

a vesico-vaginal fistula, as suggested by Freund. A transverse incision is made in the anterior fornix, the vesico-uterine fold of peritoneum is opened, and the fundus uteri is drawn through the opening, each angle of the wound being sutured to the cervix. An oval denudation is then made on the anterior vaginal wall, extending from a point just above the meatus urinarius to one-half an inch below the transverse incision. The posterior surface of the corpus uteri is then denuded, and is united to the edges of the vaginal wound. In the two cases reported the operation required from twenty-five to forty-five minutes, the convalescence was afebrile, and the pre-existing vesical disturbances were at once removed. The anterior surface of the uterus underwent a process of granulation, and fresh epithelium developed. The organ diminished in size, and eventually presented only the condition of sharp ante flexion. Kolpoperineorrhaphy should be performed in order to furnish additional support.

Ventral Hernia.—ABEL (*Archiv für Gynäkologie*, Band lvi. Heft 3) traced the subsequent condition of 665 patients upon whom cœliotomy had been performed at the Leipsic clinic in the course of eight years. Only five patients were not heard from, and in the course of his investigations the reporter sent out nearly 2500 (!) letters; 97.5 per cent. of the patients were actually seen and examined. The following deductions were drawn: The integrity of the cicatrix depends primarily upon the method of suture and the manner in which the wound heals. Separate suturing of the fascia gives the best results.

The early resumption of severe physical exercise after operation has a marked influence upon the development of herniæ, as they then usually appear early, especially when the abdominal bandage is laid aside.

Hernia is more common in fat women, because exact apposition of the fascial edges is more difficult than in thin subjects, since peritoneum and subperitoneal fat are apt to be interposed. The muscular tone and general condition of the patient have no influence on the solidity of the cicatrix, but the suture and healing of the wound—in short, ventral hernia after abdominal section—is usually due to the operator rather than to the patient.

Fixation of the Prolapsed Uterus.—MITTHAUER (*Münchener med. Wochenschrift*; *Centralblatt für Gynäkologie*, 1899, No. 14) reports cases of vaginofixation and supravaginal amputation of the cervix for prolapsus, with accompanying anterior and posterior kolporrhaphy, in which cystocele and rectocele recurred, though the uterus remained ante flexed. Even when the uterus is extirpated according to Fritsch's method the vaginal prolapse may return. The same criticism is applied to ventral fixation undertaken for the relief of this condition.

Plastic Operation for Prolapsus.—CHIARLEONI (*Arch. Ital. di Gin.*; *Centralblatt für Gynäkologie*, 1898, No. 14) describes the following operation: Triangular surfaces are denuded on the anterior and posterior vaginal walls, with their bases toward the cervix, and are sutured in the usual way. The cervix uteri is then dissected up to a distance of over two inches, is split laterally, and each half is united as high as possible to the anterior and