will necessarily favor the occurrence of a fatal result.

On the other hand, should full dilatation of the os have taken place, and the patient be exhausted from sanguineous loss, the practice of rapid artificial delivery will not rarely be followed by fatal prostration.

There is no question, in my mind, of the fact, that when it becomes the recognized practice to resort to premature delivery as a prophylactic measure in these cases, the statistics which have been quoted will be very much improved upon. By resorting to this measure we should be dealing with a woman who is not exhausted by repeated hæmorrhages; the obstetrician would be in attendance at the commencement of the labor; and he would be able by hydrostatic pressure to control flooding, while the same pressure accomplished rapidly and certainly the *first stage* of labor.

When this step has not been deemed advisable or from any cause labor has absolutely set in complicated by unavoidable hæmorrhage, there are two plans by which we may endeavor to save the lives of mother and child.

1st. We may alter the state of affairs at the cervix so that dilatation may occur without hæmorrhage.

2d. We may hasten the delivery of the child so as to render a *gradual dilatation* of the cervix unnecessary.

The means at our command for accomplishing these indications may thus be tabulated and presented at a glance:

MEANS FOR PREVENTING HÆMORRHAGE WHILE THE OS DILATES.

1. Distension of cervix by bags of water.
2. Evacuation of liquor amnii.
3. Partial detachment of placenta.
4. Complete " " "
5. The tampon or colpeurynter.

MEANS FOR HASTENING DELIVERY OF CHILD.

1. Ergot.
2. Version.
3. Forceps.
4. Craniotomy.

The following cases will illustrate these remarks.

CASE 1.—Mrs. W—, aged 26, primipara, in good health, was suddenly taken with hæmorrhage three weeks before full term. She sent for me in great haste, but being occupied, I was unable to go to her, and she was seen for me by my friend, Dr. Reynolds. He discovered that she had lost a few ounces of blood, but that the flow had ceased. Three days afterwards she was again affected in the same way, the flow ceasing spontaneously. About a week after this she was taken during the night with a flow, which was so profuse as to result in partial syncope when she endeavored to walk across the room. I saw her early the next morning, found her flowing slightly, and upon vaginal examination succeeded in touching the edge of the placenta through the os, which was dilated to the size of a ten cent piece. Later in the day, Drs. Metcalfe and Reynolds saw her and agreed in the propriety of premature delivery. In accordance with this consultation, at 7 p. m. I introduced into the cervix, with considerable difficulty and by the employment of some force, the smallest of Barnes's dilators. This in twenty minutes was followed by the next larger dilator, and in an hour by the largest. Dilatation was rapidly accomplished, but instead of removing the largest bag, I left it in the cervix until ten o'clock that night. Expulsive pains coming on at that time, I removed it, when the head rapidly engaged, and before morning Mrs. W. was safely delivered of a living girl. The placenta followed rapidly, and both mother and child did well.

Remarks.—In this case, although hæmorrhage continued slightly throughout the labor, it never amounted to a sufficient quantity to endanger the lives of either mother or child. The implantation of the placenta being lateral, cessation of the flow occurred as the head advanced and made firm pressure against the bleeding surface.

As to the fact of the case being one of placenta prævia there could be no doubt. The placenta was distinctly touched by Drs Metcalfe, Reynolds, and myself; one lip of the cervix was disproportionately developed, and the placental murmur was much more distinct over the symphysis than near the fundus.

CASE 2.—Mrs. D., a lady over forty years of age, whose last pregnancy had been completed fourteen years previously, was placed under my care by Dr. Metcalfe. She was an excessively nervous and hysterical woman, but in good health. About three weeks before full term she was taken with hæmorrhages, which lasted for very short periods, recurred at intervals of four or five days, came on without assignable cause, and ceased without remedies. The cervix was not dilated, and no physical signs of placenta prævia could be detected either by vaginal touch or auscultation. Dr. Metcalfe saw her in consultation, and as all the rational signs of placenta prævia were present, and our patient was suffering from the repeated losses, and was becoming extremely nervous and apprehensive, we concluded to bring on premature delivery. Accordingly at 11 a. m. I introduced a large sponge tent into the cervix, and at 3 or 4 p. m. removed it, and succeeded in inserting Barnes's smallest dilator. At 9 that night the cervix was fully dilated at the expense of very slight hæmorrhage, and