abortion should be considered complete unless the interior of the uterus has been thoroughly examined by the finger or by the curette, and has been demonstrated to be empty. The history given by the patient is valueless as to the appearance of clots discharged, except in so far as it indicates a previous occurrence of considerable pain and hemorrhage. If pain and hemorrhage can be proved to have occurred, the escape of the embryo has probably taken place. There remains, then, for the physician the treatment of incomplete abortion. Thorough antisepsis, patience, and accurate observation of the condition of the uterus are prerequisites for success in treating these cases. We prefer the douche-curette whose edge is not a cutting edge, but is as sharp as that of a paper-cutter. The advantage of this instrument, originally devised by Carl Braun, is the little damage which it may inflict upon the uterus, and the fact that it permits the administration of an intra-uterine douche while the curetting is going on. In septic cases, where infected decidua and membranes are removed, the tampon of iodoform gauze may be replaced by a suppository, containing 60 grains of iodoform, and inserted into the fundus of the uterus; a narrow strip of gauze may be carried within the cervical canal, and the remainder packed about the os and cervix in the vagina.

Occasionally the uterus retains an ovum for an extraordinary period, its removal being finally accomplished without danger to the patient. Cholmogoroff* reports two cases of missed abortion which were remarkable for the length of time during which the ovum was retained. In the first of these cases the life of the embryo persisted for four months, while the product of conception was retained for seven months after the death of the embryo. The entire pregnancy persisted for eleven months. In the second case the embryo perished at three months, but was retained for two months after death in the uterus. In neither case was operative interference indicated; the patients were kept under observation, and the expulsion of the ovum followed spontaneously. Both patients made uninterrupted recoveries. Very similar instances are on record which serve to emphasize the fact that radical interference, without the co-operation of uterine dilatation and expulsive contractions, is contra-indicated in these cases.

The prognosis in cases of incomplete abortion depends upon the cleanliness and antisepsis observed in the care of the patient, and the judgment displayed in interfering with her. In a series of eighty-four cases of abortion reported by Kuppenheim,* of Heidelberg, in seven only did complications of any sort arise. The method of treatment employed was that which we have outlined, the finger being used, under careful antiseptic precautions, to empty the uterus, whenever possible, in preference to instruments.

In obscure cases where grounds for suspecting pregnancy exist, where pain, shock, and hemorrhage occur, the practitioner must keep in mind the occurrence of ectopic gestation with tubal abortion; such abortion is usually incomplete, the embryo and its clots partially escaping from the tube, while the chorion or placenta remains within its cavity. An admirable description of such abortion has been recently given by Sutton. An instructive case of tubal incomplete abortion in a primipara in early pregnancy is given by Renteln. Her symptoms were abdominal pain, giddiness and flooding, which increased in spite of rest and the administration of opium. The gradual development of a tumor led to a diagnosis of tubal gestation, and abdominal section confirmed the existence of tubal abortion.

* *Zeitschrift f. Geburtshulfeu Gynäkologie*, Band 22 Heft 2.