

vagina was reduced to a very small cone of cicatrized tissue, so that repair by this means was out of the question. In a large and capacious vagina I believe that the ureter could be found and repaired by splitting open the vagina and exposing the base of the bladder, as in my method of repairing severe vesico-vaginal fistulæ.

In no case should we implant the ureter into the bowel nor tie the ureter so as to cause hydronephrosis. Nephrectomy, even as a last resort, is hardly justifiable, in view of the possibility of there being but one kidney, and of the splendid results of transplantation of the ureter.

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NOTES ON PRACTICE IN MIDWIFERY.*

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Mr. President and Gentlemen,—I wish to preface the following remarks by explaining that the points touched on are not of the abstruse order, but common, every-day subjects, a discussion of which will be of benefit to us all. My opinions have been arrived at, not from a reading of text-books, but from hard, every-day experience in a busy practice. And the success met with leads me to hope that I may be allowed to express myself with confidence engendered by the results obtained. In ten years there have been in my practice 1,250 confinements, with three deaths; 285 miscarriages, with one death. None of these fatalities could be properly attributed to my routine, but were unavoidable.

My first death was in a woman of 46, with marked disease of the aortic valves, *in extremis* when I reached her, and dying inside of ten minutes of my entrance into the house. The second was a case of placenta previa, in seventh month, in one married about five months. In an attempt by the victim to cover the anachronism by tampering with herself hemorrhage set in. She did not send for help until her loss was great, and then sent for a midwife, who told her it would come all right, and who in turn waited until she was scared by the heavy flow before sending for me. The result can be anticipated.

The third, also placenta previa, was not properly my case, fall-

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