

on suddenly, which is probably due to a slight hæmorrhage into the medulla oblongata, or to embolism, or thrombosis. The onset of this form is different from that of the typical variety in which the symptoms creep on gradually and stealthily, a slight affection of speech being usually the first symptom to attract attention. In the sudden, or, as it is called, the acute, form, the resulting paralysis is frequently unilateral, or more pronounced on one side than the other; while progressive bulbar paralysis is always gradual in its onset, and the paralysis is uniformly bilateral.

The disease is much more common in men than in women, the proportion being two of the former to one of the latter. Of five cases, of which I have kept notes, only one was a female.

---

ART. XXI.—*On Varicose Veins and their Treatment by Operation.*<sup>\*</sup>

By KENDAL FRANKS, M.D. Univ. Dubl.; F.R.C.S.I.; Fellow, and Member of Council, of the Surgical Section of the Academy of Medicine in Ireland; Fellow of the Royal Medical and Chirurgical Society of London; Vice-President of the University Biological Association; Surgeon to the Adelaide Hospital and to the Dublin Throat and Ear Hospital, &c.

ALTHOUGH the subject of varicose veins may perhaps be considered somewhat threadbare, the condition itself being of common occurrence; I consider that I am justified in bringing it before you this evening, because the result of their radical treatment hitherto has been so unsatisfactory that any procedure which promises to give more certain and lasting results, without, at the same time, increasing the risks of dealing with them, must be of interest and claim special attention. The urgency with which the authors of works on general surgery deprecate any operative procedure, except in most severe cases of the disease, sufficiently proves that hitherto no method of treatment has been so far fruitful of good as to warrant its general adoption. In discussing this subject, then, I shall deal chiefly with operative measures, and shall only allude in a passing manner to palliative treatment. And let me here, once for all, state that the majority of cases coming under notice are not cases for operation, but can be effectively dealt with by such measures as rest, bandaging, the elastic bandage, or stocking, and so forth. I shall presently state the cases which, in my opinion,

<sup>\*</sup> Read before the University Biological Association at the meeting, March 25, 1886.

are best treated by operation; but before doing so it will be necessary to consider what varicosity of the veins consists in, and to what the condition is due.

Varicose veins, then, may result, when the veins are no longer equal to the pressure of the blood within them. This may follow from two causes—one *extrinsic*, when from some remote cause an unusual amount of pressure is thrown upon the veins, such as pressure upon the iliac veins, due to overloading of the intestines or to some abdominal tumour, or, as in some forms of heart disease, cirrhosis of the liver, and such other obstructions to the free course of the blood in the veins. Or the cause may be *intrinsic*—that is, for some reason or other, the veins have lost their tone and their elasticity, and are no longer capable of resisting the normal pressure from within. It is not easy to account for this loss of tone and elasticity in the veins, which has been attributed by some to an hereditary predisposition, and by Sir J. Paget is stated to co-exist with an indolent temperament or with a debilitated condition of the general health (*St. Bartholomew's Hosp. Reports*, Vol. II.). Others look upon the condition of the veins as the result of a chronic phlebitis, analogous to chronic endarteritis, causing such an alteration in the walls of the vessels themselves that they lose their elasticity and become prone to dilatation, as we are accustomed to see it in aneurysm. This chronic phlebitis is further supposed to be due to some nervous condition which results in paralysis of the vaso-motor nerves supplying the small vessels which nourish the veins. From this results hyperæmia of the coats of the veins, ending in chronic phlebitis.

Whatever the agency at work may be, the result is the same—namely, that the balance between the elasticity of the walls of the vein and the intravenous pressure is lost, and gradual dilatation and distension of the veins ensue. This loss of balance will be felt, of course, wherever the pressure is greatest; and these situations are those, in the dependent parts of the body, where the column of blood is the longest. If we take a long U-shaped tube and almost fill it with water, the fluid in one limb will rise to the same height as in the other, but the pressure of the fluid on the sides of the tube will be greater the nearer we approach the base of the U—that is, the longer the column of fluid is. So it is in the veins. The column of blood in the veins is supported by the column of blood in the arteries, but the pressure in the veins will depend on the length of the column of blood it has to support.

No doubt nature provides a means of taking off this excessive pressure by supplying the veins with valves, so that under normal circumstances the vein has only to support the column of blood that lies between two pairs of valves. But nature has also endowed the veins with the power of distending, so as to be able to accommodate an increased quantity of blood, should there arise any temporary obstruction to its onward flow through the heart. Now, when the veins so dilate, the valves within them are drawn apart and so allow of regurgitation. This temporary distension of the veins and insufficiency of the valves is quite a normal process. But suppose that the obstruction to the onward flow of the blood, due to one of the extrinsic causes, is permanent, or that the condition of the vein walls is such that after distension their elasticity has become so impaired as to prevent them returning to their usual size, then the valves remain permanently apart, and are no longer capable of supporting the column of the blood. This throws an extra weight on the valves below, and these again yielding, the functions of the veins become more and more impaired. Now, in obedience to the general law in the body, that when a part loses its function it gradually wastes, so in the veins we find that the valves, being unable to accomplish their purposes, gradually atrophy, and may ultimately either disappear altogether, or their former existence be only recognised by thin fibrous bands on the inside of the vein. Hence it is, as Gay says, that "as a rule, veins that become varicose are destitute of valves."

Thus it happens that the veins below the original site of lesion have a permanently increased pressure of blood thrown upon them, and this alone will eventually cause them to become varicose, even though they were themselves originally healthy, and although the original cause of the obstruction to the circulation may have disappeared. Let me here give an illustration of what I mean. Suppose that the original cause of increased pressure in the veins of a limb has been due to constipation and the pressure of intestinal accumulation upon the iliac veins—suppose that this has continued long enough to cause varicosity in some of the veins of the leg, say below the knee; after a time the valves in these veins have become atrophied and the veins permanently dilated—now, suppose that under proper treatment the constipation has been cured, will this allow the veins to resume their normal condition? No; on the contrary, this very destruction of the valves has thrown a permanently increased pressure on the veins below them, and this

alone will cause them to undergo the same process, unless means be adopted to relieve them of the unusual pressure.

Some doubt has been expressed as to whether the deep veins in the leg—that is, the veins running between the muscles and those which emerge from the muscles themselves—are liable to varix like the superficial veins. I think Verneuil has satisfactorily proved that they are, and that in the majority of cases the subcutaneous and the inter-muscular veins suffer equally. It is, however, doubtful that the intra-muscular veins join in the lesion. It has been pointed out by Briquet that the place where varix first appears is at those points where large veins, emerging from the muscles, empty themselves into either the superficial or the deep veins, and that in advanced varicosity of the veins these are the places in which the disease is most aggravated. Now, the fact that for many years it was doubtful whether the deep veins ever became varicose, shows that, even when they are, the condition gives rise to comparatively little inconvenience. This, I believe, is due to the fact that, lying between powerful muscles which are constantly contracting, they are so supported and protected that, even in a varicose state, their function is preserved. And this will also explain why they do not suffer, as a rule, as often as the superficial ones, nor to the same degree; and will also explain why the intra-muscular branches themselves scarcely ever, or but rarely, are found to be in a varicose state. But it is quite otherwise with the subcutaneous veins. The skin alone protecting them on one side, can afford them but poor support, and therefore all the evil effects that can follow from varicose veins find their fullest development in connection with these superficial varices. As a result of the obstructed circulation in the veins of the leg, we find the circulation in those parts of the skin and subcutaneous tissue, from which the venous radicals arise, is impeded. The result is, the skin no longer obtains the quantity or the quality of nourishment that it should, and we then see it become discoloured. From exudation from the obstructed veins the tissues around them become infiltrated, and we find the skin of the part becoming brawny. It is a process of slow starvation. Keep it unrelieved a little longer, and the tissues, no longer receiving enough nourishment to maintain vitality, die, or, in other words, the skin sloughs, and an ulcer is left—that well-marked sore, with its unhealthy or sloughing surface, and hard, elevated, brawny edges, which is commonly, and, I believe, very properly, called a varicose ulcer.

Note, then, the sequence of events. A vein is no longer able to support the pressure of blood within it, either because it has suffered from some *intrinsic* cause which has destroyed its elasticity, or because the pressure from above has from some *extrinsic* cause become too great. It becomes varicose. Let me digress here for a moment. Some of you have seen varicose veins excised. One thing must have struck you, if you have seen many such cases, and that is that in some cases the veins are excessively thin-walled—so thin, indeed, that it is a wonder they have not burst long ago; and under these circumstances it is often a matter of considerable difficulty to dissect them out or to apply a ligature. Again, in other cases you will have noticed that the veins are extremely thick; their walls are hypertrophied. In one case, I remember excising a portion of the saphena vein just above the bend of the knee. It was as thick and as large as the iliac artery, and admitted the tip of my little finger. I found it very difficult to realise that it was a vein I was dealing with. Now, I believe we shall find that in these varying conditions we have a clue as to the cause of the varicosity of the veins. These tough, thick-walled veins, I believe, are veins which have become varicose owing to *intrinsic* causes. They have, from some cause or other, been the seat of a chronic phlebitis, and that phlebitis has given rise to hypertrophy of the coats and loss of elasticity. On the other hand, the thin-walled veins have yielded to *extrinsic* causes. They have simply had a burden thrown upon them they were unable to bear, and they have passively become dilated, and consequently thinned.

Now, to return to the sequel of events following on a vein in the leg becoming varicose. The circulation in the part is checked, the nourishment of the part is therefore seriously interfered with. The skin first becomes discoloured and suffers from a form of eczema. Finally, the skin supply is so deficient that the part sloughs, and we have, as a consequence, an ulcer. Added to this, that the vein wall may suffer, and terrible hæmorrhage may ensue not only from the lower radicals but from the trunk, in which there are no valves to check the backward flow. Now, under these varying circumstances, what treatment should we adopt? In the early stage, when as yet the vein is to a limited extent involved, but before the skin has suffered in any way, there can be no question that palliative measures should be adopted, and of these, in my opinion, the best is the elastic bandage. Its object is

to yield that support to the veins which their walls are unable to afford; and by such means, provided the offending cause be removed, and provided that the valves have not been destroyed, we may even hope for a cure ultimately. I will go further and say that in old and very debilitated subjects such palliative measures are preferable to operation, under all circumstances. Again, if the varicosity of the veins in the legs be due to an irremediable extrinsic cause, operation is obviously excluded; as, for instance, if the condition be due to pregnancy, to pressure of an abdominal tumour on the iliac veins, to disease of the heart, to cirrhosis of the liver, and so forth. Therefore, in all cases before operative measures be adopted, it will be necessary to satisfy ourselves first that such causes do not exist. From these exceptions we may deduce the cases in which I believe operation is advisable. Firstly, the varices must be due to intrinsic causes, or to remediable extrinsic causes, such as constipation, the pressure of an ill-fitting truss, tight garters, or too long standing. In these latter cases the cause must be removed. Then, again, the patients should be young, or healthy adults; and let me here say that, in my opinion, comparatively slight varicosity may induce us to operate in a young subject, which in an advanced adult would not justify us.

Subject to the conditions already laid down, if, in a healthy adult, we find a varicose condition of the veins accompanied by an ulcer, or with a brawny condition of the skin, or with eczema, if it be sufficiently extensive to give rise to pain or discomfort, I think operation is the best treatment.

Now, what do we hope to attain by operation? Complete obliteration of the diseased vein. This has been sought after in all the many and diverse methods which have from time to time been recommended. By occluding the vessel we at once remove the pressure on the parts below caused by the long column of blood in the patulous vein. The effects of this on the parts below are obvious. It relieves at once the cutaneous and subcutaneous circulation, and will therefore not only help to cure, in the most efficient manner, brawniess and eczema of the skin, and ulcers, but it removes the chief factor in causing the more distal veins to join in the varicose condition. Nor need we fear that by closing these blood-channels we shall increase the blood stasis. The venous anastomoses are so free, not only between the superficial vessels themselves, but between the superficial and deep veins, that the utmost we do is to divert the blood from the subcutaneous courses

into the inter-muscular and deep veins of the limb, where, as we have seen, they have more external means of support than those which run beneath the skin.

I have stated that all the various operations recommended for the cure of varices aim at obliteration of the vein. One exception deserves passing notice—that of Mr. Herapath, who proposed division of the falciform process of the saphenic opening in order to remove a supposed pressure on the femoral vein. After some experience of its effects, he subsequently declared that he had lost confidence in it, as the benefit he supposed he had attained was but transient. The various methods employed for procuring occlusion of the veins may be divided into—1. The production of coagulation by the external application of caustics. 2. Subcutaneous constriction of the veins, alone or accompanied by injection into the veins, or by subcutaneous division. 3. Excision of the veins. The first of these methods was, in these countries, first tried by Sir B. Brodie; he employed potassa fusa along the track of the veins, but his experience of it was not encouraging. It was subsequently re-introduced by Mayo, whose name is commonly associated with it. He used nitrate of silver, but shortly afterwards, in France, Vienna paste was substituted for this. The late Dr. Samuel D. Gross, of Philadelphia, speaks of this method as the safest, as well as the most effectual. This is the description he gives of it, and I think we can hardly say that the proceeding is not a severe one. The method “consists in making a number of eschars with equal parts of caustic potassa and quicklime, converted into a consistent paste with alcohol. Of this, a portion of the size and shape of a three-cent piece, only much thicker, is placed directly upon the enlarged and tortuous vessel, at intervals of three, four, or five inches, and allowed to remain for fifteen minutes, at the end of which the skin and connective tissue will be found to be thoroughly destroyed. The paste is now removed, and the parts, carefully washed with vinegar to neutralise any of the alkali that may still adhere to the surface, are covered with an emollient poultice, for the purpose of promoting, first, the separation of the eschars, and, secondly, the development of granulations. The cure is usually somewhat tedious on account of the length of time required to heal the issues, but it possesses the great advantage of being entirely free from danger, and always perfectly successful.” I think I shall presently be able to show that we can to-day do much better for our patients in the way of curing them expeditiously and without pain. The

second method is the subcutaneous method; and I shall very briefly enumerate the various modifications. Sir Everard Home tried ligature of the trunk of the saphena vein on the inside of the knee, and it was adopted by Sir B. Brodie, Sir A. Cooper, and others; but as fatal results followed in many cases, the method speedily fell into disrepute. More lately, subcutaneous ligature with a metallic wire has been practised by Dr. Levis in America, and is said to have proved a safe expedient. The wires separate spontaneously in from two to three weeks, especially if they are occasionally tightened.

In 1817 Sir B. Brodie recommended subcutaneous division of the diseased vein. His comment upon it later was that it appeared as "though the veins generally healed without becoming obliterated; and in case the cluster became obliterated, others took its place, and no benefit ensued." Add to this, that suppuration followed in several instances, and even death. Constriction of the vein by means of a needle passed beneath it, crossed by a figure-of-8 ligature in front of it, was first suggested by Davat, of Aix, and was subsequently advocated by Sir W. Fergusson, Velpeau, Gay, and others. Mr. Lee modified this by passing two needles at the distance of three-fourths of an inch from each other, the vein being pressed against the pin by indiarubber ligatures and divided between them subcutaneously. Previous to adopting the method of antiseptic excision of varices, I several times practised the needle operation, and I was anything but satisfied with the results. I found it caused a considerable amount of irritation, often inflammation and ulceration, and frequently without any beneficial results. On two occasions I had to have recourse subsequently to excision, to cure the veins on which I had twice in each case tried subcutaneous constriction with needles. Moreover, this method is not without its risks, for on several occasions—one of them reported by Mr. Davies-Colley (*Guy's Hosp. Reports*, 1875, p. 431)—the needle, while passing beneath the offending vein, transfixed a deeper but unnoticed vein which ran parallel with it. Mr. Howse, who is a strong advocate for the antiseptic excision method, thus speaks of the objections to the subcutaneous needle:—"Any operation which depends for its success on continuous pressure on such a sensitive structure as the skin, involves much more pain and constitutional disturbance than a clean cut wound. Indeed, the late Sir William Fergusson recommended that the pins should be allowed to remain, with the silk on them, until they had 'excited considerable swelling



and slight ulceration;' stating, further, that 'in some instances they might be left until they had separated by ulceration *through both vein and skin.*' And he justifies this recommendation by recording that in one case he compressed an inch or more of the enlarged internal saphena vein, and on withdrawing the pins, before much inflammation was excited, found that the blood again circulated through the vein in a scarcely diminished volume" (*Guy's Hospital Reports*, 1877, p. 462).

The cure of varicose veins by injecting into them perchloride of iron was originated by Dr. Pravaz, of Prague, and has been tried extensively in Germany, France, and England. Mr. Erichsen describes it as a dangerous practice, and in Germany it was "excluded by the phantom of embolism," as Dr. Ellinger said, when he endeavoured to resuscitate it. He could not, however, prevent some disastrous results, "but," writes Mr. Gay, in his work on "Varicose Disease," "Herr Ellinger is nothing daunted, upon the common principle that 'accidents will happen,' or, as he puts it, 'death will follow the treatment of other trivial cases'" (p. 146).

Lastly, I come to the treatment by excision. This is no new method; the only novelty in it consists in providing for and anticipating the dangers to which the method was liable from septic contamination of the wound. Excision was practised as long ago as the days of Celsus, who "drew a distinction between straight and convoluted varices; for the first he recommends that they should be exposed by cutting through the skin, and then destroyed by the actual cautery; whilst the latter he at once cut out with the knife" ("Holmes' System," 1870, Vol. III., p. 387).

Severinus and Fallopius tied the vein in two places, and excised the intermediate portion. This method of cure, however, so frequently led to disastrous results that till within the last few years we find it universally condemned. Thus Dr. Gross writes:—"Excision and direct exposure of the diseased vessels are too dangerous to be practised, being extremely liable to be followed by phlebitis, erysipelas, and pyæmia. My conviction is that no surgeon should ever expose a patient to such risks" (Gross, "System of Surgery," 1882, Vol. II., p. 1,047).

Under the former methods of dealing with wounds these dangers and risks were by no means imaginary, and it was not without reason that surgeons held veins in most respectful awe. But these very dangers are the dangers which the antiseptic system, when

fully carried out, abolishes, and under its protective influence veins are treated with no more respect or fear than any other tissue of the body. I have twice tied up an opening in the internal jugular vein occurring accidentally during the course of an operation, and once in the axillary vein when removing cancerous glands, without any trouble following; and in the treatment of varicose veins in the legs I excise them with the conviction that I am thereby exposing the patient to no greater risk than if they were left alone.

I will not delay you by entering into the details of the cases in which I have operated. I have full notes of eighteen cases which I have treated by antiseptic excision, besides several cases the notes of which I have not preserved. In no case have I seen "phlebitis, erysipelas, or pyæmia" follow as a result. Let me describe to you the method of operating. The patient being placed under the influence of ether, I begin by shaving the parts where I purpose to make the incisions. The skin is then carefully washed with corrosive sublimate solution; sometimes oil of eucalyptus is also used. I then usually fasten a band round the limb, immediately above the knee, so as to distend the veins sufficiently to be able to trace them accurately. I know some surgeons prefer to apply an Esmarch's bandage to empty the limb of blood, having previously marked out the veins with ink. This I do not think a good plan. In the first place, the ink is very liable to be washed out during the cleansing process; and, moreover, it is easier to secure *all* bleeding points when they can be seen. If the veins in the limb are extensively varicose, it is much better practice to excise the chief radicals at intervals, removing two or three inches at each place, than to attempt to excise a long piece of vein. Nothing is gained by the more extensive incision. Having selected the place for incision, a clean cut is made through the skin, and almost immediately the swollen vein appears. The subcutaneous tissue over it is divided on a director. Should the vein be cut, it is at once seized with Sir Spencer Wells' forceps. A strong cat-gut ligature is passed round the vein at its lower end. The vein above this is seized with forceps and the vein divided between the forceps and the ligature. It can then be easily pulled out of its bed. Any radicals going into it are ligatured and cut off; finally, the vein is tied at the upper angle of the wound and the piece excised. When the veins are tough with hypertrophied coats the proceeding is very simple; but when the veins are thin, especially if adhering to the skin, a good deal of care and patience are

required. The wound is irrigated with corrosive sublimate solution, 1 in 2,000, a little iodoform dusted over it and the edges brought together. In my earlier cases I used to insert a drainage tube, but I now think it is quite unnecessary. The wound is then enveloped in some of the antiseptic dressing, whilst a second and a third piece of the vein is treated in the same way, if necessary. If both legs are involved, the second leg is treated in the same way at the same time. Both legs are then bandaged from the toes to above the knee. As a rule, the dressings are left undisturbed for eight or ten days, and when removed we generally find the wounds healed by first intention. In a few cases some supuration occurred, but this was generally traced to some deficiency in the dressings, at a time when the dressings were improperly prepared. This only delayed the process of healing, but in every case the asepsis of the wound had been sufficient to protect the veins from contamination.

Now, let me say a few words as to the general effect of the operation. The beneficial effects have been in many cases so marked as to dispel all doubts as to the efficiency of the cure. In one case the patient was a man, aged thirty-six, who became perennially an inmate of the Adelaide Hospital to be treated for varicose ulcers. He refused several times to have any operation performed. At last I told him I would not take him in again for varicose ulcers, unless he would consent to have an operation on the veins tried. Two years ago he presented himself again, with the ulcer as bad as ever, the skin brawny and discoloured, the edges of the ulcer hard, elevated, and inflamed. He consented to an operation for the cure of the veins. I kept him in bed for several weeks, and treated the ulcer until it was about the size of a florin, and was quite healthy. I then had him placed under ether, and I excised portions of those veins which seemed to be chiefly connected with the ulcer. I may mention that all the veins operated on were above the ulcer—that is, on the side nearest the heart. The operation was performed as usual, and the dressings applied were not disturbed for a fortnight. They included the ulcer. When they were removed, the ulcer was found to be perfectly healed beneath them, and all the incisions—three in number—had healed by first intention. I allude to this case because it goes to prove that these ulcers are caused by the pressure in their efferent veins.

Early in November last I operated on a young gentleman, aged

twenty-five, the subject of extensive varicose veins in the right leg. The saphena vein at the bend of the knee was very large. He had previously been operated on by a surgeon in Dublin twice by the subcutaneous needle method, for the obliteration of the saphena vein at the knee. On each occasion three needles were passed beneath it at intervals of half an inch, and yet when I saw him this vein was as patent and as varicose as if it had never been touched, though the skin over it showed marks of where it had been constricted. I excised portions of the three most aggravated varices I could find. The wounds all healed by first intention. I saw this patient to-day. The veins operated on are all obliterated. He told me he had lost the bursting feeling in his leg from which he used to suffer, and that he had discarded the elastic stocking. The veins unoperated on remain varicose, neither better nor worse than when I saw him in November, and he is so pleased with the former operation that he wishes all the veins to be treated in a similar manner. This case illustrates the superiority of excision over the constriction method.

Before bringing this paper to a close, let me say a few words as to the permanency of the cure. Most of the writers on this subject are of opinion that the disease is incurable, and that the most to be expected from it is temporary relief, and, in fact, that the game is not worth the candle. Let us observe, however, that these conclusions are drawn from those other methods of treatment, which I have shown are in many ways defective. Since antiseptic excision has begun to be adopted, within the past ten years, we find on record many cases of cure, which have lasted over one, two, or more years, and this has been my own experience. If the varicose condition of the veins is due to a cause which we cannot hope to rectify—an extrinsic cause—we cannot expect operation to be successful. But when we can remove the cause, and when, at the same time, we treat the effect, I consider that we have just grounds for assuming that the cure will be radical. Two years ago I operated on a young man, aged twenty-six, for extensive varices of one leg. A year and a half later he wrote to me to express his great delight at the permanency of the cure; that since the operation had been performed he had been able to take long walks, to stand the greater portion of the day without the slightest inconvenience, or without any sign of fresh varices appearing. I could point to many similar cases, but I feel I have already detained you so long that I will content myself with

adding that I hope I have succeeded in impressing you with my own conviction that in antiseptic excision, in suitable cases, we have a means of treating varicose veins which offers far better and more permanent results than any other method hitherto devised, and that with ordinary care it is far safer.

---

ART. XXII.—*The Use of the Curette in the Diagnosis and Treatment of Diseases of the Uterine Mucous Membrane.\** By W. J. SMYLY, M.D. Univ. Dubl.; F.K.Q.C.P.; Gynæcologist to the City of Dublin Hospital.

BEFORE entering upon the special subject of the use of the curette, in the diagnosis and treatment of diseases of the uterine mucous membrane, permit me to guard against a possible misapprehension. I do not wish it to be supposed that because I have limited my remarks, as far as possible, to the use of a single instrument, that therefore I would limit our means of diagnosis to its use; on the contrary, it is against such exclusiveness that I wish to contend. It certainly seems strange that, although the sense of sight has long since been brought to bear upon the diseased conditions of the uterine mucous membrane, yielding, as might have been expected, most important results, we should almost have ignored this method of diagnosis, and have practically limited ourselves to the sense of touch. In proof of this I would refer to our text-books or to Dr. Edis' paper, "On the Exploration of the Uterine Cavity in Cases of Metrorrhagia," read at the meeting of the British Gynæcological Society on the 9th of last December. There he advises—and all who joined in the subsequent discussion appeared to agree with him—"in all cases where hæmorrhage from the organ persists unnaturally," to dilate the cervix and explore the cavity with the finger. Now, my present object is to state my conviction, and, if possible, to prove that this routine practice of dilating the cervix for diagnostic purposes is unnecessary; and that if an intelligent use of the curette be substituted for it, dilatation will be required in exceptional cases only. I do not, however, deny that the use of the curette for diagnostic purposes is recommended in our text-books, or that it is occasionally employed for this purpose; but the teaching in these countries appears to be this—first to explore with the finger, and if this fail, then try the curette;

\* Read before the Obstetrical Section of the Academy of Medicine in Ireland, Friday, April 2, 1886.