furnish to the accoucheur data of great and special importance, and for this reason: The wife of a working man, as anyone but the financier may know, has "no time to lie a-bed," and does invariably get up on the third or fifth day, seldom, if ever, keeping on her back till the ninth day, which is the legitimate and correct period of the higher and more respectable classes. The very necessity of getting about as soon as possible at once furnishes us with a standard of comparison of very great value. Thus, if I look into the details of the last fifty cases of forceps operation on my register, I find these women commenced their usual household or their factory work at periods ranging from the third to the tenth day, under circumstances completely favourable as to feeling, actual state, and general condition. Now let any accoucheur compare these results with those obtained from an observation of fifty cases of natural and uncomplicated labour, and he will perforce come to the conclusion that the forceps cases made as good and as quick recoveries as the cases of strictly natural and unassisted labour. Again, take these same fifty forceps cases and compare them with another series of fifty cases of tedious or protarcted and unassisted labour, and it will be found that, while the former approach very near unity as to rapidity and perfection of recovery, the latter depart considerably from this standard of excellence—if I may be allowed the expression—inasmuch as, setting aside altogether the rate of mortality, many will make more tedious recoveries and depart further from the healthy or natural standard as measured by time, and this we would set down as the tenth day. In plain English, the assisted cases get about sooner and feel better than the unassisted cases do. If this be the case—and who will now deny it?—can we doubt that the more frequent use of the forceps becomes not only justifiable, but a matter of duty? By their more frequent use we would not only lessen the maternal and infantile death-rate, but, by eliminating all or most of the causes of death and other pathological states, we would bring our patients nearer a healthy standard of recovery.

But it may be objected that the duration of recovery is too uncertain a quantity to be used as a standard of comparison, and that my statistics must be too elastic, and only an approximation to the truth. But the same objection can be urged against vital statistics of all kinds. Medicine is strictly an uncertain science, and all that the numerical method can do is to give an increased weight of probability to the truth of our investigations. Dr. Barnes, in his admirable lectures on the Convulsive Diseases of Women (The Lancet, May, 1873), says: "The laws of numbers are infallible, but not so the perceptions and the reports of observers; nor are individual cases of disease constant uniform quantities like abstract figures. I think the true clinical physician will prefer to base his judgment as to the value of different methods of treatment upon careful observation of the action of remedies and close critical comparison of cases." This if all I pretend to do. I compare the recovery in a given number with the of tedious and protracted labours, using the tenth day as the general and natural standard, and I find the forceps cases have had the best of it.

In conclusion, I would just enumerate the class of cases in which I think it justifiable and obligatory to use the forceps.

1. In all cases where the first stage of labour is completed and the head stationary in a position favourable for their use. Under these conditions I would not wait longer than two hours.

2. In cases where, though the head is advancing, the labour is tedious, from the fact of the pains being too weak or having almost ceased.

3. In cases where the pains are stronger than is warranted by the advance made.

4. In hæmorrhage, if excessive; and in some cases of convulsions.

5. In cases, favourable for operation, where the patient is very desponding or impatient.

6. In cases of a tedious nature where there is a rigid fourchette or a lengthened perineum, especially where the pains are not steady in rhythm and force, and where mother Nature seems bent on rupture. In reference to this class of cases I make no apology for quoting from a report of Dr. Clark's paper in the Dublin Quarterly Journal of Medical Science, Jan. 1873. He says: "If rigid peritoneal tissues be the obstacle, the danger of their laceration will be lessened by the forceps. The wedge-like form of the proximal end of the locked blades is an important aid in dilation. It prepares the way; meanwhile it diffuses the bearing of the uterine force along the longitude of the vagina, lessening its intensity at any point. Moreover, the experienced practitioner will remember that a majority of the cases of laceration of the perineum occur when, after long delay at that point and many ineffectual pains, the uterus, as if vexed with the futility of its efforts, with one tremendous throe suddenly bursts through the obstacle. Reflex power, when repeatedly foiled, does thus accumulate, The forceps, by securing the steady progress of the head, in some degree obviates the danger,"

7. In cases of occipito-posterior positions, unless the labour is advancing quickly. I have had four cases of the above presentations during the last year. Three were in the third position and one in the fourth. There was delay in all. All I had to do was to rotate the head so that the presentation became occipito-anterior.

8. The second twin, if a head-presentation, and not advancing quickly aftar the first.

9. To save time—i.e., if the case is favourable for forceps—I do not scruple to use the means at my command of relieving the woman from travail and myself from work.—[Lancet.

ACTION AND SOUNDS OF THE HEART.

In a paper on the action and sounds of the Heart, read before the British Medical Association, Dr. George Barton maintained that it was a mistake to believe that the ventricle is dilating when the arterial systole takes place. He summed up his views as follows:—1. The distended aorta reacts in immediate connection with the ventricular systole, crossing the sigmoid valves as its impulse is imparted to the wave. 2. The sound produced in closing the sigmoid valves terminates the first sound of the heart. 3. The second sound is produced by contraction of the auricles, as they propel the blood through the auriculo-ventricular foramen, distending the ventricle. It appears to follow the first sound, but represents the commencement of a new beat. —[The Doctor.