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☞ *Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet, Toronto."*

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TREATMENT OF PLACENTA PRÆVIA.

Fortunately this abnormal position of the placenta is of rare occurrence. Statistics vary greatly as to its relative proportion to all other labors, but judging from the records published, one case in about five hundred is a fair approximation. It is evident, therefore, that no one in private practice can possibly acquire sufficient experience, to enable him to form an opinion of any great value regarding the various methods of treatment advised or adopted. It is only from hospitals and maternities in populous centres, that we can derive sufficient information to guide us in private cases. Yet infrequent as placenta prævia is, it is very important that we should be individually prepared to meet it at any time, and have clear conceptions regarding its management.

Many learned disquisitions, and innumerable discussions have been published regarding the source of the hemorrhage. The most plausible view in our opinion, is that of Schrœder, namely: That the uterine contractions impel the blood from the place whence the placenta has been separated, and that from the separated portion, blood circulating through the chorion and villi, becomes lost. Unguarded examination may also lacerate the placental tissue, and so cause fœtal hemorrhage. But to close the source and prevent the flow is the all-important consideration. Successful treatment should be our chief object, and is the one great desideratum

Formerly the accoucheur's choice was limited, in the early stage before the os was much dilated, to plugging the vagina; forcible dilatation, version, and immediate extraction, manually, or by instruments if necessary, or separation of the entire placenta; all of which have been advocated and endorsed by eminent authorities, and still obtain among many of the prominent obstetricians of the present day.

Recently, some considerable variations to these established methods have been admitted and practised, with apparently better results, which briefly are as follows: Rupture of the membranes, if the presentation be normal. This acts, by allowing the placenta to retract from within the lower segment, and causing the presenting portion of the fœtus to act as a plug. It is claimed that this alone has proved sufficient in a large number of cases. Where necessary and possible, perform the intero-external version; bring down a leg to act as a plug, and wait for expulsion by the natural forces, or aid them very cautiously after the os has been sufficiently dilated. The advantages claimed are: That it abolishes the use of the tampon, and lessens the risk of sepsis; it allows early operation, before much blood has been lost; it arrests hemorrhage; it enables the patient to rally, gives the os time to dilate, and lessens the risk of post partem hemorrhage from laceration of the cervix or vaginal soft parts. In some cases, when everything favors extraction—such as a well-dilated os, and head low down—forceps are sometimes used, and occasionally it is found necessory to perforate and extract rapidly.

It is obvious that no one rule, or set of rules, can meet all cases; consequently the accoucheur should be thoroughly familiar with all, and in a position to select and adopt the method of delivery best adapted to his particular case. Another important question arises, when moderate hemorrhage occurs prior to full term, and placenta prævia is discovered; whether we should immediately bring on labor, or try to allay the hemorrhage and prevent its return as far as possible; pursuing the expectant plan, with the object of arriving at full term, or the nearest possible approach thereto before delivery.

Many advocate immediate delivery, considering the risk to the mother too great to permit delay; while others, equally prominent and of no less