the water in the dilator should be increased from time to time; but this requires the presence of the physician at short intervals, which is not always convenient. To overcome this objection the dilator should be distended as far as possible, and then fastened to a bandage round the body, in the same manner that surgeons tie a catheter fast in the bladder.

In using the dilator, the greatest care should be exercised in introducing it, so as not to rupture the membranes. It is always desirable to have the ovum expelled whole, as when broken its expulsion by the uterus is often very tedious, and sometimes impossible in any reasonable length of time.

It quite frequently happens that when the os is fully or sufficiently dilated the ovum is not expelled. There is a kind of inertia of the uterus, which permits its contents to remain, and this condition is often attended with hemorrhage. Ergot is then indicated. It will sometimes, but not always, excite uterine contractions, and in that way control the bleeding and expel the ovum. It is at this stage of the process, and at no other, that ergot is useful. I am satisfied from observations that much harm is often done by giving ergot before the os uteri is sufficiently dilated. It is often given to control hemorrhage in the early stage, and generally with ill effects. It rarely if ever controls the bleeding under these circumstances, and is almost sure to increase the patient's suffering if it acts at all. Used at the beginning, it is really worse than useless.

Should there be any delay in the expulsion of the ovum after the os is fully dilated, it is best to employ mechanical means to empty the uterus. The text books recommend that the ovum be removed by the finger; and if it cannot be reached by an ordinary digital examination, that the hand should be introduced into the vagina. To those who have practiced this manipulation it is unnecessary to say that it is at all times difficult and sometimes unsuccessful. In abortion in the earlier months of pregnancy one finger is all that can be admitted into the uterus, and this is insufficient to seize and remove the ovum. All that can readily be done is to detach the ovum, break it down, and then trust to its being expelled. When the uterus is larger, as at the end of the fourth month, two or more fingers can be introduced, if the hand is in the vagina; but then the fingers are too short to reach the fundus uteri and scoop out the ovum; and it is seldom that it can be seized even with two or more fingers. And to make this attempt at delivery, it is almost necessary to give chloroform, which adds delay and danger to an operation frequently ending in failure.

After having faithfully tried this standard practice, I have abandoned it for what has proved to be better. When the ovum is retained after dilatation of the os, I remove it through the speculum, by means of forceps and curette. The patient is placed in the semiprone position, and Sims' speculum introduced; the anterior lip of the os is seized with a tenaculum forceps, and the cervix drawn downwards and forwards. An ordinary dressing or bullet forceps is then carried into the uterus, and the ovum seized and brought away whole or in part. If only a part of the ovum is removed by the forceps, which is frequently the case, then the curette should be introduced, and the contents of the uterus thoroughly and rapidly scooped out. The instrument which answers best for this purpose is the curette of copper wire, without a cutting edge, described in Thomas's work on diseases of women, but it requires to be very much larger. In using this instrument with reasonable care, no injury can be done to the uterus.

The uterus usually contracts promptly, to an extent sufficient to prevent hemorrhage, when its contents have been removed by the curette. If in very rare cases hemorrhage continues even when the uterus is perfectly empty, then ergot is indicated, and should be used without delay. If that fails to produce contraction, the uterus may be tamponed with sponge or cotton. Should the bleeding still persist, cotton saturated with persulphate of iron may be used. Dr. J. Marion Sims' method of using "iron-cotton," as he calls it, as a tampon to arrest uterine hemorrhage is the best. He uses a piece of whalebone, as long as a uterine sound, tapering to a point, and curved near the end. According to the length of tampon required, the extent of the whalebone is smeared with lard, and then wrapped with layers of "iron-cotton" until the tampon is the size required. It is then carried up to the fundus uteri, and held in place, while the whalebone is withdrawn. If the uterine tampon inclines to come away, a pad of cotton placed in the vagina will hold it in place. In ten or twelve hours the tampon may be removed.

The rules of practice may be very briefly recapitulated:

1. Where the symptoms of abortion are slight, and of short duration, efforts should be made to arrest it.

2. During dilatation of the os opium should be given, if there is any call for it, and ergot should be carefully avoided.

3. Hemorrhage should be controlled by tamponing the cervix, the hydrostatic dilator being the best for that purpose.

4. When the os is fully dilated, and the ovum is not promptly expelled, after the use of ergot, it should be removed by the forceps and curette.

5. Post-partum hemorrhage should be arrested by ergot and the intra-uterine tampon.

The inflammation of the uterus, peritoneum, or cellular tissue, which may arise, should be treated on general principles.—*N. Y. Med. Record.*

CALMATIVE EXPECTORANT.

℞ Syr. acaciæ, f℥ iv;
Antimonii oxysulphuret., gr. vi;
Ext. opii,
Ext. belladonnæ, āā gr. ii.—M.

Sig.—Tablespoonful every two or three hours in acute catarrhal bronchitis with fits of dry coughg.