

thod had given good results, and when properly performed, leakages from the bowel very seldom followed the operation. He, however, could conceive of cases where the button might be an advantage, namely, when resection had to be performed in portions where the bowel was not easily accessible to the hands, such as deep down in the pelvis; but in any situation where the intestines could be brought up, and conveniently sutured, he would prefer the old method. His great objection to the "button" was the manner in which it separated. This must of necessity be by a process of ulceration, which seemed to him a very undesirable condition occurring around the two ends of a lately united bowel.

Dr. JAMES BELL closed the discussion by answering some of the principal objections to the use of the Murphy button, and giving a brief *résumé* of the complications existing in his fatal case. It was easy, he said, to see why the button did not in this case come away. In the first place, he had narrowed the bowel before it, and in the meantime the stricture which occurred in the sigmoid flexure effectually prevented it. With regard to the saving of time, this came in, in the fact that in the purse string suture, there were not more than a dozen needle punctures to be made. The only suture that required to be accurate was that which brought the two folds of the mesentery together. This certainly saved time over the ordinary suturing method, where the needle had to be entered four or five times as often. Referring to the first case, he said the sequence of events was as follows: (1) A perfectly healthy man taken with diarrhoea; (2) following this was constipation, with evidence of obstruction, of pain, and of hæmorrhage. At the first operation it was found that the obstruction existed in the small intestine, loops of which had been destroyed by a destructive ulceration. At this time there existed no obstruction in the descending colon or rectum, and after the disease of the small bowel had been removed, perfectly formed stools were passed regularly, showing the functions of the intestinal tract to be normal. Now, the interesting part of the problem is, how all this trouble could have developed. Dr. Bell's idea was that it must have originated in the peritoneum over the brim of the pelvis, and that it afterwards extended to the bowel. From a mechanical point of view this seemed the most probable sequence of invasion.

*Spitting on Floors.*—The following resolution was moved by Dr. MILLS, seconded by Dr. MCCONNELL, and carried unanimously:

Inasmuch as spitting on floors is a practice not only filthy but dangerous to health.

It is hereby resolved, to urge upon the Montreal Street Railway Company the desirability of prohibiting spitting on the floors of their cars by notices posted prominently.

*Discussion on the Management of the Third Stage of Labor.*—Dr. J. C. CAMERON opened the discussion. The third stage of labor being the separation and expulsion of the placenta and membranes, it became necessary to enquire, what were the placenta and membranes? to what were they attached, and how were they attached? He described briefly the decidual lining of the uterine cavity which prepared for the reception of the impregnated ovum; the arrival of that ovum, with its chorionic covering, planting itself in the portion of the decidua, afterwards called serotina, and the development of the decidua reflexa; the part taken by the decidua in the formation of the placenta; the formation of the amniotic sac; the growth of the ovum until it finally fills the whole uterine cavity, and unites the decidua reflexa with the decidua vera, or original decidual lining of the uterine wall. The membranes then were three-fold, and together they form a tripartite bag which is filled with fluid in which floats the embryo. Considering the character and texture of the separate membranes, and taking them in the order of their occurrence commencing from the inside, he said the (1) amnion was elastic and strong; (2) the chorion was thicker and more friable, and connected very intimately with the (3) decidua which was composed of two layers,—an internal dense and firm, an external of a more spongy character. Summing up the character of the membranes as to strength, the latter decreases from within outward; the amnion very strong, the chorion less so, the decidua, being least of all, has very little cohesion.

When labor is about to begin, the uterus is an ovoid body, with walls of tolerably equal consistence, except at the lower part where the body joins the cervix. About one-fifth of its cavity is lined with placenta, and the remaining four-fifths with the membranes. The cervix at this time is completely closed, but with the onset of pains, the bag of waters is forced down upon the internal os, and gradually opens up the cervix by a process of bulging. In order to bulge and dilate the cervix, the membranes must separate from their uterine attachments; during the first stage we find that they are separated from the lower uterine segment. At the beginning of the second stage they rupture, and there is no further separation of the membranes till after the birth of the child. At the beginning of the third stage we find the uterus reduced considerably in size, and differentiated into two parts, an upper thick-walled contractile part, a lower thin-walled dilatable part; the function of the first is to contract, and expel the placenta; of the second, to expand, and give passage to it. There is no foundation for the statement that the placenta begins to separate normally when the head is being born. How then does the separation take place? Let us first recall how the different membranes are joined together. The amnion is loosely at-