gogue cathartics, would not be indicated; indeed inasmuch as their influence was debilitating and opposed to the accessory conditions for health just mentioned, they were contra-indicated. Was the degree of renal adequacy, as determined by an examination of the urine, reliable in judging of the absence of danger from toxæmia? This question was to be answered in the negative. In some cases of Bright's disease the quantity of the urine was decreased for a long period without serious consequences. The explanation lay in the fact that the excrementitious matter was eliminated vicariously, or its effects upon the system were counteracted by other agents. On the other hand, slight inadequacy, without vicarious elimination and counteracting agents, sometimes led to serious consequences. The prognosis after coma was always grave, yet we meet with cases repeatedly in which life was preserved for a long time. Of acute pulmonary œdema the same might be said as of uræmic coma. In his experience the most serious consequence of Bright's disease was dyspnœa, or renal asthma, apparently due to toxic effects upon the respiratory center. He had never known such a case to end in recovery, but he had known life to be prolonged for several years after dyspnœa from pulmonary œdema occurring in the course of chronic Bright's disease.

Recapitulating, Dr. Flint said that subacute diffuse nephritis, having the same seat and characters as acute Bright's disease, exclusive of acuteness, occurred not only after scarlet fever and other fevers, but irrespective of these; and when it occurred as a primary affection, or in connection with other diseases, it was liable to be overlooked, or, if recognized, to be mistaken for the chronic form. Further, acute or subacute diffuse nephritis not infrequently occurred as an intercurrent affection in the course of chronic Bright's disease, and rendered the prognosis temporarily more serious. The disappearance of symptoms and the presence of health did not necessarily indicate that the chronic disease was not still in existence. Again, a susceptibility to the causes of inflammation of the urinferous tubules, irrespective of the existence of chronic Bright's disease, was to be recognized as an individual peculiarity.

TREATMENT OF ABORTION AT THE FOURTH OR FIFTH MONTH, WITH RETAINED PLACENTA.

Dr. G. R. Southwick of Boston, (in the *Am. Jour. Obs.*) gives us a very interesting paper on this subject in which he points out the change in the medical fraternity during the last few years on this subject from the expectant treatment to the radical plan of dilating the cervix and removing the secundines immediately, and very pertinently puts the query as to whether or not the pendulum of progress might not have swung too far to the opposite side from the old but easy expectant idea. He says when the labor takes place at full term the uterus contracts away from the placenta, which is a more contractile body, and thus separation takes place. The uterine muscular tissue continuing in this contracted state constricts the sinuses and hemorrhage is prevented. Thrombi form back of these constrictions and when the uterus partially relaxes in twenty-four hours, serve to plug the vessels and in turn also prevent hemorrhage. But when abortion takes place in the middle of gestation, the muscular tissue of the uterus has not reached that degree of development, and becomes ready for the metamorphosis which takes place at full term. The surface contraction is less in proportion, *i. e.*, there is less contraction to the square inch of surface, and consequently separation of the placenta is less likely to follow, both for this reason and on account of its firm attachment. Thrombi therefore do not form so rapidly, and hemorrhage is liable to ensue though not so severe as under similar circumstance at term.

In some rare cases small portions of adherent placenta become organized and a fibroid polypus hydatidiform mole develops. In nature's method of removal the blood-vessels are closed behind the adherent portions, the placental tissue gradually disintegrates and is cast off; here another element must be considered—the danger of septicemia.

Retention of a part or the whole of the placenta is, therefore, liable to give rise to one of the following complications:

1. Hemorrhage, either immediately and profuse or remote, and become continuous in small quantities.
2. Septicemia.
3. Some intra-uterine growth.

The aim of treatment is to prevent or forestall them, and may be active or conservative. Active treatment consists in the immediate removal of the secundines in every case, either by the finge, placental forceps, or curette. There is good reason to fear the results of traumatism, as inflammation of the uterus and cellular tissue, or even perforation of the uterus, especially when performed by an unskillful hand, which is not infrequently the case. Very often the removal of placental tissue is tedious and accompanied with considerable hemorrhage.

If no urgent symptoms be present the Doctor thinks it is well to see what conservative treatment will do, or plug the vagina for a few hours, and often on removal of the tampon the retained secundines are easily delivered.

It sounds very easy to read that, to remove the placenta, the uterus is to be pressed down in the pelvis with one hand externally while the forefinger of the other enters the uterine cavity, passes up over one side of the placenta and down on the other so as to hook it down and extract it from the uterus, but it is a very different thing to do it.

The pelvic tissues being tender and painful, the abdominal walls being quite thick, the uterus being high up, and the os contracted and small, the operator's fingers being short, or, when the uterine cavity is reached, the attached placental tissue