placental presentation is more or less complete, the average mortality being about 3 in 5. The maternal mortality given by the older obstetricians was as high as 1 in 3. Dr. Charpentier thinks that an experienced practitioner can almost always save the life of his patient.

The question of treatment is considered at great length. But in mentioning the different plans of treatment that have been proposed, the author confounds in a curious manner that recommended in some cases by Sir J. Y. Simpson, with that proposed by Dr. Robert Barnes. Thus at p. 420 he says these methods are "artificial delivery, ergot, the plug, rupture of the membranes, and the plan recommended by Simpson, Barnes and the English, of detaching the placenta and extracting it before the birth of the child."

The first, or artificial delivery, is a most dangerous method only suited to most urgent cases. The rupture of the membranes is very good treatment, provided the os is partially dilated. It is hard to do when the presentation is complete. The use of ergot is a powerful auxiliary, but it increases greatly the danger to the child, and is contra-indicated in contraction of the pelvis, organic disease of the uterus, and malpresentation.

The author looks upon the plug as the treatment *par excellence*. It requires to be applied skilfully to be of any great use. Charpie or tow are the best materials with which to plug, and if properly applied, the author considers such a plug superior to any description of India rubber bag which can be introduced into the uterus and inflated. The great point to attend to when plugging is to introduce enough of the charpie or tow, as much as a pound and a half of the former material being sometimes necessary. The bladder and rectum should both be emptied before we proceed to plug. Some practitioners dip the first pledget in a solution of perchloride of iron. This is not necessary.

The charpie should be rolled into small balls, the first 20 or 30 of which should have a piece of thread attached. Before being introduced they should be well covered with cerate. This renders a speculum unnecessary.

The author lays great stress on packing tightly the anterior and posterior cul de sac, but especially the latter. The success of the operation depends to a great extent on this being well done. The vagina itself should be filled with the small pledges, until they appear externally. Then you apply a handful or more of dry charpie, and over that three or four compresses, the whole being fixed by a T bandage. If this plug be well applied there can be no hæmorrhage. If the charpie at the vulva become moist it is a proof that the plug is badly applied, and it should be removed at once and reapplied. To be of much service the plug should be left in from 12 to 24 hours.

The author then examines the following objections that have been brought against the plug:

1st. That it only changes external hæmorrhage into internal.

2nd. That it tends to bring on premature labour.

3rd. That its application as well as its presence in the vagina is very painful, and prevents the rectum and bladder being emptied.

As to the first: if the membranes are still unruptured and the plug properly applied, internal hæmorrhage is impossible. If the membranes are ruptured, the chance of internal hæmorrhage is increased, and we must apply a bandage to the abdomen, and be ready, should the uterus increase in size, at once to remove the plug, and finish the labour by other means. The second is of no great weight, for the hæmorrhage generally takes place after the child is viable, and in any case we have no choice. The third can be obviated by passing a catheter, and seeing that the rectum is empty, before applying the plug.

Dr. Charpentier urges many objections against the plan proposed by M. Pajot, and practised extensively of late by M. Bailly, viz., of leaving the plug *in situ* till it is expelled by the uterine effort, pressing it back again into the vagina with the hand, during the intervals between the pains. The most serious of these is, the great fœtal mortality, which even the defenders of this plan acknowledge it entails. Again, it is not applicable in cases of malpresentation, which are common, and it requires powerful uterine action, which is rare, in cases of placenta prævia.

If, on removing the plug at the end of twenty-four hours, it is found that there is no uterine action and that the hæmorrhage has ceased, we need not reintroduce it. If there is uterine action, and the os is still very small, we should again introduce it, but not allow it to remain so long as before, at the same time giving small doses of ergot. At the end of from eight to twelve hours, we should again remove it, and proceed to puncture the membranes, provided the hæmorrhage is but slight; if, on the contrary, it is still considerable, we must again introduce the plug, and wait till the os is sufficiently dilated to allow of operative interference.

This may be either manual or instrumental, the choice being determined by the usual conditions, such as presentation, prolapse of the cord, &c., &c. Dr. Charpentier does not look with much favour on plugging by means of India rubber dilators.

The author then briefly reviews the method first proposed by Radford, and usually known as Simpson's method, evidently under the impression that the latter advised its being carried out in every case of placenta prævia. He, of course, condemns it. He then notices the method proposed by Cohen for converting a complete presentation into a partial one, by detaching the smaller segment of the placenta from its uterine attachment, rupturing the membranes freely along the edge of the detached portion, and allowing it to hang down into the vagina, and thus no longer cause any obstruction to the delivery.—*Irish Hospital Gazette.*