times in uterus and vagina, 29 times in the vagina alone, and 8 times in the uterus alone.

While the writers remark that complete rupture is far more dangerous than incomplete, they admit that in some cases it is impossible to distinguish the one from the other before the autopsy. The causes of the increased mortality in the former are, of course, hemorrhage, and to a far greater extent septic infection. They have come to the conclusion that total abdominal hysterectomy with vaginal drainage is the only feasible treatment, for the following reasons: Their 71 cases treated with douching and drainage had a death-rate of 75 per cent. They had a smaller death-rate with suture of the uterine tear, but this made a future pregnancy possible, and such pregnancy was not without risk. It has been found that the cicatrix, in future pregnancies, is very thin, and Brunings quotes one case seen by him when the scar was as thin as a sheet of paper. Varnier, out of 15 cases of rupture, had 5 repeated ruptures, and of these 3 died, while the writers themselves had one case in which the uterus had ruptured three times, the last ending fatally. They recommended vaginal drainage since they have found that abdominal drainage gives more chance of sepsis, is more liable to set up some peritonitis which may cause adhesions to the abdominal wall, and is further apt to lead to future hernia of the cicatrix. In all cases of complete rupture with escape of the child into the abdominal cavity, they recommend removal through the abdominal wound.

As for incomplete rupture, they recommend immediate extraction of the fetus, and total abdominal hysterectomy. The peritoneal cavity, in such cases, does not require such careful treatment unless signs of peritonitis are already visible. In these cases the position of Trendelenburg is recommended, while in the complete rupture, with the greater chances of septic infection, the horizontal posture is preferred.—*The Medical Chronicle.*