. D. C. NEWMAN, Spokane, Wash., stated that in his experience these lacerations of the cervix rarely become covered with normal mucous membrane. They may be patched up for a while, but they soon become infected and then there is trouble. Dr. Newman thinks that Dr. Carstens hit the nail on the head when he said that the reasons these operations are a failure is because gynecologists do not treat the patient, but only the uterus and appendages.

DR. W. E. GROUND said that it is important to follow up these patients after operation, teaching them how to live, to dress, and even how to stand and to walk, if the best results are expected.

Proprietary Preparations with Incompatibilities.—But let me warn you to place no faith in the pharmaceutical monstrosities which are said to contain pepsin combined with pancreatin, with which it is positively incompatible, nor those in which it is combined with wines or any preparation of alcohol which, except in the weakest dilutions, interfere with its action.—Boardman Reed.

ETIOLOGY AND TREATMENT OF SO-CALLED ENDOMETRITIS.*

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It is with a feeling of great diffidence that I bring before this section such a common-place subject as endometritis, but I feel justified in doing so from the fact that, taking at random six different modern text-books, I find given twenty-seven different kinds of endometritis; out of these twenty-seven varieties, there is no one variety which is mentioned in each text-book. There are three varieties (exfoliating, gonorrheal and septic) which are mentioned in four; four varieties (atrophic, hypertrophic, simple chronic and fungous or fungoid) in three; eight varieties (hemorrhagic, hyperplastic, glandular, interstitial, polypoid, simple, tuberculous and senile) in two, and ten varieties (catarrhal, decidual, menstrual, diphtheritic, infectious, syphilitic, vaginal, puerperal, putrid and villous-degeneration) mentioned once each in six different text-books. If gynecologists were earnest, serious students to-day and just beginning their gynecologic studies, they would throw up their hands in despair at twenty-seven different diseased conditions of one small tissue, each entitled to a separate pathology, symptomatology, diagnosis, prognosis and treatment; for these terms, strictly speaking, are not interchangeable. I have particularly tried to avoid using different terms that might mean the same thing, or I might have added several varieties more. If these twenty-seven varieties of endometritis really exist, they should be described in each text-book; if they do not, they should be cut out.

I do not wish to take up time with a description of the gross or minute anatomy of the endometrium, but will call attention to the fact that it differs materially from any other structure in the body; that it is not a true mucous membrane; that it is a glandular structure intimately connected with the muscular tissue of the uterus, and, therefore, is tremendously influenced by any changes which take place in the uterus; that the endometrium of the body and that of the cervix are histologically different, and that I am speaking particularly of that of the body. Its main function is undoubtedly connected with the development of the fertilized ovum. The endometrium is by nature a hemorrhagic tissue, as is proved by the flow of the menstrual period which is merely the result of an overcongested tissue and is Nature's remedy for its relief. This structure is not normally cast off in its entirety at each menstrual epoch and then renovated, nor is it even disintegrated to any considerable extent, as many would have us believe.

In regard to the pathology of the endometrium, I would like to quote, in the first place, from a text-book that was written over twenty years ago by one whom I believe is as justly entitled to be called the father of gynecology as J. Marion Sims, and whose student I had the honor to be when I was an interne at the Women's Hospital in the state of New York, Dr. T. Addis Emmet:

It is all important in this relation to understand the difference between passive congestion, which is generally venous, and inflammation, which begins as a stasis in the arterial capillaries. These terms are usually regarded as synonymous, but as erroneously as many others are which are used in uterine terminology. Inflammation always involves an infiltration of cellular elements into the parts, or a multiplica-

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tion of those already there; and this product may be recognized by an almost superficial inspection if it has not been absorbed. But we look in vain, after death, for any evidence of metritis or endometritis, or for ulceration of the cervix, as it is termed, for neither of the conditions so-called is inflammatory. On the contrary, in the conditions in which these are supposed to exist, the tissues are blanched, the blood from the capillaries having passed into the larger vessels as the heart failed to keep up the supply; and there is to be detected neither loss of tissue on the surface of the mucous membrane beyond the epithelium, if even to that extent, nor any hyperplasia in the organ itself. Inflammation, strictly speaking, can exist only in an acute form, although its products may remain for an indefinite period. Therefore, the term chronic inflammation applied to the uterus is a misnomer, and only serves to give erroneous impressions of the pathology and treatment of uterine diseases. Inflammation of the uterine body never occurs except after parturition, and those conditions which are commonly held to be the direct results of inflammation are due wholly to obstructed circulation in the organ, caused by pathologic processes in the cervix and neighboring parts. In this way the formation of flexures, many displacements, and the so-called uterine hyperplasias, with their attendant leucorrhea, are to be accounted for.

We shall have made a great advance in solving the problem as to the true pathology of many supposed uterine diseases when we seek for the cause outside the uterine limits.

In the second place, I will quote from a more modern author and at the same time one who is as well known, Dr. Howard Kelly:

Acute endometritis is generally found in acute septic processes involving the entire genital tract, but on account of the predominating symptoms of the other organs it is usually overlooked. Under any circumstances it is a rare affection.

Chronic endometritis is also rather rare. The prevailing habit of describing all scrapings, particularly because of their abundance in some cases, as examples of endometritis, is greatly to be deplored. It interferes with our getting any satisfactory idea as to the frequency of the real affection and tends to encourage unnecessary operating. The so-called "fungoid endometritis" is not a pathologic entity at all, and the name ought to be expunged from gynecologic works.

Chronic endometritis is oftenest associated with old cases of pyosalpinx; it is rarely ever found in the ordinary scrapings. The slight liability of the uterine mucosa to this affection may be ascribed to two factors: In the first place, the tendency of pus-containing tubes is to complete closure at the uterine end, and so shutting off one avenue of infection, and, in the second place, the form and position of the uterine canal is such as to afford good drainage.

After quoting two such eminent authorities on this subject, it leaves but little for me to say; but I can not help but add that a true endometritis can only exist as the result of a direct irritant to that structure, be it in the form of a microbic invasion or otherwise, conditions that rarely occur. The endometrium, owing to its intimate relations with the uterus, already alluded to, naturally will partake of any of its circulatory disturbances. The circulation of the uterus may have been interfered with, the uterus may be infected, inflammatory conditions of the appendages may affect it, it may be the home of new growths, and in all these conditions the endometrium will surely be affected, but does not represent a diseased condition by itself.

As to treatment, there is only one successful one, and that is the removal of the cause when it can be discovered. Local measures aimed at the endometrium proper will be of no avail. Scraping out parts of the endometrium with a curette will not cure a lacerated cervix, a subinvolution, a displacement, pus-tubes, a new growth, an infection nor even a vaginal or senile endometritis, whatever these terms may mean.

I have said little or nothing about a condition which,

perhaps, some of you may have in mind, and that is gonorrhoeal endometritis, and it is because I am in doubt as to the existence of a gonorrhoeal infection of the endometrium, on account of the lack of evidence. One of the text-books from which I quoted my varieties of endometritis assures us that such a condition is very common; that it frequently attacks the muscular structure of the uterus, and even produces abscess of the uterine walls. How any one can make such a statement I do not know. That the gonococcus frequently attacks the cervical endometrium is a well-established fact, but, as I have already said, I am only speaking of the endometrium of the body of the uterus, I will admit that this is a disputed point.

I have only attempted to treat this subject in a very general way, as it would be impossible to take up and to discuss each and every author's point of view and his reasons for classifying endometritis as he does, nor do I wish to deny him his right to his individual opinion. When it comes to teaching students, however, it seems to me that they have a right to the knowledge of the facts in the case, and that there should be some concerted effort on the part of teachers to learn something of the true etiology and pathology of endometritis, the knowledge alone of which will lead to a rational treatment of this condition.

DISCUSSION.

DR. H. O. MARCY, Boston said that the utricular glands of the uterus have a function far greater than is usually supposed, and less damage is done in their curettement than would be the case were it not for the fact that their deeper portions are deeply imbedded in the connective tissue layers of the uterus. But for that curetting would do irreparable damage. Shedding of the uterine mucosa is a sort of cleaning house for the little tenant that Nature desires, and a great deal of damage and very little good may be done if physicians do not understand the physiology of these glands.

DR. ERNEST F. TUCKER said that he thinks that gynecologists are not so well versed in anatomy, physiology and pathology as they should be. Most of our text-books are written by clinicians, and it throws discredit on gynecology to have such a variety of diseases mentioned in the text-books used in the colleges. This state of affairs ought not to exist, and Dr. Tucker said that he desired to impress teachers with the necessity of taking up this matter.

TRANSPLANTATION OF BONE FOR THE RELIEF OF SADDLE-NOSE.

WITH REPORT OF ONE CASE.*

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In 1900, Gersuny of Vienna reported the use of paraffin injection for the relief of deformity. Since then medical literature has been full of reports of the brilliant results attained by this procedure. The original method has been modified somewhat; we have learned by experience that all cases are not amenable to this form of treatment; we have also learned that serious complications sometimes follow its use.

In this paper I wish to make a comparison and to draw conclusions between paraffin injections and plastic surgery for the relief of saddle-nose.

The selection of cases is of the greatest importance if

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