ninth month; as the os internum dilates under the influence of painless uterine contractions, which then occur, the woman at the time of labor is usually ensanguinated, exhausted, and depressed both physically and mentally.

3. Profuse flooding generally occurring with the commencement of labor, the medical attendant is often not at hand, and reaches his patient only after a serious loss of blood has occurred.

Fortunately, this condition is usually announced during the last months of utero-gestation by premonitory signs of reliable character, and thus we may empty the uterus before the vital forces of both mother and child are exhausted by hæmorrhages, the results of repeated detachments of the placenta. My conviction is that, in every case of declared placenta prævia, premature delivery should be induced. What objections can be urged against it, other than that a child of less then nine months of intra-uterine life does not have as good a prospect of life as one which has arrived at full term? In the case which we are considering, even this falls to the ground, for an eight-months child out of the uterus, and depending upon pulmonary respiration, has a brighter prospect for life then one in that cavity depending for aëration of its blood upon a crippled and bleeding placenta. For the mother, how incomparably greater the safety which attends an emptied and contracted uterus! By inducing delivery during the ninth month of pregnancy, we should be dealing with a woman who is not exhausted by repeated hæmorrhages; we would be in attendance at the moment of cervical dilatation, and consequently the moment of danger; and we would be able by hydrostatic pressure to control hæmorrhage in great degree, while at the same time dilatation of the cervix, which constitutes the period of maximum danger, may be rapidly accomplished.

With these considerations before me, and with a certain amount of experience to support them, I cannot resist the conviction that, when premature delivery becomes the recognized and universal practice for placenta prævia, the statistics of Dr. Simpson will be replaced by others of a far more satisfactory kind.

Case I.—Mrs. W., aged twenty-six, primipara, in good health, was suddenly taken with hæmorrhage three weeks before full term. She sent for me in great haste, but, being occupied, I was unabled to go to her, and she was seen for me by my friend, Dr. Reynolds. He discovered that she had lost a few ounces of blood, but that the flow had ceased. Three days afterward she was again affected in the same way, the flow ceasing spontaneously. About a week after this, she was taken during the night with a flow, which was so profuse as to result in partial syncope when she endeavored to walk across the room. I saw her early the next morning, found her flowing slightly, and, upon vaginal examination succeeded in touching the edge of the placenta through the os, which was dilated to the size of a ten-cent piece. Later in the day, Drs. Metcalfe and Reynolds saw her and agreed in the propriety of premature delivery. In accordance with this consultation, at 7 P. M. I introduced into the cervix, with considerable difficulty, and by the employment of some force, the smallest of Barnes's dilators. This in twenty minutes was followed by the next larger dilator, and in an hour by the largest. Dilatation was rapidly accomplished, but, instead of removing the largest bag, I left it in the cervix until 10 o'clock that night. Expulsive pains coming on at that time, I removed it, when the head rapidly engaged, and before morning Mrs. W. was safely delivered of a living girl. The placenta followed rapidly, and both mother and child did well.

In this case, although hæmorrhage continued slightly throughout the labor, it was never sufficiently profuse to endanger the lives of either mother or child. The implantation of the placenta being lateral, diminution of the flow occurred as the head advanced, and made firm pressure against the bleeding surface.

Case II.—Mrs. D., a lady over forty years of age, whose last pregnancy had been completed fourteen years previously, was placed under my care by Dr. Metcalfe. She was an excessively nervous and hysterical woman, but in good health. About three weeks before full term she was taken with hæmorrhages, which lasted for very short periods, reccurred at intervals of four or five days, came on without assignable cause, and ceased without remedies. The cervix was not dilated, and no physical signs of placenta prævia could be detected either by vaginal touch or ausculation. Dr. Metcalfe saw her in consultation, and, as all the rational signs of placenta prævia were present, and our patient was suffering from the repeated losses, and was becoming extremely nervous and apprehensive, we concluded to bring on premature delivery. Accordingly, at 11 A. M. I introduced a large sponge-tent into the cervix, and at 3 or 4 P. M. removed it, and succeeded in inserting Barnes's smallest dilator. At 9 that night the cervix was fully dilated at the expense of very slight hæmorrhage, and Dr. Metcalfe then being present, I removed the bag, intending to leave the case to Nature, provided no flow occurred. Previously, during the evening, upon changing the bags, I had distinctly touched the head as the presenting part, but now, to my surprise, I found that the bag impinging on this part had caused the child to revolve in the liquor amnii, and that the breech was now within the os.

We decided under these circumstances to deliver at once. The patient being put under the influence of ether, I drew down the legs and delivered a living, female child. The placenta followed in fifteen minutes, and both patients did well, the child rapidly recovering from an injury to one of its legs, received during delivery.