HOW TO DEAL WITH THE PLACENTA.

The proper method of dealing with the placenta is one of the vexed questions of midwifery. Credé's method of expression is generally in favor with modern teachers of the art of obstetrics, but at the same time has many vigorous opponents. Recently it was announced that Credé himself had abandoned the method, but this report was found upon investigation to be entirely unwarranted. The principal objections to Credé's method are that it involves waiting some minutes after the birth of the child before delivering the placenta, that the manipulation of the womb is injurious to that organ, and that post-partum hemorrhage, retention of the membranes and even septic infection are encouraged by it.

Dr. Wm. T. Lusk answered these objections in an address delivered before the New York County Medical Association, and said that in his experience it succeeded ninety-nine times out of a hundred, in fact in all cases except where the placenta was adherent. The truth is that many of the objectors to Credé's method do not understand it. This was notably the case with Charpentier, who denounced the practice and advocated traction upon the cord instead, but any one who reads Charpentier's work on obstetrics it is evident that he has utterly failed to comprehend what Credé's plan is and how it is to be carried out. Lusk's description is so good that it is reproduced below, even at the risk of causing many of our readers to denounce it as a medical chestnut. He says: "The Credé method consists in first applying light and afterward stronger friction to the fundus of the uterus, until an energetic contraction is obtained. At its height the uterus is grasped so that the fundus rests in the palm of the hand, and the body is pressed between the thumb and fingers. The effect of external pressure thus exerted is to force the placenta from the uterus, or, in case of failure, the process is to be repeated. In experienced hands it is likely to be expelled by the third or fourth uterine contraction." It should have been added that these contractions are to be waited for at least twenty minutes.—*Northwestern Lancet.*

SIGNIFICANCE OF A "CHOKED DISC."

The so-called "choked disc" signifies only that the free circulation in the optic disc is interfered with, whatever the cause may be. Any condition, anywhere, that causes sufficient pressure on the veins that return the blood from the optic nerves, to prevent its free use and easy flow, at once causes the developement of "choked disc." The pressure allows the arterial blood to pass into the nerves, but prevents the venous blood from returning. The result is that a decidedly "passive" congestion of the discs takes place. This condition is what is designated "choked disc." While it may be the result of a tumor, it does not by any means, indicate the presence of one in the brain, since any disturbance of the circulation in the nerve, from whatever cause, gives rise to the same condition. I have seen "choked disc" caused by a tumor in the orbit behind the ball, by acute or chronic meningitis, by serous effusion within the skull, by various syphilitic affections and by various kinds of injuries of the head—in a word it results from any condition that interferes with the venous circulation in the optic disc. On the contrary, a person may die of tumor of the brain without any disturbance of the discs whatever. Græfe reported a case of tumor of the brain that involved and destroyed the entire optic chiasm, so that the nerves could not be traced through the tumor at all; yet the vision was good and no "choked discs" were present. The conclusion therefore is is that a "choked disc" is positive evidence of interruption of the nervous circulation in the nerves, but does not point to the presence of a tumor of the brain.

"Choked disc" and "optic neuritis" are sometimes spoken of as meaning the same thing.—This is a grave mistake. The former is a *passive* congestion, while the latter is an *active* inflammation of the nerves.

The localizing value of the "choked disc" is very uncurtain and unreliable. It usually comes on late in the progress of a tumor of the brain, when there is so much cerebral disturbance that it has comparatively little value as a means of localization. Visual defect, as hemianopsia, in the history af the trouble, would be a much better localizer.—A. D. WILLLIAMS, M. D. in *St. Louis Med. and Surg. Jour.*

THE BINDER.

To bind or not to bind the parturient female is a question with which the obstetrician still allows his mind to wrestle. At a recent meeting of the Obstetrical Society of London, it was concluded, in effect, that the doctor had better do as the patient felt inclined. The matter ought not to be left in such a doubtful state.—Kigdoms rise and fall, great nations dissappear, cyclonic storms and volcanic fires change the face of nature, but babies continue to be born, and the mother insists on having a binder, or knowing the reason why.

The Obstetrical Society of London should not trifle with topics of such eternal moment.—for our part, we say do not bind. The alleged comfort secured is imaginary, the idea that the binder can restore the figure is unscientific and unphysiological, its supposed power in helping involution is purely hypothetical, and the whole conception of a binder is unnatural and abhorent to common sense.

The binder is a relic, not of barbarism, for