mild septic infection promptly diagnosed when met with, and their treatment immediately undertaken, many a woman who is suffering to-day, would be well, and many a home brighter and happier. The advent of the baby would cease to be an event which is followed by more or less invalidism on the part of the mother, trouble and worry on the part of the father, and an increased income to the neighbouring gynæcologist.

Puerperal fever, as such, no longer exists, but has been relegated to the past along with milk and surgical fevers. Septic infection is the same whether it follows the work of the surgeon, gynæcologist or the obstetrician. Its forms vary with the site of the infection, the virulence of the infective agent, and the resistance of the organism attacked.

The French, German and English schools have all a more or less complete classification of septic infection in puerperal women. Some are too full, others scarcely complete enough. I venture to present to you this evening a table or classification which is the product of my reading and experience, and which can readily be carried in the mind.

The infection may be:

(1.) LOCAL.

(a) *Puerperal Ulcers.*

Greyish pseudo-membranous patches found wherever m.m. is torn. Lochia offensive. Smarting pain. Fever.

(b) *Endometritis*—Two forms,

I. Catarrhal.	*II. Pseudo-membranous.*
Vaginal m.m. red, swollen. Cervix œdematous. Os patulous. Slimy brownish lochia. Uterine m.m. covered with small cystic swelling. Fetid lochia remaining sanguinolent. Uterus well contracted. No tenderness. Abdomen flaccid.	All vaginal and cervical lacerations covered with greyish membrane, extending to endometrium. Lochia may be normal or fetid. Not much tenderness in uterus which is enlarged. Chills and fever not marked.

c *Metritis.*.

Extension along connective tissue.

d) *Peri or Para-metritis, Cellulitis.*

Extension along peri uterine connective tissue.