nervous system. As all discussions in this line mus present be theoretical and unsatisfactory, I close the consideration of this problem with the practical question: If temperature reduction does not shorten the duration, mitigate the severity, or avert serious complication in disease, and if the ratio of mortality is not so diminished as to encourage us that we are making advances by antipyretic measures, on *what bases are we justified in their use?* Evidently, only on the basis that by their use we relieve one of the many phenomena of fever. If this can be accomplished without serious loss of vitality, or at the expense of the reserved force of the patient, we are justified in their use; but do not let us imagine that by reducing temperature we are controlling fever.

PATHOLOGY OF ABORTION IN RELATION TO TREATMENT.

In a paper read before the Section of Obstetrics of the British Medical Association, Dr. Murdoch Cameron emphasizes the necessity of a careful examination of the discharged clots in every case, as the medical attendant too frequently accepts the patient's description of the discharge. In the first month the embryo may escape detection, but after that it can usually be found surrounded by its membranes, the amnion and chorion with its villi, some of which are found penetrating the decidua reflexa. To avoid the "manufacture of complications," he recommends that the membranes be left intact and encouragement given to complete the expulsion. In the early periods of pregnancy if the membranes are ruptured, there need be no hurry; but special attention should be paid to maintaining an antiseptic condition of the passages by frequent injections. If the placenta were retained he had seldom any difficulty in removing it with the finger. He had little faith in the use of instruments, unless when it was protruding from the os. He asked if the use of the blunt or sharp curette with dilatation of the os and dragging down the uterus was reasonable treatment, or whether retention of the placenta was so dangerous or common as to justify these methods? His experience did not justify such measures. With the curette one was working in the dark, and could not fail to wound the healthy membrane and so assist septicæmia, and when the amount of injury which an inexperienced person can inflict with a uterine sound was remembered, we should hesitate to recommend the curette. When hemorrhage was present he generally used an antiseptic vaginal tampon with a firm bandage, and found it sufficient. He has not had good results from ergot. If symptoms of septic poisoning are present, he uses frequent antiseptic injections. He considers that patience in these cases will do less harm than meddlesome interference. Dr. Lombe Atthill, speaking of these cases in which abortion could not be averted, said, that if hemorrhage was alarming, plugging was the most certain means of combating it. It was essential that these plugs should be removed in six hours at the farthest, when the uterus should be washed out with an antiseptic solution. It was seldom necessary to plug. He advocated the treatment by hot water injections, which was perfectly safe and nearly always efficient. He disapproved of the forcible removal of the placenta in the early months of pregnancy, until it was proved that it would not be cast off. Dr. J. A. Byrne has found that the hemorrhage accompanying or preceding abortion was, as a rule, not dangerous. He believed in the use of hot water, and also in rapid dilatation if necessary, and the removal of the ovum. In the early months of gestation there was not much trouble in removing the placenta, but after the fourth month it was most intimately attached to the uterus. Dr. A. Lawrence always plugged the cervix uteri with carbolized lint when hemorrhage was excessive. If the contents could not be cleared out he passed an iodoform bougie into the uterus and plugged with iodoform wool. If in twenty-four hours he could not clean the uterus he repeated the process. Mr. Lawson Tait was of opinion that anyone who, knowingly, left a piece of placenta after a miscarriage might well lay himself open to a charge of gross carelessness. There was no need of any dilatation or of the use of any sharp curette. His "alligator" ovum forceps would remove anything which had been left without any risk. Dr. Murphy regarded the vaginal tampon in the year 1887 as an anachronism. The place to plug was the cervix, not the vagina, and the material caoutchouc bags (Barnes' or Tarnier's), not antiseptic cotton. He thought Dr. Atthill's advocacy of the expectant treatment was founded on his experience at the Rotunda Hospital, where assistance was always at hand. In private practice this was not safe, and he invariably removed the placenta under chloroform with the fingers.—*British Medical Journal*, March 31, 1888.

WHEN TO OPEN A FELON, AND HOW TO ABORT IT.

(W. D. Hutchings, M.D.)

In order to avoid the mortifying results—necrosis, loss or deformity of finger—following deep seated paronychia, the surgeon must abandon a temporizing policy, and, at the proper time, make boldly a free incision to the pus formation. No half-way measures will answer in this case; the incision must be carried down to the point indicated, and be made sufficiently free to avoid occlusion and retention of pus, by the subsequent swelling of the parts.

The *time* to incise is an all important point in obtaining a successful issue, and is left indefinite by our best authorities. This trouble is not even noticed in the hand-books of surgery by Smith or Stimson. Surely neither of these writers ever suf-