management. The real question at issue, he thought, was whether the use of the forceps was justifiable in cases in which the os was not fully dilated. As to this, Dr. Atthill said, "I avoid the use of the forceps before the os is fully dilated in all cases in which I can do so; but, on the other hand, if a case occurs in my practice in which I believe it imperative to deliver the woman before the os is fully dilated, I unhesitatingly have recourse to the use of the forceps, notwithstanding that the os uteri is not fully dilated. I believe that practice is safer than the practice of version."

Dr. McClintock, of Dublin, could not agree with Dr. Atthill in his denunciation of ergot. He (Dr. McClintock) customarily used it in the later stages of labor, and could see no objection to its employment. He considered it a most valuable remedy, and not likely to do harm. He agreed with Dr. Barnes as to the use of the forceps in the higher operation. Dr. Roper, of the Royal Maternity Hospital, appeared as the most strenuous opponent of frequent use of the forceps. When used in lingering labor due to inertia, he used ergot at the same time. Although ergot stimulates the uterus to increased action, it does not always succeed in expelling the child. When the influence of the ergot is expulsive, the forceps is not needed. When, however, the uterus under the influence of ergot merely seems to contract upon the child, death will ensue unless the forceps are used to aid expulsion. We cannot expel the child by pressure from without on the fundus, as we can the placenta. Yet these manipulations may excite the uterus to contraction. The forceps may also be used in the opposite variety of cases, where in robust primiparæ the powerfully-acting uterus in the end is unable to overcome the rigidity of the soft parts of the outlet. We are warned by the pains becoming less forcible and frequent, and there is less movement with each pain. Here we should anticipate the occurrence of dead-lock, and supplement the powers of nature before the break-down takes place.

As to the high operation, Dr. Roper had never seen a single case of death, either of child or mother, or of damage to the maternal structures, from a protracted first stage of labor. Of course, it is understood that allusion is made to natural labors, with the exception of a rigid state of the os uteri. A wide distinction must be kept up between a head above the brim which does not come down, because in the one case it is obstructed by the brim itself (a bony obstruction) and in the other by the rigid os aud lower segment of the uterus. In nervous women who bear their pains badly, the forceps may be used with propriety. The forceps are used too frequently, and it is possible that much of the gynæcological work of the present day results from this frequent interference with the natural functions in childbirth. Dr. Roper himself has only used the forceps eighty times in nine thousand three hundred and eighty-nine cases.

Dr. Braxton Hicks spoke of *trismus* of the uterus, where the fœtus is held firmly grasped; and here chloroform may be substituted for the forceps to advantage. This irritable condition of the uterus is sometimes brought on by the too early use of ergot. Occasionally fissures of the cervix occur wi hout the forceps having been used, and occasionally, perhaps, the forceps used high up is blamed for these.

The discussion was then adjourned to a later meeting.—*Med. Times.*

PARACENTESIS PERICARDII.

Dr. John B. Roberts read a paper at the Phila- County Medical Society, (*Med. Times*), entitled "Is Paracentesis of the Pericardium Justifiable?"

Dr. Wm. Pepper said that this operation is one of a group which he had always been inclined to claim for medical men rather than surgeons, as the operation itself is a comparatively trifling one, while the questions of the time for the operation and its conditionu are of the greatest interest and importance. He agreed with Dr. Roberts in his reply to the caption of the paper, and thought that recorded results were sufficient to authorize an affirmative answer to the question.

From observation of post-mortem examinations in which unsuspected pericardial effusions are sometimes found, he had concluded that such large effusions are not infrequent, but that they may be, and doubtless often are, entirely overlooked during life. And yet the physical diagnosis is, as a rule, very simple and easy, the only possible difficulty being in the case of a dilated heart, where there is a feeble, asystolic action of the ventricles, accompanied by extended area of dulness. That this difficulty exists must be admitted, since cases have been reported in which paracentesis of a dilated heart has been performed under the impression that there was fluid in the pericardial sac, and this in the hands of men whose position is evidence that they were competent to decide. Of course, the case is different where the physician has watched the patient from the beginning, as in a case of acute rheumatism, where frequent examination of the heart is required. In such cases he would detect the early friction in the pericardium before the effusion of blood in sufficient quantity to separate its layers. The difficulty in diagnosis would only occur where you are called in to see a case that is fully developed; but even then there are points that would generally prevent a mistake: these are the altered intensity of the sounds, the relation of the cardiac impulse to the