roller bandage, but I prefer to leave it loose in a basin of bichloride solution, 1-5000, and draw it from the antiseptic solution as I place it in the vagina. Iodoform gauze torn into strips in the same way answers admirably for the same purpose. Although not absolutely necessary, it is a great convenience to have a Sims' speculum. It is very important to pack the upper part of the vagina carefully and systematically, first surrounding the cervix and then putting the cotton within the os if possible. It is not well to distend the vulva very much because it causes great pain, and it is not necessary, as pads carefully placed over the vulva, and properly retained there, will exert all the pressure needed.

During the progress of labor, while the os is dilating, the great danger is from hemorrhage. If we can manage to control the hemorrhage, as a general rule we have nothing else to do. Formerly it was considered all-important to complete the delivery as soon as possible, and hence arose the procedure known as "accouchement forcé," which is now so generally condemned. In the early stage, when there is only slight dilatation of the os, I would rely chiefly upon the tampon introduced into the vagina in the manner indicated. After the os is dilated so that the fingers can be introduced we should still check hemorrhage, and the best way to accomplish that is to cause pressure on the bleeding vessels by means of the fœtus.

I have never seen a case in which the placenta could not be pushed to one side of the internal os. As soon as one or two fingers can be passed this should be done and the membranes ruptured; then try to bring the head or breech of the child against the placenta. In some cases the forceps may be applied to the presenting head, which may then be brought down until it presses on placenta. Here it may be left, especially if the cervix is not fully dilated, and the labor finished in the normal way.

It occasionally happens in central placenta prævia that the edge of the placenta cannot be reached, even when the finger is introduced within the os and swept in every direction, separating the placenta from uterine tissue; and in such cases it is sometimes necessary to push the finger through the placental mass before the membranes can be ruptured, or the manipulations of the fœtus can be accomplished.

In the great majority of cases there is a definite line of treatment which should be adopted after the os is wholly or partially dilated, *i.e.*, the treatment recommended by Dr. Braxton Hicks: turn by the combined or bimanual method and pull down the leg until the breech presses against the placental vessels. As soon as the hemorrhage ceases, stop pulling on the leg and leave the case to nature. If bleeding recurs, pull again on the leg until the breech is brought against the placenta with sufficient force to act as an efficient tampon. Turning by Hick's method can frequently be performed when the os is sufficiently dilated to allow only one finger to pass through it.

I would summarize as follows:

(1) If hemorrhage occurs before child is viable, wait and watch carefully, unless the bleeding is copious.

(2) In all cases where the child is dead or, being alive, is viable, induce premature labor at once.

(3) In doing this use first the vaginal tampon, and complete the dilatation of the os with the fingers or Barnes' dilators.

(4) When the os is wholly or partially dilated, try to bring the head or breech in a position to act as a tampon on the bleeding vessels.

(5) In the majority of cases rupture the membranes, turn by the combined method, and pull the leg until the breech acts as a plug; then leave the case to nature, unless a necessity for interference arises.

Dr. Britton had seen four cases, of which two had been fatal. One is very apt to overlook slight hemorrhages as due to tears of small cervical vessels; but when sudden severe, perhaps fatal, hemorrhage sets in, the true cause of the trouble becomes apparent. His first case was a multipara. Os was partly dilated; some slight hemorrhage. Suddenly severe hemorrhage set in; os was dilated and a marginal placenta prævia found. Delivery was effected with forceps. Half an hour after delivery fatal post-partum hemorrhage occurred. Had the slight initial hemorrhage led to a careful vaginal examination, the fatal result might possibly have been averted.

In another case a placenta prævia was found partly covering the os; the placenta was separated at one side, membranes ruptured and version done. In this case also there was violent post-partum hemorrhage. The inside of the uterus was swabbed out with cotton soaked in tinct. ferri mur. Violent tonic contraction ensued and the case went on to recovery.

Slow delivery is not always safe. In a case of placenta prævia where hemorrhage had been so severe that sighing and complaint of constriction around the chest were marked symptoms, the os was dilated with the fingers and version done. In spite of the feet and the hips being brought down and left, very severe bleeding kept up, probably from laceration of some large cervical vessel during dilatation. In such a case speedy delivery is certainly indicated. Shortly after delivery profuse post-partum hemorrhage occurred, although it had been anticipated and every precaution observed. This bleeding lasted for an hour; seven hours afterwards death occurred from a convulsion.

Astringents might be of some use. In a multipara with central placenta prævia, the os was found to admit two fingers. The finger was swept around and then warm liq. ferri persulph., 1 in 5, injected, controlling the bleeding. This process was repeated until the edge of the placenta was reached, when delivery was effected by version.

Post-partum hemorrhage is frequent in placenta prævia because of the weakening of the patient by previous loss of blood, and because from the abnormal position of the placenta there is but little uterine tissue to contract around it, and so check hemorrhage. If the fœtus is dead the placenta is contracted; there is less circulation in the part and less danger of hemorrhage. The tampon he had used but once for placenta prævia. Hemorrhage may occur in spite of the tampon if the uterine contraction be not very strong.

In the way of prevention something might be done. Most cases occur in multiparæ who have chronic endometritis. Naturally, no doubt, the ovum adheres to the first convenient place. Owing to the endometritis, the ovum falls lower down because the normal preparation for the ovum by hy-