Prof. Parvin believes that many cases of sterility in women are due to openings that are often found in the Fallopian tubes. He contends that the impregnated ovum drops through them.

Prof. Hare says that in cases of amenorrhœa, in which apiol is prescribed, in order to have good results it should be administered at least one week prior to the time for the regular flow.

In cases of delirium tremens, Prof. Keen gives from one to two grains of opium combined with one or two grains of chloral; this to be followed by a laxative; or, if this will not move the bowels, a purge should administered the patient.

Prof. Wilson, in the earlier stages of influenza, prescribes antipyretics, but in the later stages he orders quinine to be given. He especially recommends turpene hydrate as an efficient and useful expectorating agent in this disease.

Good results have been obtained in cases of whooping cough, treated by Prof. Hare, by administering one or two grains of antipyrine in children. It tends to decrease the number of coughing spells.

After an operation for strangulated hernia, Prof. Brinton is in the habit of giving his patients one grain of opium in order to constipate him for a time. When he wishes to move the bowels he orders a weak saline to be given.

In cases of hectic fever in phthisis, Prof. Hare does not favor the use of antipyretics for the reduction of the temperature, as they are liable to bring on profuse and exhausting sweats. In their place he recommends cold sponging.

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THE TREATMENT OF INCOMPLETE ABORTION.

By incomplete abortion is meant that condition in which the fœtus is expelled during the early months of pregnancy, while the fœtal envelopes, and immature placenta, in whole or in part, are retained within the uterus. Such a condition is not at all uncommon. The abortion throughout may have been under the care of a medical attendant, who has watched its progress and made every effort to check or to guide its course; and yet at last the fœtus alone comes away, leaving its appendages behind. Or it may be that the medical attendant does not see the case at all, until after the expulsion of a mass, which proves, on examination, to be only a part of what the uterus is known to have contained.

Where the process of abortion has thus obviously been incomplete, what is to be done? This question must present itself forcibly to every practitioner, as a grave problem full of anxiety and doubt. He holds in his hand a minute fœtus, from the umbilicus of which dangles a delicate cord two or three inches in length. He knows that the other end of that cord is inside the uterus, attached to its wall where the placenta was being formed. What is his duty in the matter? Shall he follow the other end of the cord at once to its termination and forcibly remove the remnants to which it leads? Or shall he wait for nature to do the work without assistance from him? It is the object of this paper to briefly consider the proposed modes of procedure in such cases, and to state the plan that seems most advisable to the writer.

As Dr. Wm. Titit Chaney says, in the *Occidental Medical Times*, suppose that the medical attendant decides not to interfere with an incomplete abortion, but to let matters take their course. He will not lack authority for this plan, for such is the advice of many of the prominent teachers of obstetrics. Leishman suggests delay, and does not approve of interference except in cases of "profuse and repeated hemorrhage, fetid discharges and febrile symptoms." Tarnier speaks strongly in favor of allowing the uterus time to expel the secundines. And Winckel is said not to attempt active interference in such cases. These men justify their conservation on the ground that gradual separation of placenta and membranes will in time take place spontaneously, and that the uterus will then contract to expel them. Or if they do not follow the fœtus immediately, it is either because the cervix has contracted too firmly to allow of their expulsion—either condition contra-indicating active measures for their removal, because violence is apt to be done to the uterus in the process.

There are two great dangers in this conservatism: hemorrhage, either immediate or secondary, and sepsis. The bleeding that always follows separation of placenta and membranes from the uterus is checked only by firm contractions of the muscular wall. If these contractions are hindered by retention of a mass, that acts as a foreign body, keeping the walls apart, hemorrhage is very apt to continue until the mass is removed. If checked temporarily, it is apt to recur from time to time, as successive portions of the mass undergo separation, with rupture of vessels that connected them with the uterus. Again, the retained secundines offer a fertile field for the growth and development of the germs of decomposition, and so their presence is a constant menace of septic infection. These two dangers, hemorrhage and sepsis, are recognized by the advocates of conservatism, who counsel active measures in case bleeding becomes continuous or uncontrollable, or the vaginal discharge offensive and temperature high.

Why should the patient be subjected to these dangers at all? Why should she be allowed to go on losing blood, or to run the risk of