days after labour or abortion, the first thing I think of is to enquire about the condition of the lochia and bowels, and the first thing I would be likely to do would be to get free action of the bowels from calomel and salines, and order warm antiseptic vaginal douche every three or four hours.

If, after free purgation and vaginal douching, the temperature does not come down, I would examine the uterus, and if from examination I concluded a septic process is going on in the uterine cavity, I would, after cleansing the vagina with an antiseptic solution, thoroughly curette the uterine cavity with a blunt curette, and wash it out with an antiseptic douche, creolin, 2 per cent., or ac. carbolic, and then introduce iodoform gauze for drainage. Curetting is best done under an anæsthetic. The temperature should fall soon after the operation. If it does not, the gauze should be removed and the cavity again cleansed and drained. It is always necessary to exercise great care in using the curette in these cases, as the walls of the uterus are quite soft and easily perforated.

In many cases, however, when first seen, the active septic process is at a part deeper than the endometrium, in the walls of the uterus, lymphatics, tubes, peritonæum, or possibly an acute general blood infection, and not kept up by putrescence in the uterine cavity. In these cases irrigation of the uterus is worse than useless, it is often actually harmful. Here the treatment will depend on whether the process is local or general. If peritonitis occurs early, whether local or general, it is usually due to a local septic focus pre-existent in the pelvic or abdominal cavity, so that the proper treatment in such cases would be abdominal section.

The only medical treatment in such cases after free purgation would be opium for the pain, and hot fermentations to the abdomen.

If the peritonitis is part of a general septic process of the lymphatic form, I cannot see how opening the abdomen would be of much use. Later, however, if the patient survives the primary illness, abdominal section will generally be called for, for the removal of localized pus collections. The only treatment in such cases during the primary illness would be supporting and treatment towards the genital tract.

Septic metritis is usually fatal in a few days. Tait says the only remedies of any use in such cases are those of a purgative class. Laphthorn Smith, Montreal, reports in the *American Journal of Obstetrics*, January, 1892, a case of septic uterus from retained placenta. He did abdominal hysterotomy the third day after labour. The patient recovered.

It is my opinion, after reading his report, that this case would have done as well if not better, after curetting and drainage.

If localized inflammatory exudation takes place in the pelvic cavity, the case may be treated by rest in bed, opium, hot fermentations for the pain, and hot vaginal douches, and I think it best to keep the bowels open with calomel and salines. Supporting measures, too, are generally indicated. Absorption takes place in a number of cases, and in others suppuration.

When suppuration takes place, the abscess frequently points above Poupart's ligament, and may be opened in this situation. I consider it safer in such cases to delay opening the abscess until adhesion forms between the peritonæal layers, so that the peritonæal cavity will not be entered.

In some cases, however, the suppuration is in the tube or ovary, or both, and these cases can be treated by abdominal section.

I have, in a number of cases, been assistant or operator where abdominal section was called for at various periods following labour or abortion. A few of the cases I will report briefly:

Case 1.—Operator, Prof. Lawson Tait. Abdominal section ten days after labour, uterine appendages normal, a thickened mass of omentum of malignant appearance adherent to the parietal peritonæum and uterus. After removal of the mass, it was cut into and found to be an abscess of the omentum.

Case 2.—Operator, Prof. Lawson Tait. Twelve weeks after labour abdominal section was done for supposed tubal trouble. Peritonæal adhesions, parietal tubes of a healthy appearance. The right ovary presented a hard nodule the size of a hazel nut, and was removed. The left ovary normal.

Case 3.—Operator, Prof. Lawson Tait. Three months after labour, abdominal section was performed and a suppurating dermoid cyst removed. It had been tapped through the rectum.

Case 4.—Operator, myself. Two months after