It seems strange that any other habit than that of immediate closure of the wound should have obtained. In no other situation has it been the habit to prefer a healing by granulation to union by first intention. If a nostril were torn, the mouth gashed to double its size, the first effort has always been to bring the parts in close apposition and retain by sutures. But many a woman, nearly torn in two, has been allowed to suffer the slow torture of a possible healing by granulation.

As to the means to be employed, if not in one's pocket-case, they are always at hand. A button-needle and embroidery silk, or dentist's floss, have in several instances stood me instead. The silk suture is preferable to silver wire. Its perfect softness and pliability prevent all the suffering which every contact with the twisted wire occasions. The union is as perfect with silk, and though there is likely to be a little suppuration in the track of the threads, the additional comfort that is gained in motion and dressing by using a pliable instead of a stiff suture is sufficient reason for employing the former.

The second matter—often neglected, but deserving of attention in the lying-in month—is the condition of the uterus as to its position. Every woman should be examined by digital touch three or four weeks after delivery, or when beginning to move about freely upon her feet. Any descent of the uterus, or a slight alteration of normal axis is easily appreciated, but what is of more importance is then easily rectified. A light uterine support worn at this time, for a brief space, will achieve what no pessary could at a later one. I make such an examination, and if I find prolapsus or retroversion in the first or second degrees, I do not trust to nature, but attempt her aid by causing a pessary to be worn till involution has lightened the uterus, and the uterine supports have gained their tonicity and their normal size. I feel as well assured as one can, that cases of threatened severity have thus been cured.

Several cases I have had that have been relieved of chronic retroversion by the use of a pessary during the period of involution.

In cases where the uterus lies lower than normal but is anteverted, less can and less needs be done. The axis is more nearly correct and attendant inconveniences are less, while nature, in this case, is more competent to remedy the fault. But here, also, slight support by preventing passive congestion of the displaced organ, will in a measure diminish the tendency to a hyperplasia, which might result.

The nurse will usually tell the patient that the "sense of falling" is perfectly natural, and that it will disappear as strength comes. But in many cases the symptom is an indication of a true uterine displacement, which a little care will remedy, but which neglect will aggravate. There is no time so favorable to treat the malpositions of the uterus as that following delivery. The womb, as well as its supports, are then undergoing active change, and with proper assistance can regain normal strength and tone. We look to the parturient act to remove the mechanical dysmenorrhœa of the nullipara, and we may look to it also as a means of improving many cases of displacement, and most cases of hyperplasia, unless a lack of careful management, during the precious weeks following delivery allow the troubles to aggravate.

The third matter I would specify, as usually neglected but deserving of care during the lying-in month, is the prepuce of the male child. Great attention has been called of late years to the influence of phymosis upon the child's nervous system and I have had many instances where improvement in general health, as well as in local nervous disturbances, has followed the removal of an adherent prepuce. So manifest has this been to the parents, that when a male child was subsequently born in a household where a child had been circumcised, the mother has always been eager that the same operation should be performed on the successor. The popular voice is in favor of the operation. It should be attended to in the lying-in room. It is a well-known saying among nurses, that boys are worse than girls, more restless and fretful. This I think is mainly due to preputial irritation. My attention was first specially called to this condition by two cases which were unable, or very insufficiently able, to empty the bladder. The release of the prepuce immediately relieved the symptom, and one boy, who for six days had wet only once in twenty-eight hours, urinated almost regularly every three or four hours. The other, with even severer symptoms, was at once benefited, and all disposition to retention was overcome.

Since these cases occurred I have examined the prepuce in every male infant, and have operated on all that seemed to demand interference. In the majority of cases at birth there is adhesion between the two mucous membranes, the orifice of the urethra and that of the foreskin not differing much in size. In cases where the preputial orifice allows I push it back, separating the two agglutinated surfaces with a probe. This can be done, I think, in one-fourth the cases. In three-fourths either very forcible stretching or a cutting operation is needful. Of those I much prefer the latter method of treatment. A linear incision slitting the prepuce on the median line is all that is needful, and there is no necessity of circumcision. The splitting up the prepuce is efficient, and equal in appearance. Besides, a demonstrable foreskin is left, which some prefer. In manhood this method results in deformity; in childhood the result is doubtful in this regard; in earliest infancy the result is perfect, provided after operation care is taken that the foreskin shall heal, leaving the glans constantly exposed. The chief reason why the less operation is equally efficient, and therefore should be performed in early infancy, is that the cuticular and mucous surfaces are then equal in development. As the child grows the mucous surface perhaps