When he came under my care the first point to to which I directed my attention was to determine the nature of the exciting cause of the attack. There was no indication of any metastatic relation between the skin and the chest. It had been observed that after laughing much the respiration became audibly wheezy. He was only allowed out of doors on fine days, but if the wind was in any way strong, he was liable to a difficulty of breathing at night. As, however, attacks often occurred without any apparent exciting cause, I directed a careful watch to be made regarding his food, with the result that he was always best when kept strictly on a simple milk diet. During the last six months, while attention has been paid to this point, he has only had two severe attacks, and in both instances an indiscretion in food could be assigned as the cause; and during this time he has been allowed to run out of doors with a freedom they formerly did not dare allow.

He had, under the care of the late Dr. Carmichael, been treated with all the regular remedies for the skin affection including arsenic, and his mother had bestowed the greatest attention in carrying out the treatment, but she cannot say that anything had any marked effect. Finding that there was a constant sibilant rhonchus in the chest, I prescribed two grains of iodide of potass. with one drop of tr. cantharides three times a day, and potash or Vichy water ad libitum. Under this treatment, with the regulation of the diet, he has had only two attacks in six months, and is evidently steadily improving. While believing that this treatment has not been without effect, I still keep in view that the age of the child is that when the greatest success may be looked for from the natural developmental tendency towards recovery. —*Obstetrical Journal.*

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## PROLAPSE OF THE UMBILICAL CORD.

In an article on this subject (*Amer. Jour. Obstet.*' Nov., 1873; Feb. and Aug, 1874), Dr. Engelmann' of St. Louis, gives his conclusions as to the cause and treatment of this dystocia as drawn from a careful examination of a large number of cases (365) occurring either in the Royal Lying in Hospital of the University of Berlin, or in the out-door department of that institution. Of these cases, 160 were observed very carefully from the beginning to the end, and pelvic measurements made. The frequency of prolapse was found to be 1 in 18 cases of labor. In this country, the frequency would be much less, since here diseases tending to produce a deformity of the pelvis do not abound as in Germany, where these observations were made. A prolapse of the funis rarely complicates vertex presentations, but is frequently found with false presentations, as the result however, not of the fœtal position, but of the pelvico ef ormity, which tends to produce both the abnormal position and the prolapse. Breech presentations are rarely complicated with prolapse, tranverse and shoulder presentations are much more commonly, and foot presentations oftener than any other. The position of the placenta near to the os favors the prolapse of the cord. The unusual length of the cord is probably favorable to the occurrence of prolapse, but cannot be ranked among the causes. The premature rupture of the membranes at an early period of labor is one of the most common causes which tend to favor a prolapse. The chief and primary causes, however, are due to the maternal parts. While a flabby condition of the uterus and a general weakening of its muscular power, as the result of too frequent childl earing, may tend to produce a prolapse, still the chief cause is undoubtedly to be found in a contraction of the pelvis. The flattened pelvis is the most common pelvic malformation found in these cases. Prolapse is somewhat more frequent among multiparæ than among primiparæ. It is rare that the cord prolapses *after* the rupture of the membranes; ordinarily, the accident occurs at the time of the rupture, although, occasionally, the cord may be felt presenting just within the still unbroken membranes. The prolapse usually occurs at the sacroiliac fussa, less frequently in the acetabular region. Very rarely is it found to pass down in any region occupied by the occiput, or directly behind the symphysis pubis. The danger to the child comes, of course, from the pressure to which the cord is subjected during the labor, a pressure which is greater in head presentations than when any other part of the child presents. A careful *post-mortem* examination of children, whose death has been caused *inter-partum* by compression of the prolapsed cord, shows no change which could be called pathognomonic. The death is the result of asphyxia, which may occur from many other causes. The prognosis in these cases is most favorable when the feet present. Next come tranverse and shoulder presentations, although these are far more dangerous than the first mentioned class of cases, and most dangerous of all are vertex presentations. The prognosis in breech-presentations is at least equally favorable with that offered by tranverse and shoulder presentations. In a primipara, the prognosis is much less favorable than in a multipara. The life of the mother is, of course not affected by the prolapse of the cord. It is possible, however, for a serious hæmorrhage to follow the premature loosening of the placenta in those cases where the cord is drawn over the head.

As regards treatment, many cases will occur in which it will not be desirable to leave the progress of the case to nature, nor will it be necessary to perform an operation. In these cases, attention must be given to the position of the mother during labor. She should lie on the side opposite that in which the funis has prolapsed. In cases where the prolapse has taken place in one or the other of the sacroiliac fossæ, the simply placing the mother on her hands and knees may be all that is necessary for the self-adjustment of the cord. Oftentimes, however, this postural treatment is more an adjuvant to other methods of treatment than a method on which we should place our sole reliance. Version offers the best chance for the child, and should be adopted in preference to either reposition or delivery by forceps. Chloroform has proved a valuable adjuvant in any