in such cases the practice had most frequently been to take one of two courses. The first course—and perhaps that most usually adopted—was to close up the wound and to trust to relief being afforded by the division of the nerves which necessarily resulted from the exploratory incision. Such temporary relief often followed, but it was very rare to find it lasting, and he ventured to look upon such a proceeding as surgically unsound. The second course which had been adopted was to excise the offending organ, as had been done by Mr. Henry Morris. But this was too severe a remedy, and one which Mr. Morris himself condemned, suggesting that it might be wiser to incise the kidney *in situ* and to search for the stone systematically. This was a proceeding Mr. Franks had himself adopted with marked success. He did not consider that incision into the kidney substance was a formidable proceeding, and as an exploratory measure was much to be preferred to excision. Should the stone be found, it was better to find it in a kidney which, otherwise healthy, still formed part of the patient's body, than in a kidney on the dissecting table. In the case he alluded to the symptoms of stone were tenderness on pressure over the right kidney, with intense paroxysmal pain, beginning in the right renal region, and shooting down the right side into the hip and groin. There was a well-marked deposit of oxalates in the urine, but no blood or pus. When the kidney was exposed, no stone could be felt anywhere, and a needle passed systematically through the renal substance failed to detect it. Mr. Franks then incised the kidney for a length of about two inches from the convex border right through to the pelvis, and after some careful search, reached a small abscess cavity containing a small stone and some crystalline particles. The incision in the kidney had to be enlarged to the extent of three inches in order to clear out the cavity thoroughly. The patient made a complete recovery, and had not since been troubled with any of her former symptoms.

Mr. Franks also laid stress upon the importance of leaving the wound in the kidney to granulate without using any means to close it. A case he mentioned showed the aggravated symptoms of renal colic which might be caused by a foreign body such as a gauze plug inserted into the renal wound. He also thought that by leaving it gaping all blood-clots and *débris* would be gradually washed out, and thus the danger of their forming later the nuclei of stones would be avoided.

In cases of tubercular diseases of the kidney, he thought with Dr. Newman that excision of one of the kidneys should be performed, if the case could be got sufficiently early before the second one was involved. It was not easy to diagnose a scrofulous kidney from a case of stone, but an exploratory incision would clear away all doubt. The difficulty was to know whether the second kidney was involved.

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Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.

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PLACENTA PRÆVIA.

One of the most serious of the numerous emergencies of midwifery practice is hæmorrhage caused by placenta prævia. At the recent meeting of the British Medical Association, Dr. Braxton Hicks opened a discussion on this subject with a very interesting address. With reference to treatment, he thinks, with almost all obstetricians, that there is no positive safety to the patient until pregnancy is terminated. In certain cases one may temporize until the child becomes viable; but in adopting such a course an obstetrician assumes a serious responsibility which is frequently unjustifiable. The expectant plan of treatment may result in a fatal hæmorrhage during the absence of the medical attendant, and such an occurrence is one of the saddest catastrophes in obstetric practice.

When the induction of labor has been decided on, we have to consider two conditions.