these, 1 died of an intercurrent disease in 7 years and 10 months after the operation, while the remainder are still doing well, 1 for 9 years and 10 months, 1 for 9 years and 1 month 1 for 6 years and 9 months, 1 for 4 years and 3 months, 1 for 3 years and 11 months, 2 for 3 years and 6 months, and 1 for 3 years and 5 days. Let us contrast these results with those afforded by the next best operation, namely, the removal of the breast by flaps, and the evacuation of the contents of the axilla in every case. Of 328 cases of this description in the hands of Banks, Kuester, and Von Bergmann, 10.67 per cent. perished, there was local recurrence in 54.92 per cent, and 15.15 per cent. were cured, so that Dr. Gross' operation is safer by 6.23 per cent., is less liable to local recurrence by 25.97 per cent., and affords 7.35 per cent. more of permanent recoveries.

DILATATION INSTEAD OF THE SUPPORT OF THE PERINEUM.

BY H. ERNEST TRESTRAIL, M.R.C.P., F.R.C.S.

The dread of the perineum becoming ruptured during the passage of the child's head led to the practice of supporting it, and this has been more or less done from time immemorial to the present day. A large midwifery experience convinced me many years ago of the fallacy and danger of this practice; and in a paper read before the Obstetrical Society, of London, and published in their *Transactions* of 1875, I recommended a diametrically opposite line of treatment, which is certainly followed by far better results.

Let us consider for a moment the object we have in view—namely: We want the soft parts of the outlet of the pelvis to dilate, so as to allow the passage of the child's head, without its weakest part rupturing. What does support do? It presses the perineum between the hand on one side and the child's head on the other, so that the more support we give the more squeezed, thinned out, and lengthened the perineum becomes. No wonder, then, that it frequently gives way. One can hardly imagine anything so likely to favor a rupture as this pressure on both sides. True, the support may delay the advance of the head, but this pressure against the perineum rouses the uterus and makes the pains more violent, so that, if delay is the object sought, direct pressure upon the child's head is infinitely preferable, and safer in every way.

In cases of ruptured perineum what has occurred? Either the outlet was abnormally unyielding, or there was not time for it to expand, so that the weakest part gave way. The obvious way of preventing this unfortunate result is to dilate the perineum before the child's head reaches it, and practically this is easily effected. One can readily form an opinion as to the necessity for this proceeding by ascertaining the dilatability of the parts, the size of the outlet, the length of the perineum, and the character of the pains.

If there is reason to believe that the parts will not readily yield to the advancing head, they may be gradually dilated by drawing back and expanding the perineum during each pain, first with two and then with three fingers, and keeping up as firm extension as can be borne short of pain, and continued from time to time until the required amount of dilatation has been obtained.

By this simple proceeding (1) the pains are strengthened; (2) the latter part of labor is materially shortened, and is far less painful; (3) the perineum is preserved intact.

Fifteen years ago I confidently recommended the dilatation of the perineum as the best means of avoiding the danger of its rupture and of facilitating the latter stages of labor; and further experience fully confirms the favorable opinion I had then formed of its usefulness, and which led me to bring before the profession a mode of treatment which, so far as I know, had not up to that time been recommended.

RESORCIN IN WHOOPING COUGH.—Dr. Andeer (*Centralbt. f. Med. Wiss.*) employed resorcin successfully in the complaint named, giving to children half a wineglassful of a 2 per cent. solution in water, of which a portion was directed to be used as a gargle.