and fish to an ordinary diet. The patient should go home about the twenty-first day after operation.

The complications to be guarded against are pneumonia, secondary hæmorrhage, sepsis, cystitis and phlebitis. Great care must also be taken of the patient's back.

MISS DICKINSON'S PAPER.

Fothergill's operation is performed by some gynæcologists for the condition of vault prolapse of the uterus. In this condition there is a general tendency for the uterus to be displaced downwards, owing to weakness of the trans-cervical and utero-sacral ligaments and the pubo-cervical fascia. When a pelvic examination is made the cervix is found to be situated lower in the vagina than normally, and when grasped with vulsellum forceps during operation is very easily pulled to the vulva. There is usually some degree of cystocele and rectocele present also.

Pre-Operative Treatment.

These patients are usually admitted several days prior to surgical treatment, as they frequently suffer from a vaginal discharge, and it is therefore necessary to douche the vagina for some days to render it as clean as possible.

This pre-operative period is very necessary to enable the patient to adapt herself mentally to her new environment. Very much depends on the reception she receives when entering the ward or nursing home, as to the confidence she places in those around her, and the amount of co-operation she gives, which is so invaluable to the nurse. It must be remembered she has in all probability left a home, husband and children behind, and cannot help worrying over them. If she feels she is with sympathetic, understanding people, it will help her to orientate and become mentally calmer.

Thirty-six to forty-eight hours before operation, castor oil or some other aperient is given, followed by an enema two to three hours prior to the operation, and also an antiseptic douche.

The vulva is shaved and the patient allowed to take a warm bath. On the day of operation the suprapubic region and the vulva are prepared with an antiseptic solution and a sterile towel applied to the part, and bandaged in position. Some gynæcologists wish their patients to be catheterised just before being sent to the operating-room.

Post-Operative Treatment.

The patient is nursed as flat as possible. She can be comfortably nursed with one bolster and pillow beneath her head, a pillow under her shoulders and in the hollow of her back, her pelvis resting on an air-ring, and a bolster beneath the knees, unless she is stout, or has difficulty in breathing, when she will need an extra pillow beneath her head.

The patient's bowels and bladder require very special attention. Unless a self-retaining catheter has been inserted at the end of the operation, she may have some difficulty in micturating during the first few days. She should be encouraged to drink plenty of fluids and be given a urinary antiseptic, *e.g.*, Mist. Hexamine. She must not be allowed to get agitated about micturition, but assured that if she cannot micturate her urine can be removed painlessly, but that it is best for her to micturate normally. The patient's fluid intake and all urine excreted should be measured. If there is any marked difference in the two amounts, the patient should be catheterised for residual urine, which if allowed to stagnate may give rise to cystitis. The bladder should not be allowed to become distended, and if she cannot micturate she should be catheterised every twelve hours with strict asepsis. If a self-retaining catheter has been inserted, it must be changed every twenty-four hours. Its great advantage is that the patient does not keep straining to micturate, or have the mental worry as to whether she will be able to do so or not, when she has the desire.

An aperient is usually given on the second evening after operation, and from thence onwards the bowels kept well open.

It is absolutely essential that the vulva be kept scrupulously clean, and therefore it must be dressed after every act of micturition or defæcation. It should be gently swabbed clean and an antiseptic dressing applied. Gauze soaked in flavine is excellent.

The patient may need a few low-pressure antiseptic douches if a discharge appears about the eighth day after operation.

The patient should remain in bed sixteen to twenty-one days if possible. If she is poor, and her home unsuitable for prolonged convalescence and rest, it is advisable for her to have three weeks or longer at a Convalescent Home. She should be given advice (before she leaves hospital) as to types of work it is not wise for her to do, such as washing, mangling, etc., and the rest periods she should endeavour to have during the day. If this advice is overlooked or not followed, she will in all probability return to hospital in the near future with a return of her original condition. The aid of the Almoner's Department may be enlisted to secure additional help in the home, or convalescent treatment, or possibly to board out the children before the mother's return home, to lighten her domestic duties.

QUESTION FOR NEXT MONTH.

What would you require for the following treatments? Give in detail the technique you would employ in carrying them out. (*a*) Gavage Feed; (*b*) Application of Leeches; (*c*) Dry Cupping.

THE CHIEF CAUSES OF DEAFNESS.

Speaking at the recent New Health Society's Summer School at Margate, Mr. Scott Stevenson said that the chief single cause for the rejection of recruits for the Army was old or active ear disease. The chief cause of deafness was acute infectious disease, especially measles and scarlet fever. Together they caused 40 per cent. of the deafness of children in special schools for the deaf. Mumps was another important cause.

Industrial noises, especially noises created by boiler-making and riveting, said Mr. Stevenson, were not a very important cause, compared with the number of cases in the country. Industrial deafness could be prevented by muffling the noise or muffling the ears of the workers, or by using silencers.

Bathing and swimming, in certain circumstances were important causes of deafness.

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