of which you are members, and to show yourselves worthy of the great vocation with which you are intrusted."

CLINICAL LECTURE UPON SORE NIPPLES AND MAMMARY ABSCESS.

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Gentlemen:—All of you may obtain a great reputation by performing some important surgical operation; but the unfortunate fact with regard to such reputations is, that they are not easily secured, because opportunities only rarely present themselves for such operations; and, indeed, you may pass a lifetime in active practice without once being called upon to perform an ordinary amputation of the thigh or arm.

Your reputation, however, may be very much jeopardized, if not ruined, if you are not able to treat successfully a case of sore nipples or mammary abscess, and these are the cases you will see perhaps every week in your life. In these cases the responsibility will always fall upon the doctor, and unless he is familiar with their management the weight may prove more than he can well bear.

In text-books in general there is a sad deficiency with regard to description of the different forms of these troubles, the proper management, and the exact and appropriate treatment for each definite form.

Various articles, with which every practitioner is more or less familiar, are recommended for their cure, without any definite rules being laid down, where one or another will be applicable. These remarks apply with equal force to both sore nipples and mammary abscess. The forms of sore nipples are these: First, inflammation. This generally occurs in those cases where the nipple is naturally contracted, or in those cases, which are not at all infrequent, where the nipple is almost completely absent.

The child when placed at the breast has great difficulty in getting hold of the nipple, especially when the breast is distended, which renders the nipple still more retracted; it pulls away at it, and as a result of the irritation to the breast an inflammation of the nipple takes place. This inflammation of the nipple may by propagation pass into the lacteal ducts, and we may have mammary abscess as a consequence of that.

Second, fissure, or erosion of the nipple. These fissures of the nipple are of two forms. One comes from inflammation of the nipple, but there is another form which exists just at the base of the nipple, and gives the most intense pain and suffering, the patient, perhaps, bursting out into a profuse perspiration as the child is placed at the breast.

The next form of sore nipple is the ulceration which I have referred to in connection wth the case now before you. The surface of the nipple is red, and denuded of its cuticle; the nipple is very much retracted, and in this case there is a fissure at the top. The pain is very intense, and it may be that the woman experiences as much suffering from this as from anything else during the entire puerperal period. The process does not generally confine itself to the nipple alone, but the areola tissue around the nipple becomes inflamed, and as the inflammation becomes more intense, perhaps one-half or two-thirds of the nipple becomes entirely destroyed in the process. These three forms are distinctly and easily recognized; and now a few words with regard to the treatment of these different forms.

In the first place, for drawing the nipple out. There is a great difference among authors as regards the propriety of applying the child to the breast immediately after the confinement has been completed, and also as to the proper time when it should be done. Some writers recommend that it should be done as soon as possible after delivery. The reason given for this early application of the child to the breast is, that the child by nursing stimulates the breasts, which excites reflex action in the uterus, thereby producing uterine contraction, which renders the woman less liable to post-partum hemorrhage.

With reference to that point, I can say I do not consider it to be sound practice. I adopted it for some years, but have given it up entirely. You can procure uterine contraction, which will place the woman out of all danger from post-partum hemorrhage, by means which are far less exhausting for the patient than the resort to the troublesome efforts of the child at nursing. I now advise to get the woman completely restored after the fatigue of confinement before applying the child to the nipple.

The first stage after parturition is that of exhaustion. The whole effort of the system has been used to accomplish this result, and so complete is the exhaustion, that it is very commonly manifested by nervous chills. If the woman is permitted to get a few hours of sleep, her exhausted nerve-power will be restored, and *then* is the time to direct that the child should be placed to the breast.

The main reason for this is, the breast is not now distended, and the nipple is easier drawn out. The traction excites the more rapid secretion from the breast, and the first secretions from the breast are of great benefit to the child as a laxative, being its first proper food. It is then that the nipple can be more readily grasped by the child, and properly formed. If, however, you wait until the secretion of milk has taken place, and the breast has become distended, before applying the child, the distension itself causes obstruction to a free flow through the ducts, and the nipple and breast may become a very great source of irritation.

There are some cases in which the nipple congenitally is so short that the child cannot get hold, and it must be drawn out by some mechanical appliance. The most common method resorted to for accomplishing this is the old-fashioned application of a bottle, which has been filled with hot water and emptied, and the use of the breast-pump.

A few words with regard to breast-pumps. Most of them are constructed upon principles utterly devoid of common sense. Most of them have so small an opening in the part applied to the breast